



PRESIDENT'S MESSAGE

Poverty Protection

As our members and *Forum* readers know, protecting children from the effects of poverty has been an AAP headline priority for the last few years. While the American childhood poverty rate sticks stubbornly around 21 percent, assistance from federal programs drops that figure by nearly a quarter while additional state and local efforts attempt to reduce it further. As pediatricians, we are called to advocate for our patients in many ways, and this often means working to create and maintain these public assistance programs. As your voice in these matters, the MCAAP operates as a 501(c)(6) tax-exempt non-profit organization, which permits engagement in political activities.

To be sure, political advocacy is constant within the Chapter. We continuously generate position papers, provide public testimony, serve as active coalition members, and engage in face-to-face lobbying efforts. We strive to keep our elected officials mindful of the needs of children and to educate them in the impact that their decisions have on our patients. Responsibility for this falls first to our Legislative Committee and ultimately to our Board, all with the knowledgeable guidance of legal counsel, Edward Brennan, Esq. In this manner, the Chapter has long been a political force here in Massachusetts and has accomplished much to improve the lives of children.

As our Legislative Committee and Board direct the Chapter's efforts, they are frequently presented with "gray areas" wherein a specific policy may affect children, but only tangentially or as a small part of a much bigger picture. On these occasions, they must consider the impact of competing legislation, weigh the risk of

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Play as Immunization: Mitigating Stress and Supporting Healthy Development through Collective Impact

Public Health Issue

Play supports healthy child-adult connections, social emotional skills, resiliency, and executive function — making it one of the best *immunizations* we have against toxic stress, anxiety, depression,

and the behavioral issues that impede school success (Folkman and Moskowitz, 2000; Pellegrini and Bohn-Gettler, 2013; Zigler, Singer, and Bishop-Josef, 2004). In

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A family plays in the Climber during *Morningstar Access*, a unique program for children with special or medical needs.

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spite of the empirically proven benefits of play, including school success and stress reduction, many children across income groups in the United States are not currently afforded the time, space, and permission they need to build the foundational skills required to live physically and mentally healthy lives and to reach their fullest potential.

If a child has medical needs, having the time to play and be connected to their communities improves the overall efficacy of the child. Tragically, children with special needs are frequently restricted from participating in many play activities, which further impedes the social engagement they require. It is not just the child that's affected; it is the entire family that is influenced by these conditions. One of the challenges that many families face is interpersonal stress when they experience awkward moments with strangers (Seligman and Darling, 2009). Given the positive effects of play on young children's brain development and the negative effects of play deprivation, the rapid decline in access to play is a critical matter of public health.

Recently, the AAP has urged pediatricians nationwide to communicate the importance of play to families (Ginsburg, 2007; Ginsburg and Milteer, 2012). However, doctors and nurses have limited time with patients, and there is a lot to cover during annual well visits. Working together across sectors, we can achieve greater impact through strategic partnerships and shared resources to directly influence children's access to the benefits of play in everyday life. How?

Focus on Positive Impact

It is widely understood that there are several obstacles to play in young children's lives today. A recent MCAAP newsletter references substantial increases in screen time as one potential contributing factor to the decline in play (Dietz and Lustig, 2015). Parents are also blamed regarding their decisions about children's time use. Middle- and upper-income parents are criticized for over-scheduling and over-protecting their children and placing too much pressure on school success

(Anderegg, 2003; Elkind, 2001; Luthar, 2003; Warner, 2005). On the other hand, low-income families are encouraged to enroll their children in more academic extra-curricular activities (Dearing et al., 2009; Griffith and Smith, 2005; Guryan, Hurst, and Kearney, 2008; Prins and Willson Toso, 2008). It is increasingly unclear what "good parenting" means. This additional pressure and criticism of parents is not useful and can further contribute to overall family stress. By starting with parents' strengths and supporting the positive outcomes of play we can avoid blame.

Form Strategic Partnerships to Support Play

Community- or place-based efforts in supporting children's growth and development are especially important in the earliest learning years (Bruner, 2004). The play experiences that spaces such as children's museums provide "prompt parents and caregivers to explore, pose questions, make connections, exchange information and ideas, and instill in young children not only a love of learning, but also the skills for learning" (Howard, 2013). Creating an accessible and supportive environment is key to increasing children's participation in play (King et al., 2003). At Boston Children's Museum, we take our role in supporting children's healthy mental and physical development very seriously. We have developed key partnerships to make opportunities for play as accessible as possible for all children and adults within the Museum and in neighborhood-based locations such as doctors' offices across the state of Massachusetts.

Morningstar Access at Boston Children's Museum: Mitigating Stress through Special Opportunities for Play

In order to support play opportunities for children with special needs or medical needs and to foster positive social interactions among communities of families, *Morningstar Access* at Boston Children's Museum affords regular opportunities for children and adults to visit the Museum outside of normal business hours. Families can play and learn together when the Museum is much quieter and individualized accommodations are provided.

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Funded by the Liberty Mutual Foundation, *Morningstar Access* happens once per month. Please encourage families with special needs to view dates and register through www.bostonchildrensmuseum.org/morningstar.

Reach Out and Read...and Play: Opportunities for Playful Learning at Doctors' Offices

Finding ways to encourage play in children's everyday lives is critical if we want to affect systemic change. Boston Children's Museum has collaborated with Reach Out and Read to foster opportunities for children to play and learn in waiting and exam rooms. We have designed and distributed 1,200 posters, including two different activities that can be conversation starters in the context of play, fostering adult-child connection, language skills, and creativity.

One poster provides an *I Spy* challenge and the other encourages children and adults to imagine their own story. Office staff in more than 300 Massachusetts pediatricians' offices and health centers will be using these posters to facilitate conversations about the critical importance of play for all children's healthy development, school success, and stress reduction. These posters also provide patients with information about our many ways to save on Museum admission including our Target \$1 Friday Nights (when admission is only \$1 per person) and our EBT discount, a \$2.00 cash admission per guest for up to four people.

If you do not currently have these posters in your offices, please contact us to learn more. To help spread the word about access to hands-on play please direct families to www.bostonchildrensmuseum.org/visit/ways-save.

Conclusion: Given that parents are most directly responsible for decisions regarding their young children's time outside of school, they can be powerful advocates and affect change when given the right support. Through a collective impact approach across multiple sectors, we can take steps to increase play



Mother and daughter play together and practice fine motor skills.

opportunities for all children regardless of family income.

Contact: If you have questions about potential alliances, would like to learn more about brief yet critical play messages and tips you can relay to families, or to share your own "prescription for play" please contact us at juster@bostonchildrensmuseum.org or iwamoto@bostonchildrensmuseum.org.

— **Anna Housley Juster, PhD**

— **Saki Iwamoto, MS, CCLS**

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Developmental Coordination Disorder and Sensory Processing Issues in Children

Developmental Coordination Disorder (DCD) is a common diagnosis for children with motor skill and sensory processing difficulties in the absence of other conditions and learning issues. This disorder affects five to six percent of school-aged children and is more commonly diagnosed in boys.¹

Children with DCD have trouble with both fine and gross motor movements. Very often, parents may describe their child having these motor difficulties:

- Clumsiness — child frequently bumps into other objects or people, trips, and drops things
- Difficulty walking, standing, or balancing
- Problems playing sports or riding a bicycle
- Difficulty with daily living activities — getting dressed, feeding themselves, tying shoes
- Poor posture
- Messy handwriting
- Difficulty learning and applying new motor skills²

Sometimes, there is a sensory component to the disorder. Children with sensory processing/integration differences can have trouble integrating all the information received from their senses to produce coordinated motor movements and perform everyday activities.³ If a child is over reactive to sensory information, they are more sensitive to sensory stimuli than their typically developing peers. Warning signs for over reactive children may include:

- Avoids sensory environments with loud noises and too many bright colors
- Seems fearful or very distracted
- Avoids being touched or engaging in activities with lots of tactile input⁴

Children who are under reactive to sensory information have difficulty perceiving sensory stimuli, which can also affect their behavior and ability to perform daily activities. Warning signs for under reactive children may include:

- Difficulty discriminating orders and tastes

- Using too much force when picking up objects
- Being unaware to pain caused by cuts and bruises
- Engages in sensory seeking behaviors — rough housing or activities with lots of motion such as swinging⁴

Studies show children who have DCD with a sensory component can have difficulty receiving, processing, and integrating visual and vestibular feedback, which contribute to our sense of balance. In one study, children with DCD and typically developing children were asked to stand on their non-preferred leg so researchers could evaluate their balance abilities. The children with DCD showed poorer postural control and were less able to adjust to changes in posture due to slower hamstring muscle contraction and differences in processing sensory information. Balancing requires the use of multiple sensory systems, as well as proper muscle responses and movement strategies. As a way of compensating for differences in muscle contraction, visual, and vestibular feedback, the DCD group swayed their hips to maintain their balance instead of using their legs and ankles to stabilize themselves.³

Differences in sensory processing and motor skill difficulties can extend to children's everyday activities and affect their ability to learn new motor movements needed for playing on a playground, participating in sports, or daily self care.⁵ Activities that require making multiple movements at once and using different senses to coordinate movements can be difficult for children with DCD. To view a checklist to help identify sensory areas of concern, see our Sensory Motor Checklist. Parents can use this to track their concerns and discuss them with their health care professional.

Physical and occupational therapy can be used as one form of treatment to help children improve their motor skills. Treatment approaches vary depending on the child's motor abilities and whether there is a sensory component to their diagnosis. Physical therapists may work on strength building programs to build the child's

muscle strength needed for coordinated motor movements. Common occupational therapy treatments for DCD include taking more of a task specific and cognitive approach to focus on the child's motor learning.¹ Cognitive approaches to therapy may provide children opportunities to practice holding their attention and using working memory to improve their problem solving and motor task strategy. A child's treatment plan varies depending on their needs, and therapists can decide which approach would be the most beneficial.⁶

Medical professionals can ask parents or caregivers additional questions about a child's everyday behaviors and activities to help diagnose DCD. If parents have concerns about their child's sensory processing/integration, most pediatric physical and occupational therapy clinics offer free screenings. An early referral and early intervention can help children reach their fullest potential.

About Pathways.org

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. Medical professionals can contact Pathways.org to receive free supplemental materials to give away at well child visits and parent classes.

View our Sensory Integration/Processing Brochure to provide parents with information on how children use their senses and warning signs of a sensory processing/integration issue. For a free package of brochures to give away to families, please email friends@pathways.org.

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MCAAP Statement on the Chapter's Role in Combating Poverty

The American Academy of Pediatrics adopted Health Equity as a Universal Principle in 2009. The MCAAP fully endorses this principle and is committed to the promotion of health equity for Massachusetts children.

We support our members in providing the highest quality care to ALL Massachusetts children. Furthermore, as pediatricians, we recognize that EVERY child needs:

- Healthy nutrition and activities
- Stable, nurturing relationships
- A safe environment to grow up in
- The education necessary to become happy, productive adults

Poverty and social disadvantage are major threats to the ability of children to have these needs met.

In its 2013 Agenda for Children, the AAP identified poverty as a key leverage point for improving child well-being. Although Massachusetts is America's sixth wealthiest state, it is also one of the most unequal. The Commonwealth ranks fourth in income disparity and more than one in five Massachusetts children live in poverty. In its ongoing activities, therefore, the MCAAP will respond to health disparities and the impact of poverty on Massachusetts children by advocating in the following areas:

1. Economic policies that reduce poverty
2. Proper nutrition and reduction in food insecurity
3. Safe and affordable housing
4. Occupational fairness for parents
5. High quality public education not focused on high-stakes testing

Poverty Protection

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diluting our message, and avoid straying into areas that are beyond our expertise. Most importantly, they must be sure to always represent the consensus of our membership and not their own personal beliefs. Nowhere is this navigation more challenging than in response to the multi-dimensional and politically charged issues of poverty.

In this issue of *The Forum*, therefore, the MCAAP Board offers the draft of a guidance document for you to consider. It sets out reasons why the Chapter should continue to advocate around poverty as well as the general areas in which it might do so. It suggests principles and avoids specifics in order to remain useful for future boards. Although it is the result of considerable rewriting, the document is a committee product and definitely stands to benefit from your individual consideration. Please take a careful look at it, give us your feedback, make suggestions on how to improve it and, most importantly, let us know if this is the direction you expect to see from your MCAAP representatives.

Finally, in recalling our 501(c)(6) status, I would be remiss if I did not also remind you that we have a sister organization with 501(c)(3) status, the Pediatric Foundation of Massachusetts. The Foundation was created to hold and administer charitable grants and contributions apart from MCAAP lobbying efforts and is a vehicle intended to support your interests. It is maintained and available for grants and donations of all sizes and can be useful for projects ranging from a single member's special interest to a statewide public health initiative. In the coming months, look to these pages (and our website) for more on Foundation activities or give us a call today if you would like more information.

Thanks for your continued membership and support. Happy holidays and best wishes for the New Year! — **Michael McManus, MD, MPH, FAAP**



ShotClock

Providers Need to Do Better to Improve HPV Vaccination Rates

Gilkey et al¹ recently published a study examining the strength, timeliness, consistency and urgency of pediatricians' and family practitioners' recommendations for human papillomavirus (HPV) vaccine. Providers were far from stellar in strongly endorsing the vaccine, consistently recommending it, and providing it in a timely fashion based on national guidelines. The study found that about 50% of providers used a risk-based approach instead of recommending the vaccine universally. 27% did not strongly endorse its use and only half recommended same-day administration of the vaccine. 68% of the survey respondents were male and 55% had been in practice for 20 years or longer. 9% did not even stock HPV vaccine in their offices. Data from this study are similar to recent CDC recent data showing that in Massachusetts, one of the leaders in childhood immunizations, only 50% of females and 27% of males have received three doses of HPV vaccine.

Why are these poor numbers so important?

Let's look at a few facts about HPV:

- 3 million people seek care every year for HPV-related diseases.
- 27,000 new cancers are caused each year by HPV.
- HPV is the major cause of head and neck cancers; 11,000 cases of head and neck cancer are caused annually by HPV and these cancers are expected to be more common than cervical cancer by 2020; unlike cervical cancer, there is no current screening test for HPV-related head and neck cancers.
- Nearly 50% of high school students have had penile-vaginal intercourse.

- HPV can be found in women prior to their first vaginal sex.
- HPV can become "dormant" and re-emerge later in life (like varicella virus).
- Procedures to treat cervical dysplasia can increase the chances of delivering premature babies.
- HPV vaccine has been very effective in decreasing genital warts and cervical dysplasias.
- HPV vaccine stimulates higher antibody levels at age 11 than at age 18.
- After 170 million doses worldwide and multiple studies, the vaccine has been proven safe.

We have a safe, effective vaccine that can prevent the most common sexually transmitted disease and several serious types of cancer. Why aren't we more strongly urging our patients to be immunized? I believe there are several reasons that need to be addressed:

Pediatricians and family medicine practitioners haven't always been comfortable talking about sex with young patients and their parents.

Parents are reluctant to accept the fact that their children will someday be sexually active. Discussions about this vaccine often are interpreted as if their children are likely to start having sex when they are 11 or 12 years of age. We need to reframe our discussions around the fact that this is a cancer vaccine; the most important thing that this vaccine will do is to dramatically decrease the chances of getting certain deadly cancers in the future. Just like with other diseases, we give the vaccines before the diseases come along so the children will be protected whenever they are exposed to the disease. Most teens don't think very far ahead when it comes to sexual activity. How many teens have come to your offices and said, "I'm going to start having sex in six months, so immunize me now.?"

Adding another vaccine to an already busy schedule has admittedly been a hard sell.

But we have had hard sells in the past. "I just want to carry my baby home from the hospital," has given way to widespread use of car seats and seat belts with many lives being saved. "This helmet makes me look like a

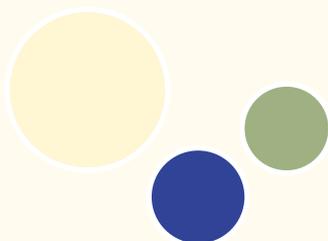
geek," has given way to widespread use of bike helmets — again with many lives saved. "Why should my baby sleep on her back," has given way to "Back to Sleep" campaigns, which have significantly decreased the incidence of sudden infant death syndrome.

Other childhood vaccines have produced almost immediate gratification for pediatricians. The incidence of HB disease, varicella, and pneumococcal disease fell fairly rapidly after introduction of those vaccines. Most recently we saw an incredible drop in rotavirus disease after the introduction of rotavirus vaccine. HPV is different. Yes, there are studies to show fairly rapid drops in the incidence of genital warts in communities that have reasonable uptake of the vaccine, so there may be a herd immunity effect. But the biggest benefit of this vaccine will show up later after patients have graduated from pediatric practices. There will be fewer cervical dysplasias, fewer LEEP procedures to treat the dysplasias, fewer premature births because of compromised cervixes, fewer cervical cancers, and fewer head and neck cancers. All this translates to fewer medical bills and fewer deaths from a preventable disease.

We haven't always had readily available information to share with patients about HPV disease. But now there are great pamphlets, videos, testimonials, and pictures available to educate patients. We have good data to show how early in life people are affected by HPV. There are also now several studies that show how much of an impact our recommendations as providers have on patients' acceptance of vaccines. If we present HPV vaccine as "the gold standard of care" (which it is), and provide a strong recommendation that patients receive the vaccine at the recommended age of 11–12 years of age, we can dramatically improve the future health of our patients. For the immediate and long-term benefits of our patients, we need to redouble our efforts to make sure our patients are immunized against HPV disease. — **Richard Moriarty, MD, FAAP, Co-Director, MCAAP Immunization Initiative**

Reference:

1. Gilkey et al; *Cancer Epidemiol Biomarkers Prev*; 24(11) November 2015



New Shortened Intervals for Postvaccination Serologic Testing (PVST) of Infants Born to Hepatitis B-Infected Mothers

New guidance entitled “Update: Shortened Intervals for Post-vaccination Serologic Testing of Infants Born to Hepatitis B-Infected Mothers” was recently published in *MMWR* (CDC. *MMWR* 2015;64:1118-1120.)

Background

Post-vaccination serologic testing (PVST) should not be performed in infants born to hepatitis B surface antigen positive (HBsAg)-positive mothers until nine months of age to avoid detection of passive antibodies to HBsAg (anti-HBs) due to receipt of hepatitis B immune globulin at birth and to maximize detecting of late HBV infection.

The optimal timing for PVST to detect a vaccine response is generally one to two months after the final dose of the hepatitis B (HepB) vaccine series. Lower levels of anti-HBs are detected when PVST occurs at an increasing time since completion of the final dose in the HepB vaccine series. As a result, the CDC found that some infants were being misclassified as vaccine non-responders, which led to unnecessary re-vaccination (see figure in the new guidance).

The PVST interval after the final dose no longer needs to extend to 18 months to accommodate infants receiving Hib/HepB (Comvax) vaccine, because Comvax has not been available for purchase from Merck in the United States since December 31, 2014.

Recommendations

- PVST (consisting of HBsAg and anti-HBs) should be performed at age 9–12 months of age for infants born to HBsAg-positive (previous recommendation was 9–18 months of age).
- If completion of the HepB vaccine series is delayed in these infants, PVST should occur one to two months after the final dose.
- Infants found to be non-responders should receive a second three-dose series followed by re-testing one to two months after completion of this series.

Benefits:

- Avoids unnecessary revaccination.

- Reduces the time that non-responder infants are at risk for transmission from household contacts with hepatitis B.
- Earlier PVST enables prompt revaccination for those infants needing a second series.

Additional information about perinatal hepatitis B management can be found on the CDC website.

If you have questions about the management of HBsAg-positive mothers and their infants or recommendations related to hepatitis B vaccination, please call the MDPH Immunization Program at (617) 983-6800, and ask to speak to an immunization nurse or epidemiologist.

Thanks so much for your continued efforts to protect our infants from perinatal hepatitis B infection! — *Susan Lett, MD, MPH, Medical Director, Immunization Program, Division of Epidemiology and Immunization, Massachusetts Department of Public Health*

Hepatitis B Birth Dose Honor Roll: Immunization Action Coalition

The Immunization Action Coalition’s **Hepatitis B Dose Honor Roll** recognizes hospitals and birthing centers that have attained 90% or higher coverage rates for administering the first hepatitis B vaccine at birth. The MCAAP Immunization Initiative and the Massachusetts Department of Public Health Immunization Program congratulate the following Massachusetts hospitals and birthing centers for joining the Immunization Action Coalition’s **Hepatitis B Birth Dose Honor Roll**:

- **Beth Israel Deaconess Medical Center, Boston, MA**
Reported a coverage rate of 91% from 10/1/14 to 9/30/15.
- **Boston Medical Center, Boston, MA**
Reported a coverage rate of 94% from 1/1/2013 to 12/31/2013.
- **Falmouth Hospital, Falmouth, MA**
Reported a coverage rate of 93% from 10/1/2013 to 10/31/2014.
- **Hallmark Health System/Melrose Wakefield Hospital, Melrose, MA**
Reported a coverage rate of 96% from 5/1/2013 to 4/30/2013 and 98% from 6/1/2014 to 5/31/2015.

- **Holy Family Hospital, Methuen, MA**
Reported a coverage rate of 96% from 1/1/2013 to 12/31/2013 and 94% from 1/1/2014 to 12/31/2014.
- **Lawrence General Hospital, Lawrence, MA**
Reported a coverage rate of 97% from 1/1/2014 to 12/31/2014.
- **Morton Hospital, Taunton, MA**
Reported a coverage rate of 93% from 1/1/2014 to 12/31/2014.
- **Signature Healthcare Brockton Hospital, Brockton, MA**
Reported a coverage rate of 98% from 4/1/2013 to 3/31/2014.
- **Sturdy Memorial Hospital, Attleboro, MA**
Reported a coverage rate of 99% from 8/1/2013 to 7/31/2014 and 90% from 7/1/2014 to 7/31/2015.

Please visit the Hepatitis B Birth Dose Honor Roll web page to see these institutions, along with other institutions across the country, and their exceptional efforts to protect infants from perinatal hepatitis B transmission (www.immunize.org/honor-roll/birthdose/honorees.asp).

Has your hospital or birthing center attained coverage rates of 90% or higher? If yes, we encourage you to apply to be included on the Hepatitis B Birth Dose Honor Roll. Instructions for submitting an application for your hospital or birthing center can be found at www.immunize.org/honor-roll/birthdose.

20th Annual MIAP Pediatric Immunization Skills Building Conference: October 15, 2015

More than 450 nurses, physicians, and community outreach and public health personnel attended the 20th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference. The Conference included both plenary and breakout sessions, as well as a viewing of the documentary, *Invisible Threat*.

MIAP Conference Awards were presented to Mary Conant-Cantor, RN, BSN, Belmont Public Schools, and Gina Destrempe, BSN, RN, UMass Lowell Health Services. Ms. Conant-Cantor was recognized for her leadership in the pediatrics community, commitment to childhood immunization and longstanding dedication to improving



Addressing Vaccine Hesitancy and Refusal Breakout Session, 20th Annual MIAP Pediatric Immunization Skills Building Conference. From left to right: Rebecca Vanucci; Verona Charles, RN; Rebecca Perkin, MD, M.Sc.; John Snyder, MD, FAAP.

the health of Massachusetts children. Ms. Destrempe was recognized for her leadership in the college community, commitment to immunization, and compassionate administration of vaccines.

Williams Adams, MD, FAAP, was also recognized as the 2015 Massachusetts CDC Childhood Immunization Champion Awardee.

MIAP thanks the following speakers for their outstanding presentations: *Plenary Sessions*: Susan Lett, MD, MPH; Nancy Messonnier, MD; Pejman Talebian, MA, MPH; JoEllen Wolicki, BSN, RN, Nurse, Educator, CDC; *Breakout Sessions*: Tricia Charles, BA; Verona Charles, RN; Hillary Johnson, MHS; Kimberly Lay, MS, MPH; Robert Morrison; Rebecca Perkins, MD, M.Sc.; Marie Regis; Ron Samuels, MD; John Snyder, MD.

MIAP also thanks Sanofi-Pasteur for an unrestricted educational grant in support of the conference.

Finally, MIAP thanks conference exhibitors Sanofi Pasteur, Berlinger, Inc., GlaxoSmithKline, MedImmune, Merck & Co., Inc., and Pfizer, for their support of the conference.

The conference presentations, both plenary and breakout sessions have been archived and can be downloaded at <http://mcaap.org/immunization-cme/#Conferences>.

Universal Availability of State-Supplied HPV and MVC4 Vaccines

In October, the Massachusetts Department of Public Health (MDPH) announced the expanded availability of human papilloma virus (HPV) vaccine and meningococcal conjugate four-valent (MCV4) vaccines effective November 1, 2015, for all children through 18 years of age regardless of insurance status.

This change in vaccine supply policy builds on the availability of hepatitis A, Tdap, and varicella vaccine for catch-up immunizations, universal pediatric flu vaccine, and meningococcal B vaccine for high-risk children previously announced. With these vaccine supply policy updates, MDPH now universally supplies all ACIP routinely recommended pediatric vaccines.

Vaccine Ordering

When placing vaccine orders for HPV and MCV4 vaccines, please order only those additional doses that you plan to administer during the next two months. As you administer doses, MDPH will approve replacement orders based on doses administered during the previous month.

Insurance Considerations

MDPH is asking insurance companies to continue to reimburse providers that privately purchased these vaccines for up to six months or until their private supply is depleted.

For additional information regarding state-supplied vaccine availability please see the updated Childhood Vaccine Availability Table which is also available on MDPH's website at www.state.ma.us/dph/imm under Vaccine Management.

If you have questions regarding this new policy, please contact the MDPH Vaccine Unit at (617) 983-6828.

Reminder: Pharmaceutical Grade Refrigerators are Required for Primary Vaccine Storage Units in 2016

In the January 2015 Guidelines for Compliance with Federal and State Vaccine Administration Requirements document, it indicated that beginning in 2016 the Massachusetts Department of Public Health (MDPH) will require all pediatric practices (any site that administers at least some vaccine to those <19 years of age) to have pharmaceutical grade refrigerators for their primary vaccine storage unit in their facility. Stand-alone freezers that are not pharmaceutical grade will be acceptable as long as they maintain the proper storage temperature.

Although there is no specific description of a pharmaceutical grade refrigerator, some of the characteristics include:

- Internal overhead fans to disperse cold air throughout the unit, eliminating cold pockets of air;
- Adjustable wire shelves to allow better air flow;
- No storage bins, or shelves on door;
- Typically, pharmaceutical grade refrigerators have a narrow operating range (less than 2 Celsius degrees or 3 Fahrenheit degrees).

Listed below are a sample of manufacturers and distributors that you may wish to consider for safe vaccine storage in your practice. **Please note that the MDPH cannot endorse or recommend specific products or brands.**

Aegis

www.aegisfridge.com

American Biotech Supply

www.americanbiotechsupply.com

Fisher Scientific (Isotemp)

www.fishersci.com

Helmer

www.helmerinc.com

Migali Scientific Refrigeration

www.migaliscientific.com

Tempure

www.tempurescientific.com

MDPH, through a grant funded by the Centers for Disease Control and Prevention (CDC), has determined that most standard domestic combination refrigerator/freezer units are inappropriate for vaccine storage. In addition, many stand-alone refrigerators

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BOOK CORNER

Seeing Clearly

As pediatric clinicians we are often proud of our abilities to recognize and practice preventative screening; to be so attuned to the milestones of our patients that we are able to support families through the touchpoints of development and help them prepare for “what is coming next.” Unfortunately, in one realm — vision — we may be missing opportunities to intervene at the earliest points. Vision impairments are common conditions among young children, affecting 5 to 10 percent of all preschool-aged children and can have a long-term impact on a child’s developmental trajectory if not identified

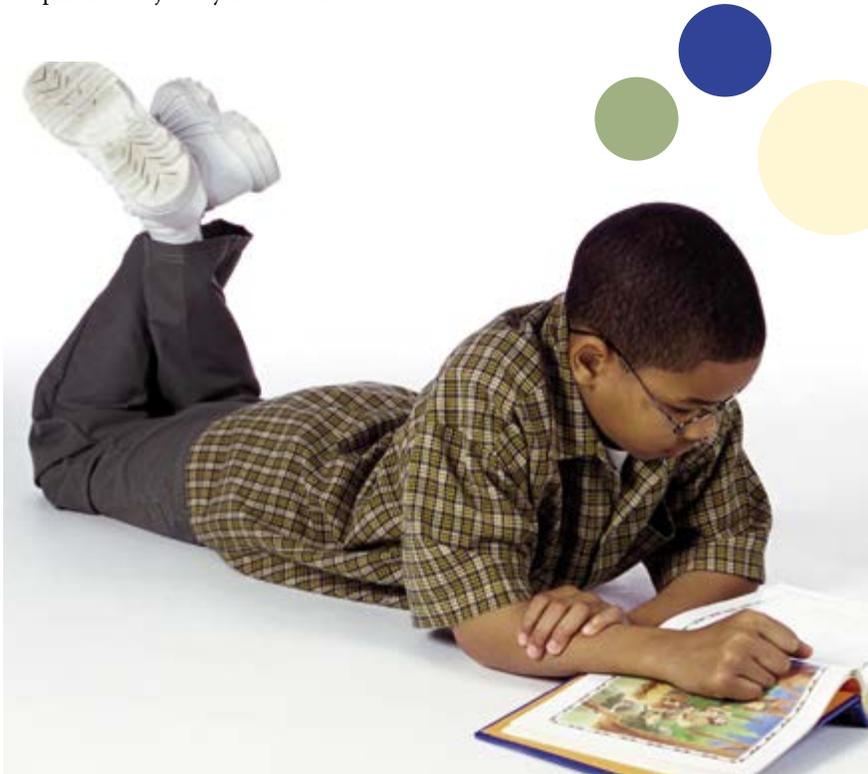
early. Recent focus on vision screening sparked by the National Center for Children’s Vision and Eye Health at Prevent Blindness (<http://nationalcenter.preventblindness.org>), has sparked many of us to reexamine what we *think* we know about child visual development.

In a recent review article in *Current Ophthalmology Report* (Hyvarinen L, Walthes R, Jacob N, Nottingham CK, Leonhardt M. 2014;2(4):142-149.), the authors summarize typical visual development with an emphasis on five critical milestones in the first year. The first mile-

stone is vision in the newborn period. In this area it is important to closely monitor those children at high risk, including prematurely born infants, children with brain damage during or soon after birth, children with epilepsy and children with all disorders causing hypotonia especially Downs syndrome.

The second milestone involves eye contact and early interaction. Recall a newborn infant’s visual system is tuned to detect social stimuli such as faces and biological movement during the first and

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Are you screening for Postpartum Depression (PPD)?

New MCPAP for Moms toolkit available at www.MCPAP.org with additional help for PCPs.

Toolkit now includes information about SWYC/MA to allow PPD screen that will be paid for by MassHealth.



ShotClock

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that are not pharmacy grade lack the necessary features for the safe storage of vaccines. As a result, MDPH is requiring the use of pharmaceutical grade refrigerators for the primary vaccine storage unit. Providers who do not transition to these refrigerators will be recorded as not meeting MDPH Immunization Program requirements during VFC provider site visits beginning

next year. These sites will then be required to receive follow-up contacts to ensure an appropriate storage unit is obtained. In addition, as part of the MDPH Restitution Policy, providers may be held financially responsible for vaccine loss due to negligence. This could be significantly more than the cost of a pharmaceutical grade refrigerator.

Exposing vaccines to freezing temperatures is the most common risk to the potency of refrigerated vaccines. It is impossible to

visually determine if a vaccine has been exposed to a freezing temperature. If this vaccine were to be administered, it may not prevent the disease. MDPH wants to ensure this never happens. With the use of continuous temperature monitoring digital data loggers and the appropriate storage equipment, we can all be more confident with vaccine potency and efficacy.

If you have questions, please contact the MDPH Vaccine Management Unit at (617) 983-6828.

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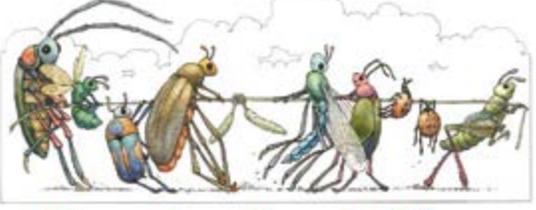
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2016 MCAAP Call for Nominations

The MCAAP 2016 election will fill vacancies on the Executive Board for vice president, secretary, treasurer, and congressional district representatives in Districts 1, 2, 3, and 8. Individuals are eligible if they are voting members of the chapter and live or work in one of the vacant districts.

Please send names of nominees to Cathleen Haggerty via email at chaggerty@mcaap.org, or fax them to (781) 895-9855. You may mail nominations to 860 Winter Street, Waltham, MA 02451. Also, please contact Cathleen if you have any interest in serving on the MCAAP Nominating Committee. Nominations must be received by February 29, 2016.

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



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JOB CORNER

Job Posting

DrumHill Pediatrics is seeking a full time/part time BE/BC Pediatrician to join our thriving practice in Chelmsford, MA. DrumHill Pediatrics is a family oriented, modern, state-of-the-art, fully electronic office with an in-house diagnostic state certified laboratory. Tufts Hospital for Children subspecialty clinics are located adjacent to the practice. More information regarding the practice can be found at www.drumhillpediatrics.com. Interested candidates should please contact Dr. David Newman: (617) 529-9667 or drumhillpediatrics@hotmail.com.

Looking to Hire or Be Hired?

Job listings are a free service provided by *The Forum* to MCAAP members and residents completing their training. Nonmembers may submit ads for a fee.*

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

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

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

Forum Editor Position

If you are an MCAAP member and interested in becoming the editor of *The Forum*, please contact Cathleen Haggerty at chaggerty@mcaap.org for more details.

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Seeing Clearly

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second month. At the age of six weeks typically developing infants have stable eye contact with his or her parents. If no enjoyable contact occurs by the age of eight weeks, the infant should be referred to an ophthalmologist for assessment of vision. Every parent is focused on the first social smile but the role of vision in this development can sometimes be forgotten.

The final three milestones can often be overlooked as they are considered part of other developmental changes in the first year. The third milestone involves awareness of hands, motor function, and anticipation. Children focus on their hands because the little fingers are seen as a gratifying pattern that is one of the most effective stimuli for the visual system. The fourth milestone is the recognition of faces, moving and form perception and the fifth, which is the most difficult to moni-

tor in primary care, matching abstract forms. Together these five milestones help clinicians monitor the healthy visual development of infants and toddlers.

So what does this have to do with books? You guessed it — use the book as a first entry point into talking about and looking at the child's vision. If you begin the discussion about early literacy in the first six months, start the conversation about what parent's think their baby sees? If you wait till the six-month visit to begin the discussion, use this as an entry point to talk about focus on faces and abstract forms. Whatever approach you use, seize the moment — your patient's visual development is depending on it!

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