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

Back to School

Greetings fellow MCAAP members! Another summer is behind us and it's time to get back to business. I hope you are rested, because we have several "irons in the fire" to update you on and then a couple of areas where we need your help.

Following many of the themes from last year, the Chapter continues to help shape policy in a number of areas. After our very successful annual meeting, Judy Palfrey's Committee on Children and Youth with Special Health Care Needs is now working with the DPH on its Health Resources and Services Administration (HRSA)-funded Systems Integration Project. Our Immunization Initiative, after successfully securing landmark legislation, is working hard to defend our gains and reduce exemptions. The Mental Health Task Force is building on its successes with MCPAP and post-partum depression screening to bring us MCPAP for Mom's. Munish Gupta and the Committee on Fetus and Newborn are working with the DPH to improve the care of opiate-exposed infants. Steve Boos and the Committee on Abuse and Neglect are forging ties with DCF to help implement recent Child Welfare League of America recommendations. There is really a lot going on and that is just a taste of it.

Also building on last year, your MCAAP Committees continue to strengthen. The Immigrant Health Committee enjoys rapid growth, is working hard on wage theft, and has begun to implement its *Chelsea Wants to Dream* project under a Healthy People 2020 grant. Our Medical Student Committee has successfully developed a succession plan and is a consistent new voice in the Chapter. Karen Sadler and Lisa Dobberteen are newly chairing our School Health

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Sanctuary Cities Protect Children

Five-year-old Laura had come to the hospital for another battery of tests to prepare for bone marrow transplantation (all identifying information changed). She was playful that day, and many hospital staff waved to her or came over to greet her, as she had spent so much time at the hospital since falling gravely ill two years ago. Yet her mother Sarah and I knew that when she is hospitalized again, she will go through many very hard moments before she can eventually go home. The awareness of what's ahead for Laura's next few months was weighing heavily on Sarah.

But she said to me, "I was afraid driving here today. You know what might happen."

Sarah, along with tens of thousands of parents like her in Massachusetts, is afraid of being pulled over by police, because as an undocumented immigrant, she cannot obtain a driver's license. From her small town, she has no other way to bring Laura to the hospital.

Programs like the Obama administration's "Secure Communities," recently ruled unconstitutional by federal courts[1], and reissued with the new name "Priority Enforcement Program," require local police to notify Immigration and Customs Enforcement (ICE) of every arrest, and detain and turn over undocumented immigrants at ICE's request. In some towns, this leads to profiling, arrests for driving without a license, and consequent deportations. I have spoken with many parents who face the choice of risking arrest and deportation for driving their child to the hospital, or of failing to get needed medical care for their child.

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Sanctuary Cities

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Sanctuary cities, or cities with Trust ordinances like Somerville, Massachusetts, address this gut-wrenching choice. Sanctuary cities respond to the fact that fear of police increases insecurity of their communities. They recognize the amply documented fact that immigrants, including undocumented immigrants, commit fewer violent crimes than others of their socioeconomic status[2–4].

Mayor Joseph Curtatone of Somerville issued an executive order last May to curtail cooperation of Somerville police with ICE. Having met some of the children struggling with loss of a parent to deportation, I know that Mayor Curtatone is protecting his city's children from devastating trauma, whose emotional scars may last a lifetime. Those scars affect not only the child whose parent was torn away, but also their cousins, classmates, and neighbors — most of them U.S. citizens. They all feel the same constant fear, whether they are old enough to understand their parents' dread of family breakup, or whether they sense only that the world is a very frightening place.

Sanctuary cities are now being attacked by politicians like presidential candidate Donald Trump, who rhetorically conflate undocumented people with rapists and killers. This is not a partisan issue. It was the Obama administration that escalated deportations to unprecedented levels. In just over five years, President Obama exceeded the 2 million deportations that President George W. Bush administered during his eight years in office[5]. And it was Governor Jeb Bush who said, "The dad who loved their children — was worried that their children didn't have food on the table. […] And they crossed the border because they had no other means […] to provide for their family. […] It's an act of love."[6]

Commentators and politicians cite statistics casting undocumented people as apparently crime-ridden. They fail to mention that reentry after deportation is now the most frequently prosecuted federal offense. Hidden in politicians' rhetoric is the fact that most supposed "criminals" did nothing except go back to where they can make a living for their family, or come back to where their family lives.

"Among unauthorized immigrants sentenced in federal courts in 2012, 68% were convicted of 'unlawfully entering or remaining in the United States,' 19% were sentenced for drug offenses, 7% were sentenced for other immigration related offenses and the remainder (6%) were sentenced for other crimes," the Pew Research Center reports[7]. Criminalization of immigrants is driven by vastly scaled up immigration prosecutions, not by their commission of acts against other people. In contrast, it is their undocumented status that leaves 11 million people in this country, among them the parents of many of our patients, especially vulnerable to become victims of crime, such as wage theft, extortion, and domestic violence. Sanctuary cities and Trust Act legislation aim to reduce the fear among immigrant families, of seeking help from authorities when they are preyed upon, by separating local police work from immigration enforcement.

If all our cities were sanctuary cities, Laura's parents would have to cope only with her illness, and with supporting her through her transplant. They wouldn't fear every day that they might be taken from their child. I hope Mayor Curtatone's vision prevails across the Commonwealth of Massachusetts. Our Immigrant Health committee is asking the Chapter to support the Trust Act[8] and the Safe Driving Bill[9] currently pending in our Legislature. ***— Julia Koehler, MD***

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9. HOUSE DOCKET, NO. 1650. An Act relative to safe driving.

Back to School

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Committee and Greg Parkinson is welcoming Lois Lee this month as co-chair of the Injury Prevention Committee. Legislative, Oral Health, and School Health Committees continue to flourish while the Pediatric Council remains as effective as ever. Again, that is just *some* of what is happening.

At our last annual meeting, we voted to expand electronic voting and, in special cases, to accept members from outside Massachusetts. These are sensible responses to the digital age and should increase both membership and participation. At the same time, the national AAP has launched a Group Membership option that promises to significantly impact states with very large academic institutions — like our own. While the ultimate effects remain to be seen, I'm hopeful that these initiatives, together with the energy generated by our recent successes, will stimulate even greater participation and carry the Chapter into exciting new areas.

But what needs to be done today? The list can be as long as your imagination, but two particular areas where I still need your help are poverty and network adequacy. Poverty has been the subject of my past columns and the Chapter launched several important initiatives last year. Yet the magnitude of the problem calls for "all hands on deck" and what we really need is a continuous flow of new ideas. I invite you, therefore, to send in your thoughts about how the Chapter can best make a difference. The second issue, network adequacy, has proved to be difficult to get at. Over the last year we have developed a dataset and some quantitative tools to explore this, but we still lack the specific examples necessary to turn numbers into advocacy. Many members continue to lament a general decrease in services for children, but we need specific examples help frame the issue. Remember that the MCAAP Pediatric Council, Legislative Committee, and Board are ready and eager to grapple with this issue, so send us your stories!

Finally, as we enter a new academic year, I'll remind you that the Chapter is the kind of "extracurricular activity" where you can quickly make a difference. Please consider joining a committee, running for office, writing for *The Forum*, or simply sending in your ideas **especially if you never have before**. You will always be welcome and we look forward to hearing from you! ***— Michael McManus, MD, MPH, FAAP***

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Saving Lives En Masse: Massachusetts Pediatricians Engage in Public Health Advocacy to Prevent Nicotine Addiction

Pediatricians care deeply about the health of all their patients and expend much effort on preventing harm, disease, and death. Encouraging immunizations, the use of bike helmets, nutritional balance, and other safety precautions are obvious examples of pediatricians directly engaging in public health and prevention. Pediatricians also engage in public health through direct advocacy. Pediatricians are now, more than ever, taking a lead in preventing tobacco use and nicotine addiction. According to the U.S. Surgeon General, tobacco use and nicotine addiction is a pediatric epidemic, with 95 percent of adult smokers starting before 21 years of age. Sadly, 103,000 Massachusetts children alive today will die from tobacco use if we do not take big steps to curb youth access to these dangerous products. Pediatricians are uniquely positioned to work with other advocates and public health leaders to save lives, given the respect they receive from community members and their status in the community.

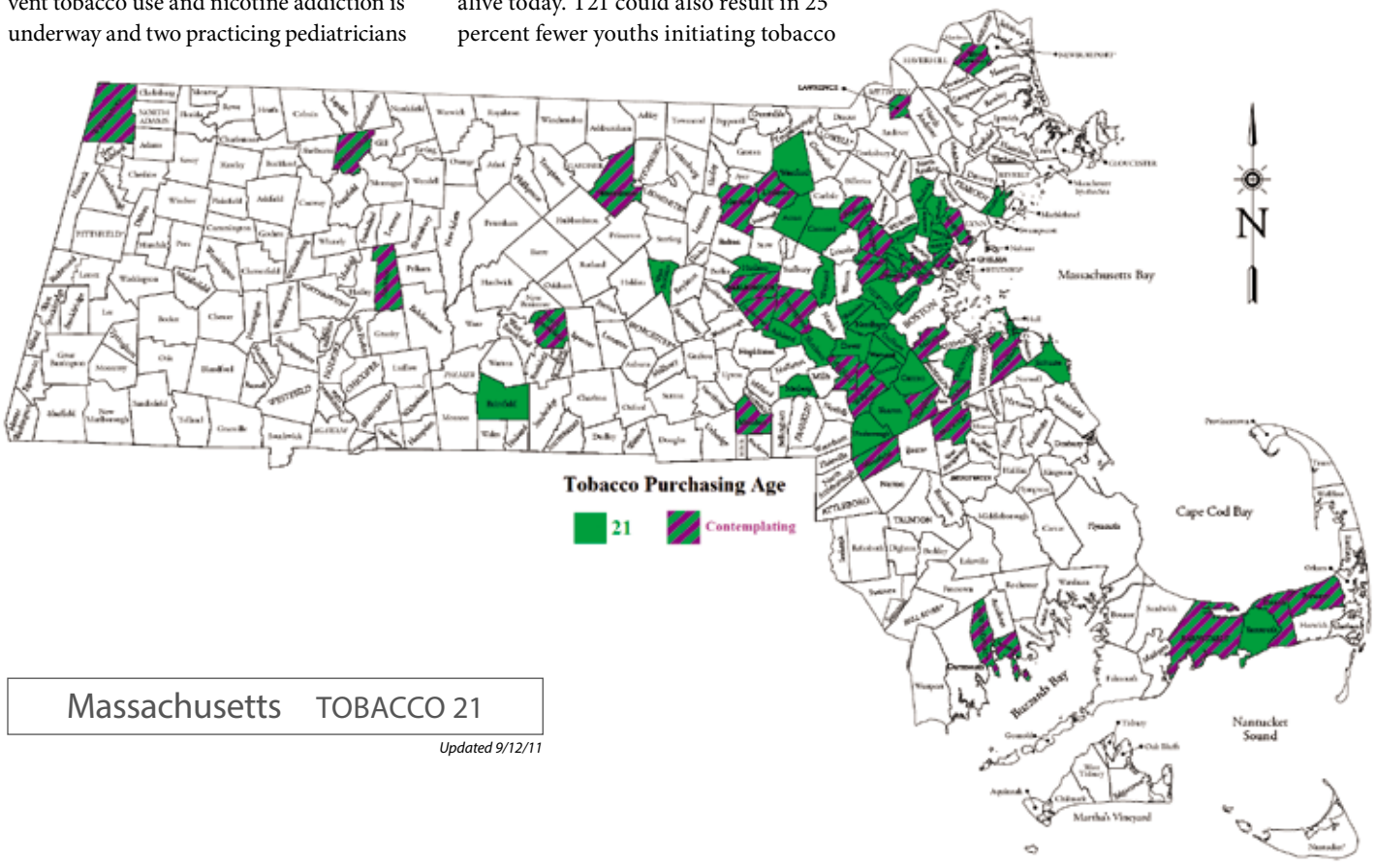
An important statewide effort to prevent tobacco use and nicotine addiction is underway and two practicing pediatricians have been deeply involved as volunteers in this work. Drs. Lester Hartman and Jonathan Winickoff have testified at nearly 100 Board of Health hearings and meetings on the need to raise the minimum legal sales age of tobacco and nicotine products from 18 to 21 years of age. They began the T21 work and have recently formed a partnership with Tobacco Free Mass and state tobacco prevention experts under the T21 campaign (www.mass21.org). As of July 31, 73 cities and towns have adopted T21 to protect the lives of young people.

"Pediatricians can have a particularly important impact in making the case for local policies to prevent tobacco use, including T21, since most of the Boards have physicians, nurses, and other health care professionals and welcome physicians' input," according to Tami Gouveia, executive director of Tobacco Free Mass, the state's tobacco prevention coalition. Pediatricians can reference the recent report by the Institute of Medicine* that predicts that T21 will result in 4.2 million fewer years of life lost for children alive today. T21 could also result in 25 percent fewer youths initiating tobacco use. Cheap, sweet, and easy-to-get products are available in convenience stores across the state. Pediatricians can reference these and other points found at www.mass21.org in letters, email, testimony, and phone calls of support to their local boards of health.

It should also be noted that T21 cannot solve this pediatric epidemic alone. Pharmacies should follow the model of CVS and stop selling tobacco products. Policymakers should close the loophole that allows the sale of flavored cigars and e-cigarettes, and the use of e-cigarettes where the clean indoor air law applies. And funding for the state tobacco control program should be restored so that all communities can update and enforce tobacco policies and laws at the minimum levels. — ***Ken Farbstein, MPP***

If you would like to protect the youths in your community by expressing your views to your local Board of Health, or to learn more, please contact Ken Farbstein, MPP, Grassroots Campaign Coordinator at (781) 635-7646, or Ken.Farbstein@cancer.org.

*The Case Summary of the IOM report is at iom.nationalacademies.org/Reports/2015/TobaccoMinimumAgeReport.aspx.



Massachusetts TOBACCO 21

Updated 9/12/11

DEVELOPMENT CORNER

Importance of Play in Children's Development

Encouraging Playtime to Foster Children's Development

Play is critical for children's development because it provides time and space for children to explore and gain skills needed for adult life. Children's playtime has steadily decreased due to limited access to play spaces, changes in the way children are expected to spend their time, parent concerns for safety, and digital media use. Between 1981 and 1997, the amount of time children spent playing dropped by 25%.[1] During this same time period, children 3 to 11 years of age lost 12 hours a week of free time and spent more time at school, completing homework, and shopping with parents.[2]

Play can be defined as "any spontaneous or organized activity that provides enjoyment, entertainment, amusement or diversion."[3] When children play, they engage with their environment in a safe context in which ideas and behaviors can be combined and practiced children enhance their problem solving and flexible thinking, learn how to process and display emotions, manage fears, and interact with others.[4] Free, unstructured play allows children to practice making decisions without prompted instructions or the aim of achieving an end goal. They can initiate their own freely chosen activities and experiment with open-ended rules.

Social changes and new technologies have greatly impacted the way children play and the amount of free time they are given. Children's playtime continues to decrease as a result of:

- **Emphasis on academic preparation at an early age:** 30% of American kindergarteners no longer have recess.[1]
- **Electronic media replacing playtime:** 8–10 year olds spend nearly 8 hours a day engaging with different media, and 71% of children and teenagers have a TV in their bedroom[5]
- **Less time spent playing outside:** A study following young children's play found that kids under 13 years of age sometimes spend less than 30 minutes a week outside.
- **Perceived risk of play environments:** In one study, 94% of parents cited safety concerns (e.g., street traffic and stranger danger) as a factor influencing where their children play.[1]
- **Limited access to outdoor play spaces:** Only 20% of homes in the United States are located within a half-mile of a park.[1]

As a result of reduced playtime, children are spending less time being active, interacting with other children, and building essential life skills, such as executive functioning skills, that they will use as adults.[6] During well-child visits, health care professionals can inquire about children's playtime and media usage, and provide suggestions to promote quality playtime. The American Academy of Pediatrics recommends health professionals pick two targeted questions to ask parents at well-child visits, such as:

1. The number of hours the child spends engaged in screen time
2. Whether there are digital devices in the child's bedroom[5]

Children's play behaviors may vary based on cultural norms and family preferences. While some cultures emphasize individualism and independent play, others engage in more parent-directed play and activities. This can influence how children play with toys and interact with their peers and family members.[7] To help provide advice to families with different values, styles of play, and communication, health professionals can offer these recommendations from the American Academy of Pediatrics:

- Allow for 1 hour a day of unstructured, free play[5]
- Limit child's media time to less than 1 to 2 hours a day
- No media usage for children under 2 years of age
- Establish "Screen-free zones" by keeping TVs, computers, and video games out of children's bedrooms

- Limit "background media" use during playtime and family activities because it is distracting for children and adults
- Establish a plan for media use (e.g., when and where media is used and length of time child uses media)

Pathways.org is a national not-for-profit dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. To help parents learn about important topics in development and milestones for their child, Pathways.org provides free supplemental materials for well child visits and parent classes. View our new play brochure at http://pathways.org/print to access information created for parents on the importance of children's play. ***— Danielle Dietz, MA, CCC-SLP, and Emmy Lustig***

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ShotClock

National and State Vaccination Coverage Data for the 2014–2015 School Year

"Vaccination Coverage among Children in Kindergarten — United States, 2014–2015 School Year" (www.cdc.gov/mmwr/preview/mmwrhtml/mm6433a2.htm), was published in the *Morbidity and Mortality Weekly Report* (MMWR) on August 28. This information also is posted on CDC's website, **SchoolVaxView** (www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/index.html).

SchoolVaxView provides data, information, and news about school vaccination coverage from state and territory reports of the estimated number of children in childcare, kindergarten, and middle school who have received vaccinations recommended or required by their state. On this site you can learn more about the number of schoolchildren who have received vaccinations, along with other school vaccination topics.

The Massachusetts Department of Public Health (MDPH) has published the 2014–2015 Massachusetts kindergarten and grade 7 immunization survey results by school. The survey results are posted on the MDPH website at the following link: www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/school-immunizations.html#School Immunization Data.

Providers may find this information helpful when talking with parents about immunization and exemption rates in their communities. The availability of this information 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.

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

From the MDPH Immunization Program: Massachusetts HPV Vaccination Report

In July, CDC issued its fourth quarterly Massachusetts HPV Vaccination Report (http://mcaap.org/wp2013/wp-content/uploads/2014/02/Massachusetts_HPVReport_July2015.pdf). This quarter's report focused on the latest 2014 NIS-Teen coverage estimates for adolescent vaccinations.

Key findings from the survey about HPV vaccination rates include:

- In 2014, vaccination coverage increased for both female and male adolescents 13–17 years of age.
- The rates for girls increased by 7 to 14 percentage points depending on the dose in the series. The increase for males was only 2 to 9 percentage points.
- Despite these improvements, only 69 percent of girls and 54 percent of boys have received at least 1 dose of HPV vaccine.
- HPV vaccination rates lag well behind other routinely recommended adolescent vaccines.

MDPH has been working in collaboration with partners across the state to improve HPV vaccination coverage.

Recommendations:

- Give a strong clear, routine recommendation for HPV vaccine in the same way and during the same visit as the other adolescent vaccines.
  - Say: "Today your child is due for 3 vaccines — HPV, Tdap, and meningococcal."
- Use the "HPV vaccine is cancer prevention" message. Parents identify cancer prevention as important in their decision to vaccinate their children.
- Remind parents that the HPV vaccine is safe and effective. Address any questions directly and confidently.
- Don't wait to vaccinate! HPV vaccine is more effective when given at 11–12 years of age.
- Employ other evidence based strategies to improve HPV coverage rates, such as using office systems, immunization registries, and standing orders.
- Assess and vaccinate at all visits to reduce missed opportunities.

Visit the clinician-specific CDC web portal for more resources and materials: www.cdc.gov/vaccines/YouAreTheKey (www.cdc.gov/vaccines/who/teens/for-hcp/hpv-resources.html).

Additional guidance on 9-valent HPV vaccination:

A clinician-specific resource sheet provides additional guidance for use of 9-valent HPV vaccination: www.cdc.gov/vaccines/who/teens/downloads/9vHPV-guidance.pdf.

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

If you have any questions about the report, please contact me or Rebecca Vanucci, our

immunization outreach coordinator at (617) 983-6534 or rebecca.vanucci@state.ma.us.

Thank you again for your ongoing efforts to increase HPV immunization coverage!
— Susan M. Lett, MD, MPH, Medical Director, Immunization Program, Division of Epidemiology and Immunization, Massachusetts Department of Public Health

AAP HPV Champion Toolkit

The American Academy of Pediatrics (AAP) has developed a human papillomavirus (HPV) toolkit for health care professionals, which provides easy access to the best available HPV vaccination resources. This toolkit is intended to help members of the pediatric office team and others to protect children from HPV infections and future HPV-related cancers.

The HPV Champion Toolkit resources include:

- Quality improvement resources
- Answers to frequently-asked HPV questions
- Presentation slides for training activities
- CME and MOC opportunities
- Video clips
- Printable resources
- Articles about HPV

To access the HPV Toolkit, visit: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/HPV-Champion-Toolkit.aspx.

Immunization Initiative Webinar Series Update

The MCAAP Immunization Initiative Webinar Series aims to provide current and timely immunization updates in a medium that is easily accessible during the work day or online at one's own convenience.

Chapter members receive regular webinar updates and registration information via email. If you aren't currently receiving information but would like to, please contact Cynthia McReynolds at cmcreynolds@mms.org or (781) 895 9850.

To access previous webinars, visit http://mcaap.org/immunization-cme/#webinar.

Upcoming Webinars

October 29, 2015, 12:00-1:00 p.m.

2015–2016 Influenza Season Update; MDPH Vaccine Update

Susan Lett, MD, MPH; Medical Director, MDPH Immunization Program

November 19, 2015, 12:00–1:00 p.m.

Vaccine Storage and Handling and Vaccines for Children (VFC) Compliance Training

Robert Morrison, Vaccine Manager, MDPH Immunization Program

December 3, 2015, 12:00–1:00 p.m.

Autism "101"

Alison Singer, Co-Founder and President, Autism Science Foundation

3rd Annual Cervical Cancer and HPV-Related Cancers Summit — November 6, 2015

The 3rd Annual Cervical Cancer and HPV-Related Cancers Summit: Addressing the President's Cancer Panel Recommendation from the National Vaccine Advisory Committee HPV Working Group, will be held from 8:00 a.m. to 2:30 p.m., on Friday, November 6, 2015, at the Dana-Farber Cancer Institute, Boston, Massachusetts. The Summit is a collaborative effort between Dana-Farber, the MCAAP, and the MDPH.

Key topics for this year's Summit include: The President's Cancer Panel Recommendations from the HPV Working Group of the National Vaccine Advisory Group; state, national, and international HPV vaccination and cervical cancer prevention efforts; and updates on HPV-related anal, cervical, head, and neck cancers. Additionally, "Someone You Love: The HPV Epidemic" will be viewed during the Summit. For more information about this documentary, visit www.hpvepidemic.com.

For more information about the Summit, visit www.dana-farber.org/HPVSummit.

Please contact Eileen Duffey-Lind at Dana-Farber (eileen_duffey-lind@dfci.harvard.edu), if you have any questions or need additional information.

Upcoming Immunization Initiative Advisory Committee Meeting

The next Immunization Initiative Advisory Committee Meeting will be held on Wednesday, December 9, 2015, beginning at 6:30 p.m. Dinner will be served.

Please contact Immunization Initiative Program Manager Cynthia McReynolds, if you would like to attend the meeting at cmcreynolds@mms.org or (781) 895-9850.

Immunization Initiative Grand Rounds Seminars

For almost 20 years, the MCAAP Immunization Initiative has worked with pediatric departments to present Grand Rounds seminars on pediatric immunization. Expert faculty address current immunization issues, and also respond to attendees' needs and interests. Most of the presentations will be an hour long. Each participant will receive a packet of handout materials that includes helpful current information, such as recent guidelines on immunization, summary charts, study results, and guides to the office management of immunization.

There have been many recent developments in immunization, including disease outbreaks (measles, mumps, pertussis), new ACIP recommendations, the introduction the Massachusetts Immunization Information System (MIIS), new guidelines for vaccine management in the office, and increasing parental concern about vaccine safety and the immunization schedule.

The seminars have been very well received and have provided attendees with access to current and practical immunization information. Seminar presentations are posted on the MCAAP Immunization Initiative website, http://mcaap.org/immunization-cme, for downloading as a convenient resource.

We are interested in working with your pediatric department or practice to present an immunization update. If you are interested in scheduling an immunization update or would like more information, please contact Cynthia McReynolds of the Immunization Initiative at cmcreynolds@mms.org or (781) 895-9850.

Hunger Is a Child Health Issue

When working with families facing economic hardship in which young children seem to have chronic poor health, iron deficiency, hospitalizations, special health care needs, and/or developmental concerns, pediatric professionals do not always think of the prevalent, invisible, yet very remediable risk of household food insecurity. Household food insecurity (limited or uncertain access to enough food for all household members to live active and healthy lives) has been linked to these negative health and developmental outcomes among children.[1, 2, 3, 4, 5, 6] Children living in households with even marginal levels of food insecurity, who are often categorized as food secure using national standards, are also at risk of adverse health outcomes compared with children in families who do not report hardships in accessing food.[7]

During the Great Recession, food insecurity rates rose alongside unemployment rates. While data from the first half of 2015 show a decline in reports of people struggling to afford enough food,[8] food insecurity continues to remain elevated to above pre-Recession levels.[9] The prevalence of food insecurity is higher than the national average among households with children under 18 years of age and even higher in households with children under 6 years of age.[10] Furthermore, families of children with special health care needs (SHCN) are nearly twice as likely as families of children without SHCN to be at risk of food insecurity.[11]

The AAP recommends that pediatricians screen for food insecurity during clinic visits, refer at-risk households to appropriate resources in the community, and advocate for policy changes that improve food insecurity.[12, 13, 14] Children's HealthWatch validated the Hunger Vital Sign™, a two-question food security screening tool based on the U.S. Household Food Security Survey Module.[15] The Hunger Vital Sign identifies families as at-risk of food insecurity if they endorse that either or both of the following statements is "often true" or "sometimes true" (vs. "never true"): (1) Within the past 12 months, we worried whether our food would run out before we got money to buy more and (2) Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

Many health facilities, recognizing the importance of diagnosing and treating food insecurity, have implemented the Hunger Vital Sign as routine clinical care. Some of these facilities have incorporated it into the Electronic Health Record and all now refer patients to either internal resources, such as on-site food pantries, hospital-based meal programs funded through the USDA Summer Food Service/Child and Adult Care Food Program, hospital-based (Supplemental Nutritional Assistance Program) SNAP and Women, Infants, and Children (WIC) application assistance, or external resources, including referrals to community-based organizations such as the Project Bread FoodSource Hotline (www.projectbread.org/gethelp or (800) 645-8333). A recent Internal Revenue Service (IRS) ruling may spur additional innovative approaches to alleviating food insecurity among patient populations. Recognizing the importance of efforts to improve food security, the IRS allows nonprofit health facilities to claim an exemption on federal tax returns for services related to improving nutrition access.[16] Health facilities across the nation that are using the Hunger Vital Sign have created innovative systems of various sizes and costs for responding to food insecurity. A list describing services provided by health facilities using the Hunger Vital Sign may be found on the Children's HealthWatch website, at www.childrenshealthwatch.org/public-policy/hunger-vital-sign.

— Allison Bovell, MDiv, Stephanie Ettinger de Cuba, MPH, and Deborah A. Frank, MD, FAAP

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BOOK CORNER

Literacy and Brain Development

In April 2012, the World Literacy Foundation issued a report that highlighted the economic and social cost of illiteracy to the global economy.[1] It discussed the causes and issues surrounding illiteracy, the direct link between poverty and illiteracy, the very real and measurable impact literacy has on the growth of an economy, and recommendations for combating the state of illiteracy as it stands in the world today. The findings of this final report stated the cost of illiteracy to the global economy was estimated at 1.19 trillion dollars and the effects of illiteracy are very similar in developing and developed countries. The bottom line of the report was that the majority of illiteracy is preventable, attributable to inadequate resources, motivation, and/or stimulation required to learn to read. Sobering and a tad depressing to the average pediatric clinician and yet we know we have the opportunity to move that trajectory by encouraging parents to read aloud to their children from birth.

Perhaps that statistic of 1.19 trillion dollars has more impact on our thinking than the evidence to date for the power of reading aloud. As clinicians we feel our evidence needs to be based on hard reproducible science and we added more to that foundation in a recent study published by Hutton and colleagues in *Pediatrics* September 2015.[2]

In this very innovative study, the researchers attempted to examine how language networks become "ready" for reading and to what extent they are influenced by home literacy environment or interventions during the critical pre-kindergarten period. In their study, they took a subsample of children 3 to 5 years of age who underwent blood oxygen level dependent FMRI while listening to a story. This task requires the application of emergent literacy skills supporting extraction of meaning of words (semantics) including vocabulary and listening comprehension. The "semantic network" includes left-sided inferior frontal, middle temporal, inferior parietal, and lateral occipital lobes.

They hypothesized that children who were read to more at home previously would show greater activation after controlling for household income. Cognitive stimulation in the home was measured using the preschool version of the StimQ. This measure consists of mostly "yes" or "no" questions and they administered three subscales: *Reading*, reflecting access to books, frequency of shared reading and variety of books read; *Parental involvement* in developmental advance reflecting the teaching of specific concepts such as letters; and *Parental Verbal Responsivity* reflecting verbal interaction. Parents were also asked to report the age of initiation of reading to their child aloud.

The final analysis consisted of 19 children in whom they found that when controlled for household income, higher reading exposure on the StimQ *Reading* subscale was positively correlated with neural activation in the left-sided parietal-temporal-occipital association cortex, a "hub" region supporting semantic language processing. They concluded that in preschool children listening to stories, greater prior home reading exposure is positively associated with activation of brain areas supporting mental imagery and narrative comprehension. The researchers evoke the term "biological embedding" which describes the long-term impact on brain development resulting from the cognitive stimulation and nurturing during early childhood.

Fairly straightforward study: when you "exercise" areas of your brain previously, it is "more capable" to move to the next step. Yet the power of these color images of brains in a journal or newspaper to influence parental behavior is significant because here is "hard evidence" that early language experiences really matter in brain development. So let's start spreading the word: if you want your kindergartener "ready to read," lay the groundwork from birth by reading aloud. If you are interested in making your role more active by giving all parents access to the tools to make reading aloud happen, contact the Reach Out and Read Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or the Massachusetts Coalition Medical Director Marilyn Augustyn at Marilyn.augustyn@bmc.org. ***— Marilyn Augustyn, MD, FAAP***

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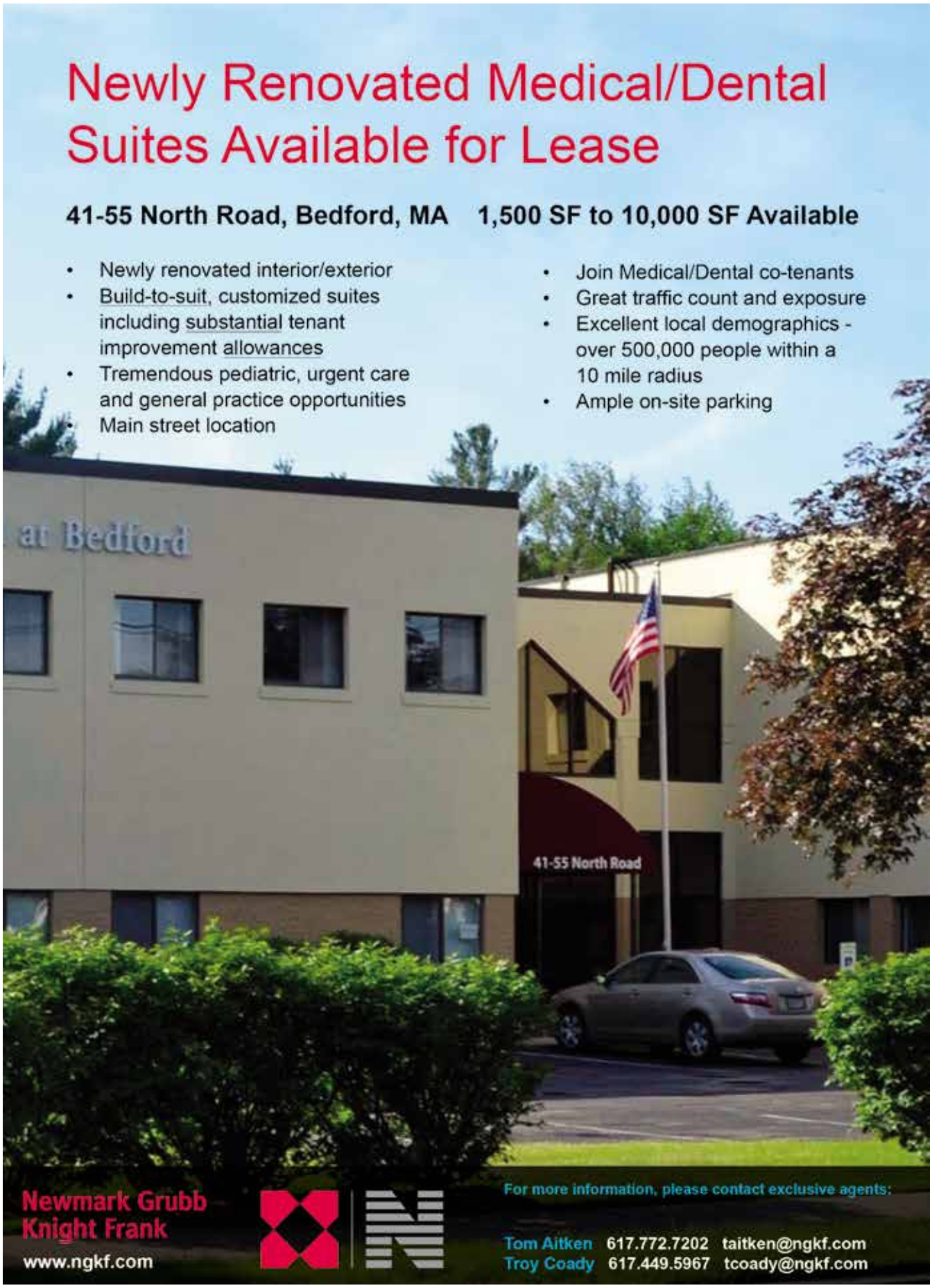

Submissions for the next issue of *The Forum* should be sent to chaggerty@mcaap.org by November 30, 2015.

Medical Students Support the Massachusetts Special Olympics

On June 7, 2015, a group of medical students from across Massachusetts joined forces at Boston University's Nickerson Field to volunteer for the day at the Massachusetts Summer Olympic Games. Though this spectacular event has been taking place for years, this year marked the first year that medical students organized as a group to volunteer.

Approximately 25 students volunteered for morning and afternoon shifts at the Unified Partners event. During this event, individuals with and without intellectual disabilities trained together and competed on the same team on a variety of track and field events. Students volunteered as time keepers, score keepers, photographers, escorts, and even Awards and Results Directors. Despite the competitive nature of the games, the echo of cheers and cheek to cheek smiles seen throughout the day showed just how much fun all the athletes and volunteers were having.

The event was coordinated by the a group of medical students from the Medical Student Committee of the MCAAP with support from John O'Reilly, MD, and Judith Palfrey, MD, doctors who are passionate about helping children with disabilities.

According to Dr. O'Reilly, "I am very happy to know that the next generation of pediatricians will see our kids first as people and competitive athletes rather than as patients with disabilities. I think that everyone who spends time with the athletes will leave with admiration for their efforts and a smile from their shared joy."

Given the success of this event, the medical students have been invited back to volunteer for the Massachusetts Special Olympics for future events. Also, an after-event survey showed that volunteers not only found this to be a rewarding experience but are interested in volunteering again. If you would like to volunteer for the Massachusetts Special Olympics as a volunteer, coach, or even a Unified Partner, please check out the official site at www.specialolympicsma.org/get-involved.

— Aylin Sert, UMass Medical Student

Medical students join forces with Special Olympics volunteers to show their support at the Unified Partners track and field day, June 7, 2015.

MCAAP Resident and Medical Student Activities

RFDASH 2015

Residents and fellows from pediatric residency programs throughout the state joined in an effort to advocate for children during the annual Residents and Fellows Day at the Massachusetts State House (RFDASH) on June 10. The event, founded 10 years ago by residents at MassGeneral Hospital for Children (MGHfC), was organized this year by MGHfC pediatric residents Rachel Sagor, MD; Michael

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2015 RFDASH participants.

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Activities

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Epstein, MD; Molly Wolf, MD; and Aisha James, MD.

Since its inception, the event has allowed residents and fellows to express their support for 27 bills, many of which have been passed and are current Massachusetts law. This year the group advocated for improving earned income tax credit for working families, securing funding for rapid pediatric psychiatric consultation in the primary care setting, and improving regulation of, and limiting underage access to electronic cigarettes. This year's keynote was given by immediate past president of the American Academy of Pediatrics and professor of pediatrics at Harvard Medical School, primary care pediatrician, Dr. James Perrin. The residents also received lobbying and advocacy training from experts in the field, as well as briefings about the bills by area medical professionals, before meeting with representatives to discuss the bills. ***— Rachel Sagor, MD***

Parks4Kids Campaign at Franklin Park 2015

The MCAAP Medical Student and Resident Committees hosted its first Annual Parks4Kids Campaign at Franklin Park in Boston on Saturday, April 11.

MCAAP committee members and a group of teens from Hyde Square Task Force, a local after-school community program, joined together to plant young trees and clear invasives in the 200 acres of woodlands in Franklin Park, a forest oasis in the heart of the city. They also picked up winter litter to help prepare the park for local kids to use this spring and summer.