



## PRESIDENT'S MESSAGE

### A Strategic Refresh for MCAAP

Last week, the Chapter appointed two resident members (and MGH pediatric residents), Aisha James and Caitlin Naureckas, to provide representation to the Massachusetts Coalition to Prevent Gun Violence. The coalition is an umbrella organization that was formed in 2013 after the Sandy Hook Elementary School shooting in Newton, Connecticut. Its purpose is to bring together numerous regional and national organizations to provide education and advocacy to address the gun violence epidemic. The coalition's purpose is certainly consistent with the mission of the Chapter to support "...the attainment of optimal physical, mental, and social health for all infants, children, adolescents, and young adults." To the extent that the Chapter's Coalition representation is a group appointed for a specific Chapter function, it is essentially an additional committee — at last count, one of 28...we think...

Over the last year, Liz Goodman, Chapter vice president, undertook a tremendous challenge: an inventory and analysis of the Chapter committees. She found 27, but it's very possible that there could be a few dormant groups lying in wait for the reappearance of a significant issue affecting children in the Commonwealth. The "committees" take on many forms: some are executive board sub-committees (bylaws, CME, membership, nominating); others are well-established groups addressing important issues (e.g., child abuse, children with special health care needs, immigrant health, legislation, medical students, oral health, school health); and others consist of one to several individuals who are "Go-To" experts in

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## LEAPing Forward to Help Prevent Peanut Allergy

*(This article was modified from an original posting on MassGeneral Hospital for Children News and Atrius' "the Wire," written by Michael Pistiner, MD, MMSc.)*



For over a decade, many pediatricians followed the guidelines set forth by the American Academy of Pediatrics, telling families to delay the introduction of highly allergenic foods, like peanuts, to children at risk of developing food allergies. In early 2015, the landmark **LEAP (Learning Early About Peanut)** study demonstrated that the prior recommendations may have missed the mark. Gideon Lack and

colleagues performed a large prospective study on infants at risk of developing peanut allergy (severe eczema and/or egg allergy). They found that in this high-risk group, early introduction of peanut-containing foods between 4 and 11 months of age could drop the risk of developing peanut allergy by 80 percent! This about-face offers an amazing, yet challenging

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Photo by Lisa Dobberteen, MD, FAAP, 2017

## EDITOR'S NOTE

### Teachable Moments

My mother used to say, “It all comes down to manners.” I often wonder what she would think about current events in our country today? The lack of civility in social discourse is dramatic; the graphic incitement of violence against others is horrific.

Children are very aware. Even with the most careful supervision and limitation of screen time, frightening images such as the marchers in Virginia carrying torches and chanting racist and anti-Semitic slogans are pervasive. Children who’ve been shielded from the graphic images themselves may hear others talking about them at school.

The reality of Hurricane Harvey, as well as images of families stranded in the flooded areas of Houston and surrounding towns, has also been distressing to children and adults as well. At press time, the sun has finally come out in Houston and the long process of rebuilding their lives has begun for many Texas families. We stand in solidarity with our Texas colleagues and their patients, and hope for enough courage, resources, and faith to support them in every way. See the AAP statement at [www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Statement-on-Hurricane-Harvey.aspx](http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Statement-on-Hurricane-Harvey.aspx).

How can we, as professionals who care deeply about children, best support parents and children and answer their questions about what is happening today? Some of the images and events are more than overwhelming for us as adults.

Parents may be afraid to ask or even unsure of how to open the conversation.

I’ve found an open-ended question such as “has your family been affected by some of the recent events here and elsewhere?” to be a good conversation opener. It conveys to families you are willing to listen to their concerns. They may not even realize how much events have affected their children, but we know children will often display symptoms involving sleep, appetite, and emotional regulation, when influenced by current events.

The AAP has great resources for talking to children about difficult subjects. HealthyChildren.org, the AAP’s website for parenting information, is a trusted source for parents and caregivers. For additional information, you can visit [www.healthychildren.org/English/family-life/Media/Pages/Talking-To-Children-About-Tragedies-and-Other-News-Events.aspx](http://www.healthychildren.org/English/family-life/Media/Pages/Talking-To-Children-About-Tragedies-and-Other-News-Events.aspx).

It is always important to remind parents that they are their children’s first, and most important, teachers and role models. Whether it’s modeling participation in a march to demonstrate our values of free speech, contributing to disaster relief, or the importance of putting cell phones away so as to be present during pediatrician visits and family mealtimes — children are always watching. In big and little ways, we can encourage families to take advantage of teachable moments, whenever and however they may arise.

— *Lisa Dobberteen, MD, FAAP*

## A Strategic Refresh for MCAAP

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strategic areas (e.g., breastfeeding, emergency management, environmental health, fetuses and newborns, injury prevention, tobacco control). Some are tremendously active with monthly meetings, while others are “standing by,” awaiting key activity.

The Chapter is fortunate to have so many willing and capable members. Additionally, past leaders remain involved to provide direct support or an experienced perspective whenever requested. It is not unusual to have several past Chapter presidents, or even past AAP presidents, present at a board meeting. Even with such robust participation, there are other members who have something substantive to offer as well to improve child health. There is also an opportunity to improve the Chapter’s effectiveness with better organization and processes.

Five to six years ago, the Chapter engaged in a strategic planning process to respond to these issues. I think that it’s time for a refresh. Consistent with its mission, the most important opportunities relate to our ability to advance the health of children in the Commonwealth. Beyond that, are we optimally supporting our members in their professional



practice in a way that they can effectively advance children’s health? How about their personal well-being? Finally, are the Chapter structure and processes set up in a way that a volunteer organization, supported by tremendously capable administrative staff, can best achieve its mission?

Over the next several months, we’re going to address these issues. This could easily be an interminable process, but we’re not going to let that happen. We will need to be smart about how we carry this out. We’ll have to generate lists of high impact priorities, and as with good quality improvement practice, we will need to

identify measurable outcomes and key drivers of success.

Liz’s work provides us with a tremendous starting point, but the executive board will need member input. A key component of any strategic planning process is a needs assessment, and we will be reaching out to all of you for help as we work to make ourselves better prepared to respond to the child health challenges of coming years. — **DeWayne Pursley MD, MPH, FAAP, president, MCAAP**

For more information on Chapter activities, or to become involved, please contact Cathleen Haggerty, executive director, MCAAP, at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).

## 2017–18 Influenza Season Recommendations

In the August 25 issue of *Morbidity and Mortality Weekly Report (MMWR)*, the Centers for Disease Control and Prevention (CDC) published “**Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2017–18 Influenza Season**” ([www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm?s\\_cid=rr6602a1\\_w](http://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm?s_cid=rr6602a1_w)). This report updates the 2016–17 recommendations of the Advisory Committee on Immunization Practices (ACIP) regarding the use of seasonal influenza vaccines.

Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. A licensed, recommended, and age-appropriate vaccine should be used.



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## New AAP Policy on Transition to Adult Care — What You Need to Know

This month, the American Academy of Pediatrics released an updated policy on transitioning to adult care, which can be viewed at <http://pediatrics.aappublications.org/content/early/2017/08/17/peds.2017-2151>.

Unlike previous policies, this statement does not name a specific age for patients' transfer out of pediatrics. Rather, the policy encourages pediatricians, health care systems, and payers to be flexible in their approach to young adults, especially those young adults with special health care needs. The authors call for an update to *Bright Futures* to develop guidelines for the care of patients in their 20s.

Although there may be flexibility on the age of transfer to adulthood, there remain several best practices to facilitate a comprehensive, planned, and patient-centered transition. The Maternal Child Health Bureau's **Got Transition** program ([www.gottransition.org](http://www.gottransition.org)) offers the following guidance:

1. Develop a transition policy, which can facilitate conversations between patients, families, and staff. The policy should include the practice's overall approach to adolescent care.
2. Create a registry of high-risk patients to monitor their progress in preparing for adult care. Many Electronic Health Records include population health management tools that facilitate registry development.
3. Assess for adolescent developmental milestones, just as you would assess for young child development. Several tools are available through the Got Transition website.
4. Assist your patients with planning for adult life, including changes to insurance status, as well as educational/vocational needs. Massachusetts has several online resource directories that are freely available. INDEX, a service of the Eunice Kennedy Shriver Center at UMass, offers an online directory of resources for people with disabilities (<https://disabilityinfo.org>). HelpSteps, developed by pediatrician Dr. Eric Fleegler at Boston Children's Hospital,



provides information on a variety of community-based programs ([www.helpsteps.com](http://www.helpsteps.com)).

5. Actively guide your patients in their transfer to an adult provider. Pediatricians should provide specific recommendations for adult practices, as well as assistance with transferring records. Families can be encouraged to maintain a portable medical summary that highlights the patient's care needs; examples can be found on the Got Transition website. For patients with special health care needs, the pediatrician should give a warm handoff to the receiving adult provider, whether via email, phone call, or a typed clinical summary.

6. Check in with your patients after they transfer care. Feedback on the transition experience can improve care of other patients and families. Consider involving your patient advisory board to help create your practice's approach to transition care.

We all want what's best for our patients as they age out of our care. The transition to adulthood should be flexible, comprehensive, and patient-centered. Successful transitions are possible!

— *Kitty O'Hare, MD, FAAP, Weitzman Family BRiDGEs Adult Transition Program, Boston Children's Hospital, Brigham and Women's Hospital, [frances.ohare@childrens.harvard.edu](mailto:frances.ohare@childrens.harvard.edu)*

## LEAPing Forward to Help Prevent Peanut Allergy

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opportunity to decrease peanut allergy prevalence and stop a food allergy before it begins.

### Give babies peanut? What do the experts say?

In response to the LEAP findings, the National Institute of Allergy and Infectious Diseases, commonly known as NIAID, created an expert panel to develop comprehensive recommendations and update existing guidelines. The panel released the Addendum Guidelines for the Prevention of Peanut Allergy in the United States in February 2016. Three guidelines, each applied to a different infant risk group, were released: **high, moderate, and low risk.**

- **High Risk:** Infants with severe eczema and/or egg allergy should have age-appropriate forms of peanut introduced at 4 to 6 months of age, or as soon as possible if delayed, after appropriate screenings. These could include an evaluation with possible skin testing and oral challenge or supervised feeding performed by allergist; or negative immune-cap-specific IgE to peanut only, if poor access to an allergist. Prior to feeding, other age appropriate solids should already be tolerated.
- **Moderate Risk:** Those with mild/moderate eczema do not require allergist evaluation or any prior testing. Keeping in mind family and cultural practice and preference, these children should have age appropriate forms of peanut introduced around 6 months old. If caregivers or health care providers desire a supervised feeding, allergist evaluation, or both, then the family should request an allergy referral.
- **Low Risk:** Infants without eczema or any food allergy. Without screening, they can have age-appropriate forms of peanut introduced into their diet together with other solids in accordance with family and cultural preferences and practices.

### Sounds easy enough, but how do we implement this in practice?

Pediatricians must be familiar with current NIAID Addendum Guidelines to properly screen for risk factors. Infants



appropriately identified will require access to testing and board-certified allergists comfortable with treating infants.

Allergists should also ensure their teams are familiar with the recommendations and are equipped to caring for infants. They must prioritize at-risk children and have access to oral food challenges in a timely fashion and in a safe environment. Strong collaborations between primary care pediatrics and allergists are key to successfully implementing the NIAID guidelines.

The ability to perform food challenges in a timely manner is vital to a child's future success. This important systemized procedure is the gold standard to determine if a person is truly allergic to a food.

In most cases, a food challenge helps determine that a patient is not allergic and can safely eat a food without experiencing a reaction. These procedures necessitate appropriate space for observation and treatment of allergic reactions, if needed, in addition to well-trained staff.

### What's beyond LEAP?

Very important questions come up when implementing these new guidelines that the Food Allergy Prevention Program will work through:

- What about other foods, like tree nuts?
- What if kids are older than 1 year?

- What if a sibling or parent has a peanut allergy?
- What if kids have other food allergies?

Learning as we LEAP: This is an exciting time and together we will LEAP forward to prevent peanut allergy.

— **Michael Pistiner, MD, MMSc**

For more information, contact Michael Pistiner, MD, MMSc, director of Food Allergy Advocacy, Education and Prevention for Mass General Hospital for Children's Food Allergy Center at [mpistiner@partners.org](mailto:mpistiner@partners.org).

He has special interests in infant food allergy management, family and pediatrician food allergy and anaphylaxis education, as well as facilitating collaborations between pediatric allergists and pediatricians. Dr. Pistiner has worked closely with pediatric teams to implement the National Institute of Allergy and Infectious Diseases (NIAID) peanut feeding guidelines/recommendations. He is a fellow in the American Academy of Pediatrics, where he is a member of Section on Allergy Immunology Executive Committee, Council on School Health and the Massachusetts Chapter of the AAP. He is also a member of the American Academy of Allergy Asthma and Immunology and the American College of Allergy, Asthma and Immunology. Additionally, he serves on the medical advisory board of Asthma and Allergy Foundation of America, New England Chapter and is a voluntary consultant for the Massachusetts Department of Public Health School Health Service Unit.

#### Resources

Complete Addendum Guidelines ([www.niaid.nih.gov/sites/default/files/addendum-peanut-allergy-prevention-guidelines.pdf](http://www.niaid.nih.gov/sites/default/files/addendum-peanut-allergy-prevention-guidelines.pdf))

Addendum Summary for Clinicians ([www.niaid.nih.gov/sites/default/files/peanut-allergy-prevention-guidelines-clinician-summary.pdf](http://www.niaid.nih.gov/sites/default/files/peanut-allergy-prevention-guidelines-clinician-summary.pdf))

Addendum Summary for Parents and Caregivers ([www.niaid.nih.gov/sites/default/files/peanut-allergy-prevention-guidelines-parent-summary.pdf](http://www.niaid.nih.gov/sites/default/files/peanut-allergy-prevention-guidelines-parent-summary.pdf))

Instructions for Parents and Caregivers on Feeding Peanut Protein to Your Infant ([www.niaid.nih.gov/sites/default/files/addendum\\_guidelines\\_peanut\\_appx\\_d.pdf](http://www.niaid.nih.gov/sites/default/files/addendum_guidelines_peanut_appx_d.pdf))

Annals of Allergy, Asthma & Immunology. Feb.17;118(2): 166–173e7.

# ShotClock

## Immunization Administration by Certified Medical Assistants

In November 2016, a Massachusetts law relating to the administration of immunizations by Certified Medical Assistants (CMA) became effective (<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section265>).

In December 2016, the Massachusetts Department of Public Health (MDPH) published a Circular Letter (DCP 12-12-664) regarding the new law ([www.mass.gov/eohhs/docs/dph/quality/boards/nursing/immunization-memo.pdf](http://www.mass.gov/eohhs/docs/dph/quality/boards/nursing/immunization-memo.pdf)).

The law allows a primary care provider acting within his or her designated scope of practice to delegate the administration of an immunization of a patient to a CMA who meets specific qualifications. It was noted in the letter that regulations promulgated by the department would be forthcoming.

A primary care provider (PCP) may delegate the administration of immunizations to a medical assistant who:

1. Has graduated from a post-secondary medical assisting education program accredited by the Commission on Accreditation of Allied Health Education Programs, or the Accrediting Bureau of Health Education Schools
2. Is employed in the clinical practice of a licensed primary care provider
3. Performs basic administrative, clerical, and clinical duties upon the specific authorization and under the direct supervision of a licensed primary care provider

The law also authorizes the commissioner to recognize other certificate programs or methods as providing an acceptable level of training, authorizing medical assistants to administer immunizations as specified in that chapter.

On August 10, 2017, the MDPH published a Circular Letter (DCP 17-8-102) providing further guidance on the new law ([www.mass.gov/eohhs/docs/dph/emergency-services/advisories/cma-circular-17-8-102.pdf](http://www.mass.gov/eohhs/docs/dph/emergency-services/advisories/cma-circular-17-8-102.pdf)). The

Circular Letter sets forth criteria that PCPs may use to assess the adequacy of a medical assistant's training and/or certifications for the purposes of administering immunizations while the regulations are being drafted.

Method 1, Formal Education and Certification Examination, covers instances where a medical assistant has graduated from an acceptable post-secondary program (training criteria are detailed in the Circular Letter) and passed a certification examination. PCPs must obtain and retain sufficient records from a medical assistant to make a reasonable assessment as to whether the Method 1 requirements have been met.

In addition to formal education and certification (Method 1), a PCP may also authorize medical assistants to administer immunizations according to specific experience qualifications (Method 2): Medical assistants may also qualify through three (3) years or more of applicable professional experience in the administration of immunizations, as assessed by the PCP. The training criteria set forth in Method 1 should be taken into account by a PCP when assessing the professional experience of a medical assistant.

In both Method 1 and Method 2, PCPs who determine that a medical assistant may be authorized to administer immunizations must

include an appropriate notation in the medical assistant's personnel record that the requirements have been met and the medical assistant is authorized to administer immunizations under the required conditions of supervision.

The Circular Letter provides links to additional resources and also email contact information for further inquiries.

The MDPH regulations regarding administration of immunizations by CMAs will be circulated once they are published.

— *MCAAP Immunization Initiative*

## MDPH Joint Policy 2017-08: Pharmacist Administration of Vaccines

The Massachusetts Department of Public Health (MDPH) recently published **Joint Policy 2017-08: Pharmacist Administration of Vaccines**. The Policy can be found at [www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/alerts/policy-17-08.pdf](http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/alerts/policy-17-08.pdf).

The following summarizes the Joint Policy:

**Vaccines authorized by this Policy/  
vaccine recipients covered by this Policy:**  
Qualified pharmacists and pharmacy interns



may administer those vaccines included in the latest recommended immunizations as approved by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Control and Prevention (CDC) to individuals **9 years of age and older**.

**Requirements for vaccine administration:**

To administer vaccines, a prescription, prescriber directive, or standing order is required. A standing order to administer single-dose emergency epinephrine is also required. Additionally, federal law requires that a vaccine provider must give the patient or legal representative the appropriate Vaccine Information Statement (VIS) whenever a vaccine is administered.

**Communications:** A notification/record of immunization should be provided to the patient's physician. If an immunization is being administered to a person younger than 18 years of age, information on primary care providers in the pharmacy's geographic area should be provided. If the purpose of the visit is for a childhood immunization other than influenza vaccine, counseling on the importance of establishing and maintaining a relationship with a pediatric or family practice for ongoing medical and well-child care must be provided.

**Disclosure of Free Pediatric Vaccine Availability:**

The policy states that the MDPH Immunization Program provides all routinely recommended childhood vaccines free of charge to health providers for administration to individuals through 18 years of age regardless of insurance status. To receive free state-supplied vaccines, health care providers must enroll in the Immunization Program utilizing the Massachusetts Immunization Information System (MIIS) and must agree to comply with all of the associated program requirements. If the site is not enrolled in the MIIS, parents/guardians of patients under 19 years of age must be informed that there may be a significant out-of-pocket expense for the vaccine and must be informed that they can obtain the vaccine at no cost through their primary care provider.

**Vaccine storage and handling:** Pharmacists must ensure that all vaccines are stored and handled according to both the vaccine package inserts and the latest CDC guidelines and recommendations on vaccine storage and handling.

**Reporting of adverse events:** The National Childhood Vaccine Injury Act (NCVIA) requires all health care providers to report any adverse event listed by the manufacturer as

a contraindication to further doses of the vaccine or any reportable adverse event occurring within the specified time period to the Vaccine Adverse Event Reporting System (VAERS).

**Training:** Pharmacists and pharmacy interns administering vaccines must attend and pass an accredited training course, as detailed in the policy.

The Joint Policy includes resources and contact information for further inquiries.

— *MCAAP Immunization Initiative*

## From the MDPH Immunization Program

### School Immunization Updates

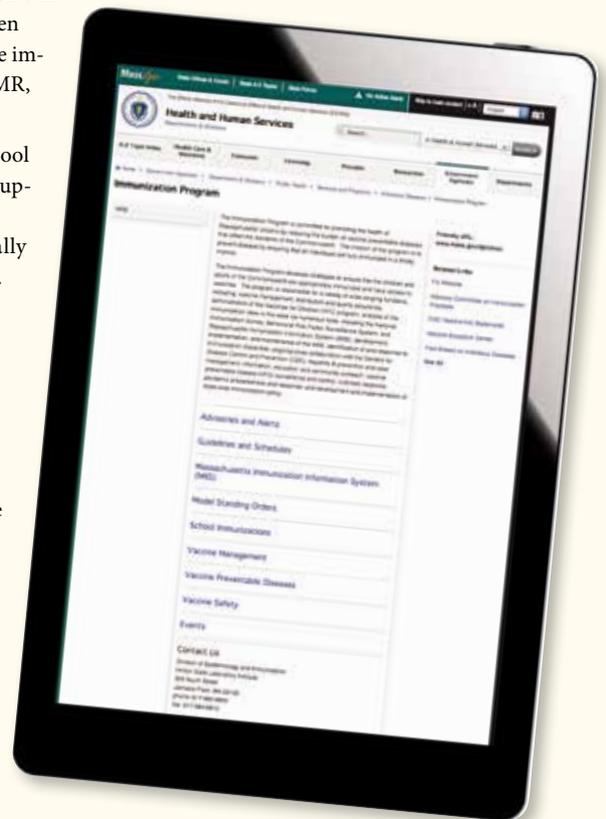
Over the past several years, the Massachusetts Department of Public Health (MDPH) Immunization Program, with support from the MCAAP Immunization Initiative, has successfully advocated to make school-level immunization data and exemption rates publicly available on the internet. The goal of making this information available is to help improve collaboration between immunizing clinicians, school nurses, parents, and other vaccine advocates to ensure that Massachusetts' children are protected by herd immunity and pockets of under-immunization can be addressed. Students in kindergarten through 12th grade are required to be immunized with DTaP/Tdap, polio, MMR, hepatitis B, and Varicella vaccines.

The Immunization Program's School Immunization website was recently updated to describe the importance of school requirements and the publically available school immunization data. The main changes to the page included:

- a. Content on the page geared toward a general public audience
- b. School data maps on exemption rates and guidance on how to interpret each of the maps
- c. Resource list for parents with descriptions of each resource/link
- d. New resource page for school nurses at the bottom of the page entitled "School Immunization Information for School Nurses"

School immunization rates provide insight into the vaccine coverage in communities across the state. Since immunization rates are not uniform across the state, school immunization data found on this website highlight areas that may be more susceptible to vaccine-preventable diseases.

In addition, the Immunization Program recently updated their school requirements table with the following footnote to describe exemptions, including annual renewal of both medical and religious exemptions: "†Medical exemptions (dated statement signed by a physician stating that a vaccine(s) are medically contraindicated for a student) and religious exemptions (dated statement signed by a student or parent/guardian, if the student is <18 years of age, stating that a vaccine(s) are against sincerely held religious beliefs) must be renewed annually, at the start of the school year." School nurses can now use this annual renewal as an opportunity to remind parents of the benefits of vaccines, answer any questions the parents may have, and encourage them to visit their health care provider to receive the vaccines they need. The school requirements table, as well as other school immunization information, can be found by visiting [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm) and clicking on School Immunizations.



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## From the MDPH Immunization Program

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### Pharmaceutical Refrigerator Requirements – Reminder!

Reminder: As of January 1, 2018, 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, excluding flu-only sites) to have pharmaceutical grade refrigerators for all refrigerated vaccine storage units in their facility. You can find more information in the Guidelines for Compliance with Federal and State Vaccine Administration Requirements, found at [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm) under Vaccine Management.

### Consequences of Vaccine Hesitancy

A recent *JAMA* article “Public Health and Economic Consequences of Vaccine Hesitancy for Measles in the United States” discusses how even “a 5% decline in MMR vaccine coverage in the United States would result in an estimated 3-fold increase in measles cases for children aged 2 to 11 years nationally every year, with an additional \$2.1 million in public sector costs.” These estimates would be considerably higher if it included infants too young to receive the vaccine, adolescents, and adults.

— *Rebecca Vanucci, MA, Immunization Outreach Coordinator, MDPH Immunization Program*

## From the CDC: New Vaccine Administration e-Learn Is Available

The Centers for Disease Control and Prevention (CDC) has released a new Vaccine Administration e-Learn, which is available on its Continuing Education web page at [www.cdc.gov/vaccines/ed/courses.html#elearn-vaccadmin](http://www.cdc.gov/vaccines/ed/courses.html#elearn-vaccadmin). The e-Learn is a free, interactive, online educational program that serves as a useful introductory course or a great refresher on vaccine administration.

Proper vaccine administration is critical for ensuring that vaccines are both safe and effective. Vaccine administration errors happen more often than you might think. Of the average 36,000 reports received annually by the Vaccine Adverse Event Reporting System (VAERS), about 1,500 are directly related to administration error.

Some of the most common vaccination administration errors include:

- Not following the recommended immunization schedule
- Administering improperly stored or expired vaccine and/or diluent
- Administering the wrong vaccine — confusing look-alike or sound-alike vaccines, such as DTaP/Tdap or administering products outside age indications

The self-paced e-Learn provides comprehensive training, using videos, job aids, and other resources to accommodate a variety of learning styles, and offers a certificate of completion and/or Continuing Education (CE) for those who complete the training.

The CDC encourages you to share information about the Vaccine Administration e-Learn with your colleagues.

If you have any questions or would like more information, please contact the CDC at [nipinfo@cdc.gov](mailto:nipinfo@cdc.gov).

— *MCAAP Immunization Initiative*

## Immunization Initiative Grand Rounds Seminars

For 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 are an hour long. Each participant will receive a packet of handout materials that includes current immunization 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 (e.g., measles, mumps, pertussis), new ACIP recommendations, guidelines for vaccine management in the office, and increasing parental concern about immunization.

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

— *MCAAP Immunization Initiative*



## Upcoming Conferences and Meetings

### Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting

October 5, 2017, 4:00–6:00 p.m.

Massachusetts Medical Society, Waltham

For more information, visit [www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html](http://www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html).

### 22nd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

October 12, 2017, 9:00 a.m.–4:00 p.m.

Best Western Royal Plaza Hotel, Marlborough

On-site registration is available. The on-site registration fee is \$95.00.

For more information, visit [www.mcaap.org/immunization-cme](http://www.mcaap.org/immunization-cme).

### Grand Rounds Seminar

October 25, 2017, 8:00–9:00 a.m.

Heywood Hospital, Gardner

Presenter: Richard Moriarty, MD, FAAP

For more information, please contact Cynthia McReynolds ([cmcreynolds@mms.org](mailto:cmcreynolds@mms.org)).

### Advisory Committee on Immunization Practices (ACIP) Meeting

October 25–26, 2017

Atlanta, Georgia

ACIP meetings are open to the public (in-person and by telephone/webinar). Pre-registration is required.

For more information, visit [www.cdc.gov/vaccines/acip/index.html](http://www.cdc.gov/vaccines/acip/index.html).

### MCAAP Immunization Initiative Webinar Series

November 2, 2017, noon–1:00 p.m.

2017–2018 Influenza Season Update; MDPH Vaccine Update

Presenter: Susan Lett, MD, MPH

For more information, visit [www.mcaap.org/immunization-cme](http://www.mcaap.org/immunization-cme).

### Grand Rounds Seminar

November 7, 2017, noon–1:00 p.m.

Signature Healthcare Brockton Hospital

Presenter: Richard Moriarty, MD, FAAP

For more information, please contact Cynthia McReynolds ([cmcreynolds@mms.org](mailto:cmcreynolds@mms.org)).

### 2nd Annual Massachusetts PTA Health Summit Taking Action! Keeping Children, Schools, Families and Our Communities Healthy!

November 16, 8:30 a.m.–2:30 p.m.

Massachusetts Medical Society, Waltham

For more information, visit [www.massachusettspta.org/New\\_site](http://www.massachusettspta.org/New_site). (Please note CME/CEU credits are not available for attending the Summit.)

### 5th Annual HPV/Cervical Cancer and HPV-Related Cancers Summit

December 1, 2017

Dana-Farber Cancer Institute, Boston

For more information, visit [www.dana-farber.org/HPVSummit](http://www.dana-farber.org/HPVSummit).

### National Influenza Vaccination Week (NIVW)

December 3–9, 2017

For more information, visit [www.cdc.gov/flu/resource-center/nivw/index.htm](http://www.cdc.gov/flu/resource-center/nivw/index.htm).

### Immunization Initiative Advisory Committee Meeting

December 5, 2017, 6:30–8:30 p.m.

Massachusetts Medical Society, Waltham

For more information, please contact Cynthia McReynolds ([cmcreynolds@mms.org](mailto:cmcreynolds@mms.org)).

### Advisory Committee on Immunization Practices (ACIP) Meeting

February 21–22, 2018

Atlanta, Georgia

ACIP meetings are open to the public (in-person and by telephone/webinar). Pre-registration is required.

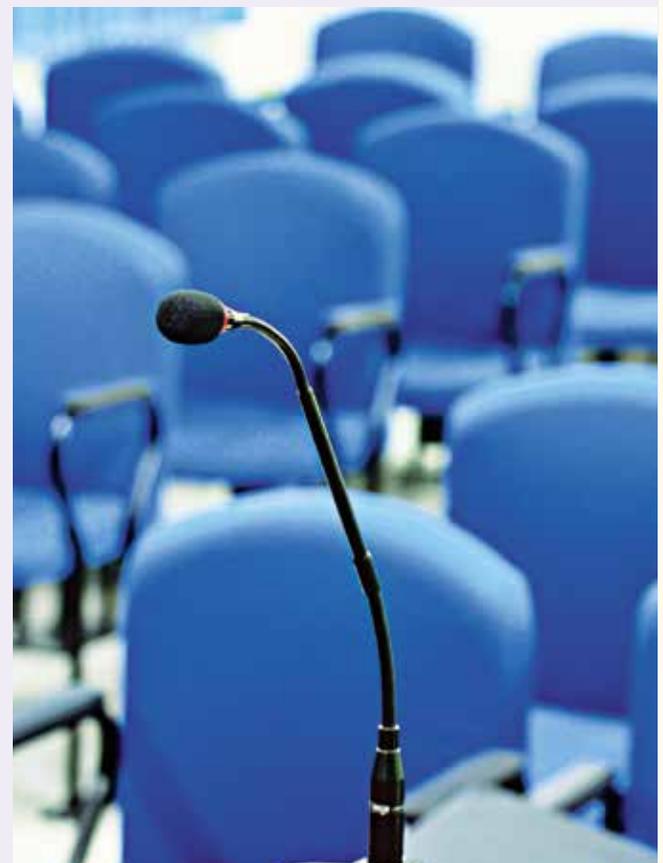
For more information and to register, visit [www.cdc.gov/vaccines/acip/index.html](http://www.cdc.gov/vaccines/acip/index.html).

### Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting

March 8, 2018, 4:00–6:00 p.m.

Massachusetts Medical Society, Waltham

For more information, visit [www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html](http://www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html).





## Dads Get Postpartum Depression Too...

Society is rapidly evolving in many ways. In the past century jobs shifted from farms to manufacturing; in this century jobs have shifted from manufacturing to service industries and the roles of men and women continue to evolve. These shifts have occurred rather quickly, leaving little time for women and men to adjust to their new roles. Some of these roles are counter to many standard societal expectations of what men and women do, in the workplace and at home. These expectations and even stereotypes are difficult to overcome because they have been ingrained in our society for hundreds of years. For example, it is hard for many to accept the stay-at-home father taking care of the children and home or the mother as the major wage earner for the family, even though either one may work out best for that family.

The role of the dad, the structure of the family in terms of composition, and who lives in the family group as well as who is the nurturing parent at home with the children are all shifting. We have begun to see a robust literature confirming the importance of dads in their children's lives. Studies have shown that all dads have a significant impact on their children. Many dads have accepted their new roles in the family and are truly enjoying the emotional rewards they derive from

caretaking as well as supporting their partner. Fathers are now facing the same work-family conflict that women have long experienced; they may want to spend more time at home and lessen their workload because they value a strong relationship with their children.

Dads have a different parenting style than moms and their input is significant. Young children with a close relationship to their dad are less likely to act out in school and less likely to get expelled from preschool. They are more likely to start their elementary school education in a positive way. With a strong start to their education, children are twice as likely to go to college. Girls, with dads who are interested in their academics and are nurturing in their relationships, are more likely to be in a relationship with a kind and understanding partner and to complete college and enter a challenging career. And the converse is true as well; when dads are not involved, their children suffer. For example, boys who experience less bonding with their fathers are more likely to have lower satisfaction with their lives overall.

There is growing evidence that fathers experience a number of physiological changes when their partners are pregnant.

Dads probably don't know about the hormonal changes they themselves undergo during their partner's pregnancy and continuing after delivery. It is theorized that the changes are related to helping the dad become a more nurturing parent. Some of the associated changes affect male aggression, loss of muscle mass, and weight gain. Bodily changes may be perceived but the underlying cause may not be understood. With society's obsession with appearance and looking fit, these body changes may lead to further self-esteem problems for the new dad.

A major risk factor for poor father-child interaction is a dad with postpartum depression (PPD). For some dads PPD is more profound and difficult. Men may not be living with their children, may have children with different partners, may be incarcerated and separated from their children, or may have been raised in a household where there was no male role model to help define positive and negative parenting practices. Postpartum depression can occur in any father, but often dads cannot verbalize or express, or choose not to verbalize, their feelings.

A dad may start to worry about his role in regards to caring for his newborn child.

*continued on page 11*

**Dads Get Postpartum Depression Too...**

*continued from page 10*

He could experience concerns about financially supporting the child and family, or have concerns about the new family and how it will be structured. As the mom starts working on either nursing or bottle feeding, the dad may feel left out due to the loss of an interactive role with the newborn or partner. All of these issues can lead to depression after birth and this can severely impact both parents and child. The situation is exacerbated if both parents experience PPD. In that case it is critical both parents get help.

The rate of male PPD varies between 6 and 10 percent. It is more likely to occur if there is a past history of depression or if his mate is depressed. PPD cannot be detected without screening. Since the effect of PPD can contribute to at least four Adverse Childhood Experiences

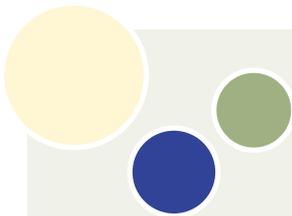
(ACE) in the home setting (parents getting physically aggressive with each other, substance use, separation, and depression) it is imperative to try and identify those fathers who are depressed and offer them counselling. Dads who do get depressed and are not offered help may continue to spiral down, further impacting the home environment in a negative fashion.

We should screen for depression and other conditions, according to the US Preventive Services Taskforce, as there is effective and evidence-based treatment available. The screening tool, which is the same survey of 10 questions used for moms, is the **Edinburgh Postpartum Depression** screening tool. The pediatric office is the best place for screening because 75 percent of dads visit the pediatrician at some point. Many dads have not yet connected with a primary care physician for themselves because they are still relatively young without particular medical needs. A visit for the

whole family or a visit for the father in particular can become routine for every newborn of a certain age. This will ensure that dads get screened at the best time to pick up paternal depression, which is between 3 and 6 months postpartum.

Implementing screening of dads can easily be added to the visits for babies and their parents in the first six months. Moms are already being screened with the same tool and the pediatrician can open the discussion about either parent feeling depressed. There is a need to have trained providers to treat these dads, along with mothers experiencing PPD as well, in a therapeutic environment that is caring and supportive. Recognizing and treating PPD in either or both parents will strengthen and support the growing little family, and help their child succeed.

— **Mark Friedman, MD, FAAP**



**American Academy of Pediatrics**

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Hezekiah Beardsley Connecticut Chapter

**Welcomes the Massachusetts AAP Chapter (MCAAP) Members to Participate in their 2017 Webinar/Teleconference Series**

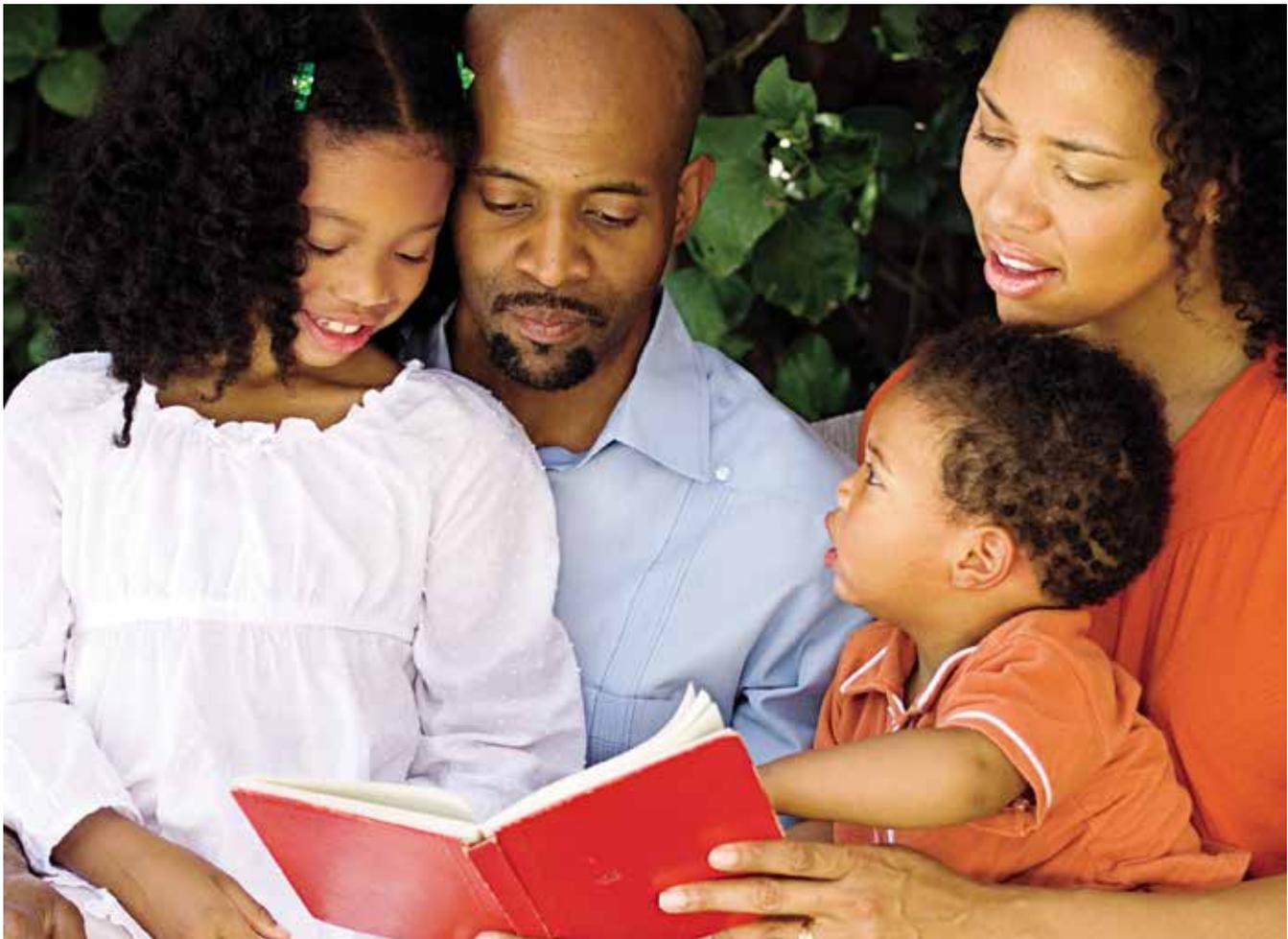
The Connecticut Chapter of the American Academy of Pediatrics is proud to announce that this is their 10th year providing CME/CEU opportunities to their members and non-members across the state of Connecticut — and now in the state of Massachusetts — through their online webinar series.

This series offers 10 webinars per year for only a small fee (see rates below) to receive a CME/CEU certificate. This program has been highly successful in educating health care professionals. The CTAAP webinar series provides participants with up-to-date information on a wide variety of subjects relating to pediatrics, including physical health, mental health, and behavioral health, as well as updates on vaccines, billing and coding, HIPAA regulations, and more.

As always, the programs are **FREE** to anyone who would like to participate. The fee is only for those requesting CME or CEU credits. — **Yvette Moretti, marketing/communications manager, Connecticut Chapter, AAP**

RATES	10 PROGRAM SERIES	SINGLE PROGRAMS
Not Requesting CMEs or CEUs	Free	Free
MCAAP/CTAAP Members	\$150.00	\$20.00
Non-members	\$175.00	\$25.00
ARNPs and PAs	\$115.00	\$20.00
RNs and other (CEUs)	\$115.00	\$20.00

For more information about this webinar/teleconference series, visit [www.ct-aap.org](http://www.ct-aap.org), email [staff@ct-aap.org](mailto:staff@ct-aap.org), or call (860) 525-9738.



### BOOK CORNER

## Helping Kids Grow in School

Recently, I sent my oldest son off to college, so the transition that fall brings has become particularly poignant. As pediatric clinicians, we are confronted daily with growth and change, and rather than dreading it, we are concerned by its absence.

But there is always a nostalgic ring to the first days of school, even as commercial stores now start pushing back-to-school supplies as soon as the flags are down from the Fourth of July!

But how important is the start of school and how can we help the families we care for make it a positive experience? A recent report from the Harvard Family Research Project reported that a smooth transition to school can pay dividends down the road. But for children on the lower end of the socioeconomic divide — those who could most benefit from

support and preparation — a well-planned transition is hardly the norm (Caspé M, Elena Lopez M, Chatrabhuti C, “Four Important Things Research Tells Us About the Transition to School,” 2015).

The report summarizes recent statistics on kindergarten entry. For example, in the 2011–2012 cohort, many incoming families were impacted by poverty with 26% of kindergartners living in households that were below the federal poverty threshold. In 2012, 48% of kindergartners were not enrolled in any preschool program prior to kindergarten entry. The researchers define the transition to school as a process — not just a one-time event — that begins during children’s preschool years and continues into and through third grade. As clinicians who see children regularly during these years, perhaps this is where we come in?

The report discusses four key aspects to consider regarding school transition.

#### 1. Transition is an equity issue.

Research has shown that children from privileged socioeconomic backgrounds are better prepared for achievement when they enter school than children from disadvantaged backgrounds. Teasing out the “why” is harder but likely involves quality early childcare, family stress, and social support.

#### 2. A smooth transition to school makes a difference for children’s outcomes.

Research shows that children who receive greater support through the process have improved academic achievement, more positive social and emotional competencies, and fewer problem behaviors.

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## DEVELOPMENTAL CORNER

## Children's Executive Function Skills and Academic Achievement: How the Two Are Linked



The relationship between a child's executive function skills and academic achievement has been widely studied and found to be significantly correlated. Like most areas of development, it's best for caregivers to help children develop these skills at an early age so they can meet academic expectations in their school years. All children use executive functions in the school setting to complete complex cognitive tasks, follow rules, and suppress impulsive behavior.<sup>1</sup> However, the way in which children apply executive function skills successfully in school changes as they develop. Caregivers frequently look for ways to boost their young children's academic performance with additional tutoring in school subject areas, and summer school. Activities that require children to integrate and apply executive functions in broader contexts may provide the best foundation for later academic achievement.<sup>2</sup>

Young school-aged children use individual executive functions, such as working memory, to learn the foundational concepts of reading, writing, and basic arithmetic. Essentially, they use executive functions to learn skills that later become automatic. For example, when a child sounds out a word, her working memory helps her recall letter sounds and apply this information to make sense of the word's meaning. It takes years for reading to become an automatic task for children. Once they acquire this skill, the complexity of settings in which they must use executive functions increases.<sup>2</sup>

As children progress into middle childhood and adolescence, they learn how to apply multiple executive functions simultaneously to understand advanced subject material. Difficult word and math problems require children to apply problem solving, strategy creation, and self-monitoring, all of which can only be

carried out if a child uses her working memory, flexible thinking, and inhibition control together. When children struggle with the transition from using individual executive functions on automatic tasks to integrating executive functions together in a global context, they are less prepared for the demands of higher education and working life in adulthood.<sup>2</sup>

Because executive function development is so important to children's learning and can be predictive of their school readiness and academic achievement, it's important to help them grasp how to use these skills in broad contexts. Health care professionals can explain to caregivers how activities outside of school promote a broad range of executive function skills and teach children how to coordinate these functions together, which then promote success inside the classroom as

*continued on page 18*

## SBIRT: Addressing Adolescent Alcohol and Drug Use

A recent CDC report noted that teen drinking has declined, but also emphasized that one in three high school students had drunk alcohol in the previous 30 days and one in six were binge drinkers (Esser et al., *MMWR*, 2017). Youth are also picking up messages from the larger society that marijuana use has little risk and some, who may have access to family or friends' pain and/or anxiety medications, may start misusing those.

### SBIRT

Asking about alcohol and drug use using an age-appropriate validated screening instrument: **S**creening tool; **B**rief **I**ntervention when alcohol and/or other drug use is revealed; and **R**eferral to **T**reatment for the small number of patients who may need further assessment and more focused care. SBIRT is an evidence-based practice recommended by the American Academy of Pediatrics (AAP Committee on Substance Use and Prevention, *Pediatrics*, 2016).

SBIRT as part of routine health care visits can help reduce harm due to alcohol

and/or drugs. In our current environment parents and other adults are concerned about addiction, which is only one of the many possibilities of harm for youth. Adolescents who use alcohol or drugs are more likely, when intoxicated, to suffer harm such as injuries from car and other vehicle crashes, fights, falls; unplanned pregnancies; STIs; alcohol poisoning, or drug overdose. The earlier age at which a child starts to use alcohol or drugs, the more likely he or she is to develop a life-long problem with substances (Hingson et al., *Arch Pediatr Adolesc Med*, 2006).

Research has shown that physicians are pretty good at determining which patients may have progressed to serious substance use disorders, but less able to recognize which patients are misusing alcohol and or drugs occasionally or even regularly (Vinson et al., *Ann Fam Med*, 2013).

*The Massachusetts Adolescent SBIRT: Toolkit for Providers* (developed through a partnership involving Boston Children's Hospital, MA Child Psychiatry Access Program MCPAP, Massachusetts Department of Mental Health and Massachusetts

Department of Public Health/Bureau of Substance Abuse Services) uses a four-question pre-screen called the **Screening to Brief Intervention Tool** or **S2BI**. The toolkit recommends using the CRAFT screener when the S2BI results indicate that a further assessment is needed.

The toolkit and S2BI screener were developed recognizing the need busy practices have for a quick screener, and for guidance on next steps with a positive screening result. The toolkit includes recommendations for best practices, various techniques for advice, case studies, more background information, and references.

Engaging adolescents in conversations about alcohol and/or drug use can be a challenge, but discussing use in the context of overall health and brain development may encourage a patient to open up about use. Routine screening can be done using paper or computer. Providing feedback with a follow-up conversation that reinforces healthy choices with a negative screen, or engaging a patient whose screen was positive with further assessment questions and conversation about reducing or stopping use can be done by a nurse or social worker. Those conversations will vary depending on the patient's age and use. When use is highly risky a referral for further assessment and/or treatment may be in order.

Though the physician's intervention and advice may carry greater weight with some patients, this critical prevention/harm reduction conversation can be carried out by other professional practice staff. When incorporated as a routine part of the health care visit, patients understand that staff team members are led by the physician.

The free toolkit is available for order from the Massachusetts Health Promotion Clearinghouse at <https://massclearinghouse.ehs.state.ma.us> in the Alcohol and Other Drugs section. The kit and its various pieces can also be downloaded from that site. Prevention-focused materials included in the kit, along with others at the Clearinghouse, are available for parents

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## Writing and Submitting a Resolution — A Step-by-Step Guide

The following is a quick reference for the “how to” of writing resolutions. To review more detailed information, please see the “Guidelines for Submitting Resolutions” located on My AAP, which can be viewed at [www.aap.org/en-us/my-aap/chapters-and-districts/Resolutions/Pages/Submitting-Resolutions.aspx](http://www.aap.org/en-us/my-aap/chapters-and-districts/Resolutions/Pages/Submitting-Resolutions.aspx) (AAP ID and password required).

**The purpose of a resolution** is to provide a formal mechanism whereby the members of the Academy can give input concerning Academy policy and activities.

### What is a resolution?

- Request that the Academy develop a statement or otherwise take action on a particular issue.
- Request that the Academy inaugurate a new program or activity or reconsider a current AAP program or activity.
- Request that the Academy change its operating procedures.

All resolutions are *advisory* to the Board of Directors and are not binding.

### I have an idea for a resolution... now what?

- **Who can write a Resolution** — Fellows of the Academy with or without group endorsement, chapters, committees, councils, sections, and districts.

- **Contact your District Chapter Forum Management Committee (CFMC) Representative** — All 10 districts of the AAP have a CFMC representative and these CFMC members can assist you with the resolution writing process. CFMC representatives can also help guide the development of resolutions at district meetings for presentation at the Annual Leadership Forum. CFMC members also track resolutions before and after the Annual Leadership Forum, and maintain ongoing contact with resolution authors, providing updates on Academy responses. *Your CFMC representative is available to guide you in the resolution writing process.* To see who your CFMC representative is, visit My AAP.
- **Fill out the Resolution Template**, which can be found at [www.aap.org/en-us/my-aap/chapters-and-districts/Resolutions/Pages/Submitting-Resolutions.aspx](http://www.aap.org/en-us/my-aap/chapters-and-districts/Resolutions/Pages/Submitting-Resolutions.aspx).

### The Body of a Resolution

- **“Whereas” clauses** should define the problem, relevance of the problem, and possible solutions. Three to four clauses are acceptable.

- **“Resolved” clauses** should stand alone and request action by the Academy. No more than two resolves are acceptable.
- **Fiscal Notes** are generally supplied by staff, but whenever possible, authors are encouraged to supply fiscal notes upon resolution submission.

## Please Don't Miss the November 15 Deadline!

Resolutions MUST be submitted by November 15. Any resolutions submitted after November 15 and before the opening session of the Annual Leadership Forum (typically mid-March annually), will be considered LATE RESOLUTIONS. Submit Resolutions to Jonathan Faletti, manager, Chapter Programs, via email at [jfaletti@aap.org](mailto:jfaletti@aap.org) with a “cc” to your CFMC representative. If you have any questions, please contact Jonathan Faletti at (800) 433-9016, ext. 4752, or [jfaletti@aap.org](mailto:jfaletti@aap.org).

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## Writing and Submitting a Resolution — A Step-by-Step Guide

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### The Anatomy of a Resolution

Following is an explanation of the resolution format:

**Resolution #:** A number will be supplied by Central Office.

**Title:** It should reflect the action for which the resolution calls.

**Sponsored by:** The sponsor of the resolution must be identified. Resolutions can be submitted by fellows, chapters, committees, councils, sections, or districts. Resolutions can only be sponsored by chapters, committees, councils, sections, or districts. Sponsorship implies agreement on the resolution content. Please note that provisional sections cannot sponsor resolutions. Multiple sponsorships are not necessary.

**Date:** The date by which a resolution is submitted. (**Deadline: November 15**)

**Disposition:** It reflects the vote of the Annual Leadership Forum.

**Whereas:** These statements should be written clearly to define the problem and state that a solution is possible. Please remember that the Whereas statements are not voted on and should be limited to *three or four* in order to assure that the focus remains on the resolved portion of the resolution.

**Resolved:** Each resolution must contain a Resolved statement that stands alone and requests action by the Academy. The resolution may not have more than **two resolves**. The resolution also may not include bullet points within the resolved. For the purpose of clarity, we encourage authors to limit the character length of each resolved.

**Fiscal note:** Fiscal notes are generally supplied by staff, but whenever possible, the authors are encouraged to supply fiscal notes upon resolution submission.

**Refer to:** Resolutions should be referred to the Annual Leadership Forum or, if **urgent**, to the AAP Board of Directors.

**Author/Contact Person:** Fellow(s) who drafted the resolution and can be contacted for clarification. Resident and candidate fellows who author resolutions must also obtain the support of an AAP full fellow to co-author the resolution. Resolutions are limited to two authors.

**Email:** Email address where the author/contact person can be reached.

**Background Information:** The author of the resolution should supply background material, if possible. Staff will gather information as well. This information will be sent to the Chapter Forum Management Committee to review.

— *American Academy of Pediatrics*

## 2017–18 Influenza Season Recommendations

*continued from page 3*

For the 2017–18 influenza season:

- Quadrivalent and trivalent influenza vaccines will be available
- Inactivated influenza vaccines (IIVs) will be available in trivalent (IIV3) and quadrivalent (IIV4) formulations
- Recombinant influenza vaccine (RIV) will be available in trivalent (RIV3) and quadrivalent (RIV4) formulations
- Live attenuated influenza vaccine (LAIV4) is not recommended for use during the 2017–18 season due to concerns about its effectiveness against (H1N1)pdm09 viruses during the 2013–14 and 2015–16 seasons

Recommendations for different vaccine types and specific populations are discussed in the report. No preferential recommendation is made for one influenza vaccine product over another for persons for whom more than one licensed, recommended product is available.

Updates to the recommendations described in this report reflect discussions during public meetings of the ACIP held

in October 2016, and February and June 2017; February 22, 2017; and June 21, 2017. New and updated information in this report includes the following:

- Vaccine viruses included in the 2017–18 US trivalent influenza vaccines will be an A/Michigan/45/2015 (H1N1)pdm09–like virus, an A/Hong Kong/4801/2014 (H3N2)–like virus, and a B/Brisbane/60/2008–like virus (Victoria lineage)
- Quadrivalent influenza vaccines will contain these three viruses and an additional influenza B vaccine virus, a B/Phuket/3073/2013–like virus (Yamagata lineage)
- Information on recent licensures and labelling changes is discussed, including licensure of Afluria Quadrivalent (IIV4; Seqirus); Flublok Quadrivalent (RIV4; Protein Sciences); and expansion of the age indication for FluLaval Quadrivalent (IIV4; ID Biomedical Corporation of Quebec), previously licensed for  $\geq 3$  years, to  $\geq 6$  months
- Pregnant women may receive any licensed, recommended, age-appropriate influenza vaccine
- Afluria (IIV3; Seqirus) may be used for persons aged  $\geq 5$  years, consistent



with Food and Drug Administration–approved labeling

- FluMist Quadrivalent (LAIV4; MedImmune) should not be used during the 2017–18 season due to concerns about its effectiveness against influenza A(H1N1)pdm09 viruses in the United States during the 2013–14 and 2015–16 influenza seasons

— *MCAAP Immunization Initiative*

### References

- CDC influenza website: [www.cdc.gov/flu](http://www.cdc.gov/flu)  
 MDPH influenza website: [www.mass.gov/flu](http://www.mass.gov/flu)  
 MCAAP Immunization Initiative flu section: <http://mcaap.org/immunization-whatsnew>

## Helping Kids Grow in School

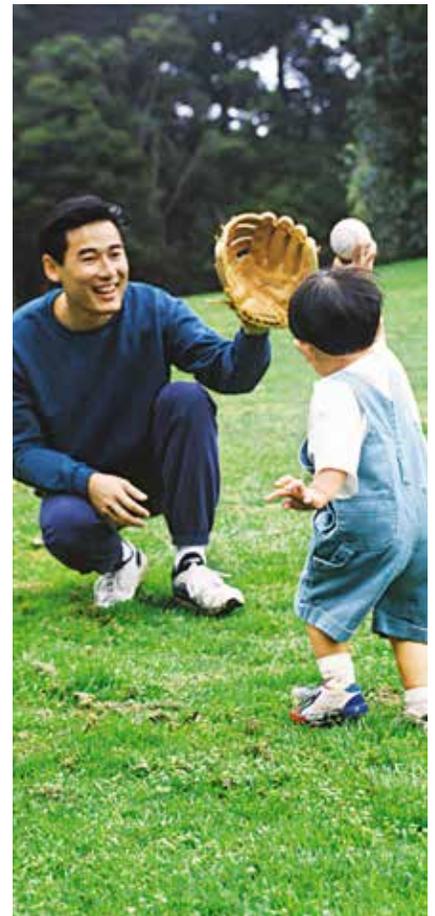
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- 3. Families play an important role in the transition to school.** The one constant across all the experiences children have is their family. Studies support that families who engage in activities such as telling stories, reading aloud, singing, doing puzzles, and playing math and science games prepare children for the demands of kindergarten. These types of activities foster a “growth mindset,” one which helps children understand that school and learning are important. This is further reinforced by adjustment of family activity and sleep routines to follow the structure of a school day.
- 4. Strong family-school-community relationships are essential.** To avoid a falling-off of family engagement as elementary school progresses, the report recommends that at the start, schools should communicate with families what they are doing to ease the transition, and families must understand their important role in school success throughout all the child’s education.

This is where an additional component could be added to point four: strong family-school-community-medical home relationships are critical! As clinicians, we need to be more than the last stop for the up-to-date physical at kindergarten entry. The AAP statement on school readiness (High P, “School Readiness,” *Pediatrics* 121(4), 2008) recommends that as part of daily practice, pediatric clinicians can promote the “5 Rs” of early education — that is, reading together as a daily family activity; rhyming, playing, and cuddling together often; routines and regular times for meals, play, and sleeping, which help children know what they can expect and what is expected from them; praise as reward for everyday successes; and reciprocal and nurturing relationships, which are the foundations of healthy child development. Now that the first bell has rung, let’s make this a great school year for all of the children.

— **Marilyn Augustyn, MD, FAAP**

For more information about Reach Out and Read and early literacy, email Massachusetts Program Director Christine Garber at [Christine.garber@reachoutandread.org](mailto:Christine.garber@reachoutandread.org) or Massachusetts Coalition Medical Director Marilyn Augustyn at [Marilyn.augustyn@bmc.org](mailto:Marilyn.augustyn@bmc.org).



## SBIRT: Addressing Adolescent Alcohol and Drug Use

*continued from page 14*

and for youth. These free materials can be also ordered in bulk for use in pediatric and family practice offices.

Note: The AAP recently produced a toolkit, *Substance Use Screening and Intervention Implementation Guide*. That guide adapted some content from the *Massachusetts Adolescent SBIRT: Toolkit for Providers* and other resources.

### SBIRT Training

The Massachusetts Department of Public Health Bureau of Substance Abuse Services funds MASBIRT Training and Technical Assistance (TTA), which can go to practices for consults, help them develop implementation plans, and provide skills training in screening and brief intervention, along with follow-up coaching and technical assistance when needed. More information is available at [www.masbirt.org](http://www.masbirt.org). MASBIRT TTA staff have worked

with several pediatric and family practices throughout Massachusetts.

### Treatment and Recovery Resources

When treatment is indicated, it’s important to know that there are more likely to be openings in the youth and young adult serving substance use disorder (SUD) treatment system than in the adult system. The Bureau of Substance Abuse Services’ Office of Youth and Young Adult Services ([www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/addictions/drugs-and-alcohol/youth-services.html](http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/addictions/drugs-and-alcohol/youth-services.html)) funds a free consultation and referral resource for youth serving organizations and health care practices statewide. Staff knowledgeable about youth SUD treatment and about Massachusetts youth providers are available to help physicians and other professionals, as well as parents, with questions and with referral to age-appropriate licensed treatment services.

Contact Youth Central Intake and Care Coordination (Youth CICC) at (617) 661-3991 or (866) 705-2807 (toll free). Concerned parents and providers can also contact the Bureau’s statewide Helpline at <http://helpline-online.com> or (800) 327-5050.

Families may also need support. Learn to Cope ([www.learn2cope.org](http://www.learn2cope.org)) has chapters around the state and provides support for parents whose children have a substance use disorder.

Resources are available to help practices support prevention and/or delay of first use, intervene early; know about referral resources to help parents and youth facing substance use challenges, and support harm reduction and recovery. These services can support practices in their promotion of long-term health and development of youth throughout Massachusetts.

— **Carol D. Girard, Massachusetts DPH**

For more information, contact Carol D. Girard, Massachusetts DPH, at [carol.d.girard@state.ma.us](mailto:carol.d.girard@state.ma.us).

## Children's Executive Function Skills and Academic Achievement: How the Two Are Linked

*continued from page 13*

well as socially and in everyday life. Some simple activity suggestions include:

- **Physical exercise:** Research suggests certain types of physical activities can foster children's executive function development, which also promotes academic achievement.<sup>3</sup> Motor tasks and games with complex coordination and cognitive components are beneficial for developing children's sequencing, monitoring, and planning. Medical professionals can suggest games such as *Freeze Dance*; *Red Light, Green Light*; and *Duck, Duck, Goose* for young children because these activities require them to apply inhibition control to practice focusing their attention. Organized sports are also beneficial for executive function development because children must use working memory to implement game rules and mental flexibility to adjust their playing strategy.<sup>4</sup>
- **Unstructured play and playdates:** Pretend play helps children exercise flexible thinking to change roles and come up with new ideas for their storyline. They must also use inhibition control to practice sharing toys and refrain from making inappropriate comments in front of peers.<sup>4</sup> As children have more free time over the summer months, caregivers should plan for additional playdates and fun outings with friends.
- **Board games:** Any game with rules requires children to use working memory. Simple games for younger children include card matching, while more advanced games may require children to form a playing strategy and adjust their plan based on other players' actions.<sup>4</sup>
- **Chores:** These activities allow children to practice sorting, organizing, sequencing, and following directions every time they help around the house. The routine is so critically important for their executive function development, because they must repeat the same skills daily or weekly. Children of all ages can practice cleaning their bedrooms, which requires using working memory to remember where each item belongs and inhibition



control to stay on task and not get distracted. Young children can start by putting toys away in the correct bins, and as they get older they can help with tasks such as folding clothes and vacuuming.

- **Limit screen time and encourage high quality viewing:** The American Academy of Pediatrics recommends children have no more than one hour a day of screen time.<sup>5</sup> Encourage caregivers to permit only one form of media during this hour and make sure children under 18 months stay away from screens.<sup>5,6</sup> Using multiple forms of media together inhibits executive function development because it is overstimulating. Screen time also distracts children from other types of activities that are more beneficial for development, such as unstructured play, crafts, and reading.<sup>5</sup>  
— *Bobbie Vergo, OTD, and Emmy Lustig*

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 supplemental materials for well child visits and parent classes. Visit <https://pathways.org/print> to view our executive function brochure and to access information created for parents on executive function development and age appropriate games to play with children.

#### References

- <sup>1</sup>Samuels et al. Executive functioning predicts academic achievement in middle school: A four-year longitudinal study. *Journal of Educational Research*. 2016; 109(5): 478-490.
- <sup>2</sup>Best et al. Relations between Executive Function and Academic Achievement from Ages 5 to 17 in a Large, Representative National Sample. *Learning and Individual Differences*. 2011; 21(4): 327-336.
- <sup>3</sup>Aadland et al. Relationships between physical activity, sedentary time, aerobic fitness, motor skills and executive function and academic performance in children. *Mental Health and Physical Activity*. March 2017; 12: 10-18.
- <sup>4</sup>Enhancing and Practicing Executive Function Skills with Children from Infancy to Adolescence. Center on the Developing Child: Harvard University. [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).
- <sup>5</sup>American Academy of Pediatrics Announces New Recommendations for Children's Media Use. Oct. 2016. [www.aap.org](http://www.aap.org).
- <sup>6</sup>Baumgartner et al. The Relationship Between Media Multitasking and Executive Function in Early Adolescents. *Journal of Early Adolescence*. 17 Feb. 2014; 34(8).

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