



## PRESIDENT'S MESSAGE

### Wishing You the Very Best for 2018!

At the end of every year, the American Academy of Pediatrics (AAP) requires that each state Chapter submit an annual report outlining their priorities, goals, and infrastructure. In our Chapter's report, one of the identified areas of focus was school health. The MCAAP recognizes the importance of strong coordination between the pediatric providers and school systems.

To support the Chapter's commitment to addressing school health issues, this year's Annual MCAAP Edward Penn Memorial CME Lecture and Business Meeting, "School Health in Massachusetts: School and Health Care Providers Working Together to Promote the Health and Wellbeing of Children and Youth," will be held on May 9, 2018, at the Massachusetts Medical Society in Waltham, Massachusetts from 9:30 a.m. to 4:00 p.m. The program will focus entirely on school health issues with additional attention to children and youth with special health care needs (CYSHCN). Topics will include:

- State of School Health Services in Massachusetts
- Innovative Models of School Health (School Based Clinics, Co-located Mental Health Services)
- Addressing Disparities through School Health
- Envisioning High Quality School Health Care
- IEPs and Tools for Referrals
- Substance Abuse
- LGBTQ Youth in Schools

This CME program is an example of how we strongly encourage our committees to collaborate on shared goals. The

*continued on page 3*

## Table of Contents • Winter 2018 • Volume 19 No. 1

President's Message . . . . .	1	22nd Annual MIAP Pediatric Immunization Skills Building Conference . . . . .	7
How Scaffolding Helps Build Executive Function Skills . . . . .	1	2018 Immunization Initiative Webinar Series . . . . .	8
Editor's Note . . . . .	2	Upcoming Conferences and Meetings . . . . .	8
The Quiet Room. . . . .	4	MDPH Changes Lead Regulation for Pediatric Health Care Providers. . . . .	9
Silver Diamine Fluoride: Is It the New Magic Bullet for Dental Caries? . . . . .	5	New Child Development Series for Young Parents Coming in 2018 . . . . .	9
In Memoriam . . . . .	5	Book Corner . . . . .	10
ShotClock . . . . .	6	Two New Resources for Depression Available . . . . .	11
Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose within 24 Hours of Birth. . . . .	6	2018 MCAAP Call for Nominations . . . . .	12
Immunization Action Coalition's Hepatitis B Birth Dose Honor Roll . . . . .	6		
Immunization Rates Update. . . . .	7		

## DEVELOPMENTAL CORNER

### How Scaffolding Helps Build Executive Function Skills

Do you talk to parents about *executive function*? Many parents are not familiar with this term. The executive function (EF) skill set acts as a coordination center in the brain and depends on three main functions: working memory, mental flexibility, and inhibition control.<sup>1</sup> These crucial skills are needed to perform daily tasks, such as prioritizing, controlling impulses, filtering distractions, and

accomplishing goals. Issues with executive function in children may look like the following:

- Trouble with organization
- Struggling with time management
- Difficulty with open-ended assignments or tasks and trouble starting tasks by themselves

*continued on page 3*



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**EDITOR'S NOTE**

## Some Year-End Musings

Gun violence continues to be a public health problem. It is beyond appalling that we have to stop and think, "Where was that last shooting?" because there have been so many. We are fortunate to live and practice in Massachusetts, the state with the most carefully crafted firearm safety laws and the lowest rate of deaths from guns. Keep asking the families of your patients about firearms in the home. Talk to, support, and thank our legislators.

Climate change is real and is also a public health problem. We have seen this with the intensity of storms and their aftermath all over our interconnected world. As with most issues, it impacts most severely the young, the poor, and the elderly. We need to continue to advocate for change in this area. Have you thought about solar panels for your office and home?

Reading matters, still and always. Dr. Augustyn's review of cutting edge science in this edition's Book Corner confirms this once again. Keep talking to the families of your patients about more books, less screen time. And do others feel as strongly as I do that parents and caregivers should not be on their phones during our time together in their children's appointments?

Sexual harassment and dating violence start at shockingly early ages. If we don't ask, our patients may not tell us. We need to redouble our efforts to let children and teens know we care, and we want to know.

Teens are confused about marijuana: its legality, medical use, and more. We need to continue to be clear that marijuana is not good for the developing adolescent brain. In addition, we know the opioid crisis has touched our teen patients as well as their parents. Are you supporting SBIRT (screening, brief intervention, and referral to treatment) implementation as well as naloxone for first responders in your town, and have you considered becoming a suboxone prescriber?

And given all of the above, it is ever so important to keep doing what we do to help the children we care for grow up to be healthy, strong, kind adults. Thank you for all you do, every day. I wish you and your families, staff, and loved ones the best for 2018!

— **Lisa Dobberteen, MD, FAAP**

Although many of you read Dr. Masiokas' and Dr. Griggs' poignant piece "The Quiet Room" in the *New England Journal of Medicine* when it was originally published, we feel it is worthy of reading and sharing many times, and so have included it in this edition of *The Forum* on page 4.



Bournes Pond Magic Photo by Matt Dobberteen

## Wishing You the Very Best for 2018!

*continued from page 1*

MCAAP CME Board Subgroup worked with the chairs from the School Health and CYSCHN Committees to develop this year's program.

The Chapter has an active CYSCHN Committee that is comprised of a group of pediatricians, family advocates, medical students, residents, and representatives from the Massachusetts Department of Public Health. The committee was formed in 2015 to address the needs of Massachusetts CYSCHN and their families in accessing quality

care and access to a medical home. The Chapter also has an active School Health Committee that has two primary functions. The first function is to be a resource for Massachusetts school physicians, many of whom are not pediatricians. The School Health Committee provides networking activities, educational presentations, and legislative lobbying on areas of school health interest. The second function is to provide a forum for any pediatrician who has an interest in school health issues.

We expect a very good turnout at this year's Annual Meeting and we encourage you to join us! The Chapter has applied

for CME credits and the cost is \$80 for members and is free for medical students and residents. A detailed program will be sent to members this month. For more information or to preregister, please contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).

Finally, it's important to note that we are entering into the next phases of our strategic plan and will be working to further focus our priorities based on our recent needs assessment and strategic planning recommendations from the AAP. Stay tuned!

## How Scaffolding Helps Build Executive Function Skills

*continued from page 1*

- Inability to complete assignments efficiently
- Difficulty with memorizing or remembering rules<sup>2</sup>
- Impulsivity<sup>1</sup>

Executive function involves goal-directed behavior that not only influences success in academic achievement and daily activities, but influences success later in life through job skills, social skills, and independent living skills.<sup>3</sup> If a child is having issues with executive function, it is important to intervene early in order to give the child every opportunity for success.

It is important to understand that children are not born with these skills, but they're born with the potential to develop them.<sup>1</sup> Adults aid in the development of a child's executive function skills in various ways including establishing routines, demonstrating social behavior, guiding children through modeling the use of executive function skills, and maintaining supportive, stable relationships.<sup>1</sup> If parents notice executive function issues, they should begin intervention by making adaptations at home. Using charts, checklists, and schedules on a daily basis helps children build a routine and accomplish goals. Examples of home interventions include but are not limited to the following:

- **For homework time:** Set a specific time each day after school when the child

will begin homework and designate a distraction-free area. This will help establish a routine and allow the child to focus on the tasks each day.

- **For managing the day:** Teach the child to use a daily agenda planner to promote organization.
- **For getting ready for school:** Create a morning routine with visual cues and reminders for each step of the process, such as brushing teeth, combing hair, putting on each layer of clothing, tying shoes, etc.
- **For remembering instructions:** Create a mnemonic to help with recalling multi-step instructions.<sup>4</sup>

Along with adaptations to daily activities, parents should also use scaffolding as a method to teach their children and guide them through tasks. Scaffolding is a learning technique in which the adult relinquishes control of a task to the child over time. The effectiveness of scaffolding hinges on the contingency rule: when the child struggles, the adult should increase the level of support provided, and when the child succeeds, the adult should gradually decrease the level of support.<sup>5</sup> Scaffolding allows parents to adjust their support-based on the child's needs. For example, when teaching a child to brush their teeth independently, parents can use scaffolding to help their child achieve this daily skill. The parent may first start by brushing the child's teeth for them and then slowly decrease their amount of help

over time, from being prompted with cues to complete independence.

While scaffolding and daily home adaptations are effective beginning steps for early intervention at home, clinical intervention may be necessary if improvements are not seen. For a diagnosis, refer your patients to a neuropsychologist or a child psychologist. For ongoing treatment, you should refer patients to occupational therapists or speech therapists. Occupational therapists and speech therapists will work on the underlying issues that are preventing a child from developing healthy executive function skills, as well as work with the child and family to develop specific strategies that will be most beneficial.

— **Bobbie Vergo, OTD, and Janey Grubmuller**

For more information about executive function and other issues related to childhood development, please visit [www.pathways.org](http://www.pathways.org) or email [friends@pathways.org](mailto:friends@pathways.org). Pathways.org, founded in 1985, provides parents and health professionals with free educational resources on children's motor, sensory, and communication development to promote early detection and intervention.

### References

- <sup>1</sup>Executive Function & Self-Regulation. Center on the Developing Child at Harvard University. <https://developingchild.harvard.edu/science/key-concepts/executive-function>. Accessed October 26, 2017.
- <sup>2</sup>Morin A. 9 terms to know if your child struggles with executive functioning issues. National Center for Learning Disabilities. [www.ncl.org](http://www.ncl.org). Accessed November 6, 2017.
- <sup>3</sup>Anderson M, Brydges CR, Fox AM, Reid CL. A unitary executive function predicts intelligence in children. *Intelligence*. 2012;40(5):458-469. doi: 10.1016/j.intell.2012.05.006
- <sup>4</sup>Executive Function Interventions. Children's Hospital of Philadelphia. [www.chop.edu/centers-programs/executive-function-consultation-education-and-skills-excel-clinic/interventions](http://www.chop.edu/centers-programs/executive-function-consultation-education-and-skills-excel-clinic/interventions). Accessed November 8, 2017.
- <sup>5</sup>Mermelshine R. Parent-child learning interactions: A review of the literature on scaffolding. *Br J Educ Psychol*. 2017;87(2): 241-254. doi:10.1111/bjep.12147

## The Quiet Room

*This article was first published in the New England Journal of Medicine on November 15, 2017. The original can be found at [www.nejm.org/doi/full/10.1056/NEJMp1714825](http://www.nejm.org/doi/full/10.1056/NEJMp1714825).*

At the end of an inconspicuous hallway and strategically placed far from the controlled chaos of the trauma room lies a dimly lit waiting area that we in the medical field call “the quiet room.” It is a bland spot; a few soft chairs surround a table that holds a box of crisp institutional tissues. There may be a picture or two on the wall, but generally it is an unassuming room where we physicians tell mothers about the deaths of their children, far too often because of firearm violence.

As we make our way to this room, we recite a careful script; we use words intended to ease this painful first-and-only meeting. The reality is that over the years, we have found that there is no good way to tell a mother that her child has died, especially when the unexpected death might have been avoidable.

We introduce ourselves as the doctor who took care of their child. We take a deep breath, look into their eyes, and quickly break the devastating news — there is no reason to delay. What follows is the visceral, piercing shriek of a mother’s wailing, “Please God, not my baby!” We often weep with these mothers, we sometimes quietly blame ourselves for not being able to do more to save their baby’s life — and when they are alone, as is often the case, we hold them up while they cry.

We walk away from the encounter, our stomachs churning from the stale, metallic scent of a child’s blood barely dried on our clogs, our faces streaked with tears, and our hearts gripped in a vise as we tell ourselves that this senseless dying must end. But it doesn’t end. Another child is shot, and another mother is heartbroken.

There is nothing quiet about this room.

In the month since the mass shooting in Las Vegas, over 1300 more Americans have been killed, and more than twice that number have been injured, by firearm violence. Every day, 46 children and

teenagers are shot and 7 of them die. The overwhelming majority of those shootings and deaths are the result of interpersonal violence, though some are from an accidental discharge of an unsecured firearm and some are suicides and are attributed to underlying mental illness.<sup>1</sup> Sometimes the shooting is described in a bylined article in the local newspaper, but most of the time it is not reported at all. What does get reported skews toward senseless acts of terror, with the blame placed squarely on the shoulders of a mentally ill monster. But gun violence in the United States is not primarily a mental health problem.

Nearly a month after the deadliest mass shooting in modern American history, which killed 58 people, we predictably find ourselves witness to another mass shooting, this time in a small town near San Antonio, Texas. In this attack, 25 Americans, including a pregnant woman and up to 14 children (the most children affected since the shooting in Newtown, CT, in 2012), were murdered by a single perpetrator during Sunday prayer services. On the evening news, only hours after the tragedy, we are told once again that it is time for “a national conversation about guns.”

From the vantage point of a trauma surgeon, conversation seems a terribly feeble response. Gun violence, whether on the streets of Chicago or in the churches of Charleston and Sutherland Springs, is a national health emergency. It is an epidemic as deadly as the global Ebola crisis or the opioid epidemic in this country. But in those emergencies, a call for action has been followed by at least some action, not simply by the ritual and empty call for thoughts and prayers and, at most, a mere discussion. Congress appropriated \$5.4 billion for the Ebola response as part of its final fiscal year 2015 spending package. The Centers for Disease Control and Prevention is awarding more than \$40 million to support state efforts to address the opioid-overdose epidemic. After the introduction of the Dickey Amendment in 1996, government funding for research into firearm injuries and deaths has been restricted.

President Donald Trump has said that gun violence in America is a mental health problem, but the issue is far more complicated. Only if funding for research on firearm-violence prevention and public health surveillance is reinstated can we determine the best approach to addressing the public health crisis of firearm violence. Furthermore, expanding the National Violent Death Reporting System from 40 states to all 50 states plus Washington, D.C., would provide more information about where we should be focusing our attention.

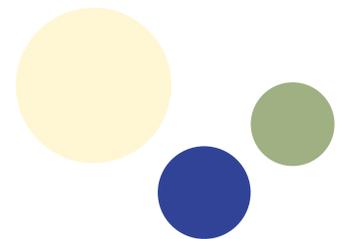
In addition, the American Academy of Pediatrics has laid out three key priorities for confronting the crisis<sup>2</sup>: access to appropriate mental health services, particularly to address the effects of exposure to violence; enactment of firearm legislation that includes stronger background checks, banning assault weapons, addressing firearm trafficking, and encouraging safe firearm storage; and protecting the crucial role of physicians in providing anticipatory guidance to patients about the health hazards of firearms.

It is time for more than a discussion. Surely there is, in our collective power, some more concrete way to address the public health crisis that is gun access. We can no longer allow one mother after another to know the pain of losing a child to senseless gun violence. We remain haunted by their screams. — **Peter T. Masiakos, MD, and Cornelia Griggs, MD**

### References

<sup>1</sup>Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Ann Epidemiol* 2015;25:366-76.

<sup>2</sup>American Academy of Pediatrics. Gun violence prevention: federal priorities to keep children safe ([www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/AAPFederalGunViolencePreventionRecommendationstoWhiteHouse.aspx](http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/AAPFederalGunViolencePreventionRecommendationstoWhiteHouse.aspx)).



## Silver Diamine Fluoride: Is It the New Magic Bullet for Dental Caries?

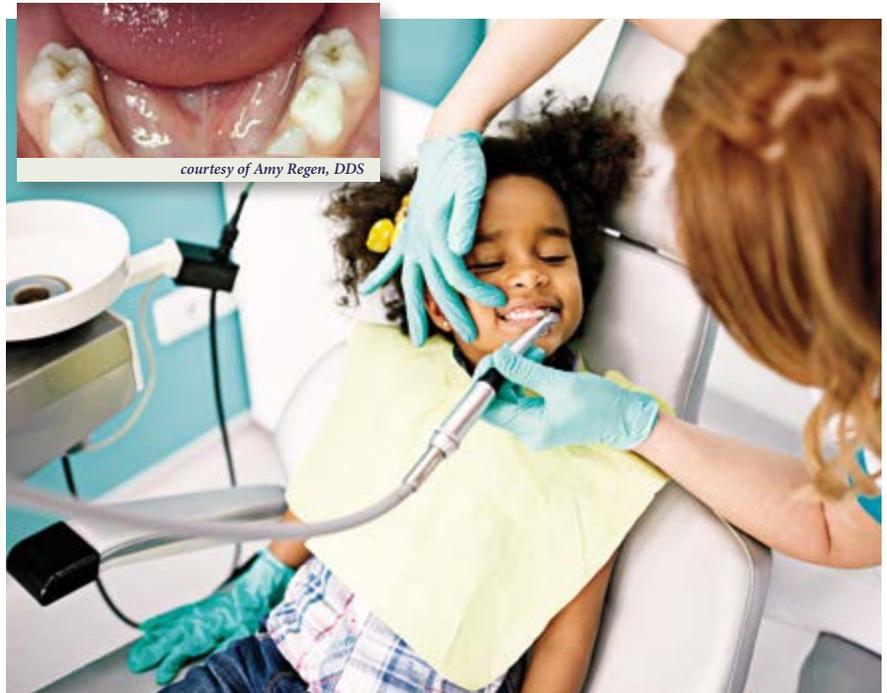
Have you recently noticed some black teeth in a child's mouth? You may be seeing teeth that have been treated with silver diamine fluoride (SDF) by a local dentist. SDF is a cavity-arresting topical medication used to stop or slow down the cavity process, and is applied without having to remove any tooth structure.

It is a conservative treatment used on an asymptomatic tooth, and acts by killing bacteria and hardening the remaining tooth.

Silver diamine fluoride has been used abroad in countries like China, Japan, New Zealand, Argentina, and Australia for over 80 years. It has been found to be a safe, cost effective way to medically manage dental caries.

When used with carefully selected patients, SDF can arrest more than 90% of caries. It is an excellent option for many patients, including the pre-cooperative patient, the elderly, and those with cognitive or physical disabilities. It can also be used to stabilize rampant caries, treat relatively inaccessible caries and caries caused by salivary dysfunction, and manage dental disease in immunocompromised populations. When SDF is applied once a year it is more effective than fluoride varnish applied four times per year.

Application is very easy. It works best when the teeth are air-dried and isolated with cotton to maintain moisture control. It is a liquid that is brushed onto the carious lesion for one minute. There are no



courtesy of Amy Regen, DDS

post-treatment restrictions, and the patient can eat and drink right away.

The main downside of the treatment is that the SDF will stain any carious lesion black or dark brown. The darkening of lesion happens over a 24-hour period. It does not stain healthy tooth structure. If the liquid contacts soft tissue, it will leave a brown "tattoo" stain, but that fades and completely goes away between 24 and 72 hours.

To maintain the arrested lesion, the liquid may have to be reapplied every 3–6

months. Teeth treated with silver diamine fluoride often need to be later restored with more traditional dental procedures.

SDF is a great option to have for treating caries in the pediatric population. It may be the magic bullet for certain patients, but it won't work for all patients. For the best success, it requires proper case selection, parent education, and close follow-up as future restorative care may be indicated. — *Amy Crystal Regen, DDS, Chestnut Dental Associates*

For more information, please visit [ChestnutDental.com](http://ChestnutDental.com).



### IN MEMORIAM

#### Walter Harrison, MD

The MCAAP sadly reports the death of a beloved friend, colleague, and champion for children. Dr. Walter Harrison (1944–2017) was in private practice for over 35 years and served many roles in the Chapter, including chair of the Children's Mental Health Task Force and the Pediatric Council. Our sincere condolences to his large family, including his five children and six grandchildren.

For full text of his obituary, please see <http://www.legacy.com/obituaries/bostonglobe/obituary.aspx?pid=187517764>.

Editor's note: If current members would like to recognize a cherished colleague, please submit an obituary to [ldobberteen@mcaap.org](mailto:ldobberteen@mcaap.org). We will publish brief "In Memoriam" notices with the full text of obituaries available online.

# ShotClock

## Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose within 24 Hours of Birth

### Updated Policy Statement from the American Academy of Pediatrics

The American Academy of Pediatrics (AAP) has recently published an updated policy statement, "Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose Within 24 Hours of Birth" (<http://pediatrics.aappublications.org/content/pediatrics/early/2017/08/24/peds.2017-1870.full.pdf>). In the updated policy statement, the AAP recommends that the first dose be given within the first 24 hours, because this timing maximizes the effectiveness of the vaccine in preventing newborn infection. (The previous policy statement included an option to delay the first dose of hepatitis B vaccine until the first newborn pediatric checkup.)

The AAP statement recommends that all medically stable newborns with a minimum birth weight of 2000 g (about 4 lb., 6 oz.) receive the vaccine within 24 hours of birth. The updated AAP statement follows the practice now recommended by the Advisory Committee on Immunization Practices.

The policy statement outlines the following recommendations as key steps for implementing appropriate administration of the birth dose of hepatitis B vaccine:

- Identify HBsAg-positive mothers before delivery and document maternal HBsAg status in infant records.
- Resolve unknown HBsAg status of mothers as soon as possible around delivery, and document maternal status in infant records.
- For all infants born to HBsAg-positive mothers, administer both the hepatitis B vaccine and HBIG within 12 hours of birth, regardless of any maternal antenatal treatment with antiviral medications.
- For all infants with a birth weight greater than or equal to 2000 g born to HBsAg-negative mothers, administer the hepatitis B vaccine as a universal routine prophylaxis within 24 hours of birth.
- For all infants with birth weight less than 2000 g born to HBsAg-negative mothers, administer the hepatitis B vaccine as a universal routine prophylaxis at 1 month of age or at hospital discharge (whichever is first).
- For all infants born to HBsAg-unknown mothers, administer hepatitis B vaccine within 12 hours of birth, and do the following:
  - For infants with a birth weight greater than or equal to 2000 g, administer HBIG by 7 days of age or by hospital discharge (whichever occurs first) if maternal HBsAg status is confirmed positive or remains unknown.
  - For infants with a birth weight less than 2000 g, administer HBIG by 12 hours of

birth unless maternal HBsAg status is confirmed negative by that time.

- Document infant vaccination accurately in birth hospital records and in the appropriate CDC Immunization Information Systems and state immunization registry. Review documentation accuracy periodically and address identified errors.
- Develop procedures to educate all personnel involved in newborn care about recommendations for the birth dose of hepatitis B vaccine, including those personnel who provide care at planned home births.

### — MCAAP Immunization Initiative

#### Reference

AAP Committee on Infectious Diseases and AAP Committee on Fetus and Newborn. Elimination of perinatal hepatitis B: providing the first vaccine dose within 24 hours of birth. *Pediatrics*. 2017;140(3):e20171870. <http://pediatrics.aappublications.org/content/pediatrics/early/2017/08/24/peds.2017-1870.full.pdf>.

## Immunization Action Coalition's Hepatitis B Birth Dose Honor Roll

The Immunization Action Coalition's (IAC) Hepatitis B Birth Dose Honor Roll recognizes US birthing institutions that have attained a birth dose coverage rate of 90% or greater and have met specific additional criteria. These criteria help define the important elements of a birth dose policy that are needed to ensure newborns do not fall through the cracks when medical errors occur.

To be included in IAC's Hepatitis B Birth Dose Honor Roll, a birthing institution must have the following:

- Achieved, over a 12-month period, a coverage rate of 90% or greater for administering the hepatitis B vaccine before hospital discharge to all newborns (regardless of weight), including those whose parents refuse vaccination. (Newborns who are transferred to a different facility after birth due to medical problems do not need to be included in the denominator.)
- Implemented written policies, procedures, and protocols to protect all newborns from the hepatitis B virus infection prior to hospital discharge.

The MCAAP Immunization Initiative would like to congratulate the following



institutions for making the Massachusetts Hepatitis B Birth Dose Honor Roll:

- Beth Israel Deaconess Medical Center
- Boston Medical Center
- Cape Cod Hospital
- Falmouth Hospital
- Hallmark Health System/Melrose-Wakefield Hospital
- Harrington Memorial Hospital
- Holy Family Hospital
- Lawrence General Hospital
- Lowell General Hospital
- Morton Hospital
- Signature Healthcare/Brockton Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center

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](http://www.immunize.org/honor-roll/birthdose). — **MCAAP Immunization Initiative**

## Immunization Rates Update

From the Massachusetts Department of Public Health

Massachusetts has some of the highest vaccination rates in the country, according to data collected by the Centers for Disease Control and Prevention through the National Immunization Survey (NIS). The NIS estimates vaccination coverage among US children between 19 and 35 months of age (NIS-Child) and 13 and 17 years of age (NIS Teen).

For children 19–35 months of age, Massachusetts ranks first in the nation in immunization coverage rates for MMR, DTaP, Polio, Varicella, and pneumococcal conjugate (PCV) vaccines, as well as for the series of seven vaccines (listed in the table above) recommended for children before they turn two years of age. For adolescents, Massachusetts ranks first in the nation in Tdap and varicella coverage, and is in the top 10 states for all adolescent vaccine coverage rates. Most parents are getting the first dose of HPV vaccine for their child. In 2016, 71% of teens between 13 and 17 years old in Massachusetts received one or more doses of HPV vaccine, an increase of 3 percentage points from 2015. We

still have work to do, however, to bring HPV vaccination rates to the same level as other adolescent vaccines.

### Child – 19–35 Months of Age

	MA	US
4+ DTaP	94%*	83%
3+ Polio	100%*	92%
1+ MMR	99%*	91%
Hib (Full series)	93%*	82%
3+ Hep B	97%*	91%
1+ Varicella	97%*	91%
4+ PCV	95%*	82%
<b>Teen – 13–17 years of age</b>		
Tdap	97%	88%
≥MCV4	90%	82%
1+ HPV	71%	60%
HPV UTD†	57%	43%

\*Surpasses the Healthy People 2020 goal of 90%.

†Includes those with ≥ 3 doses, and those with 2 doses when the first HPV vaccine dose was initiated prior to age 15 years and there was at least five months minus four days between the first and second dose.

The Massachusetts Department of Public Health (MDPH), in collaboration with various partners including the MCAAP Immunization Initiative, the MA Chapter of the PTA, Massachusetts PTA, and school nurses, works on numerous initiatives to educate the general public, providers, and policymakers about vaccines. Multiple communication campaigns throughout the year aim to raise awareness of the benefits of vaccines and increase coverage levels.

While Massachusetts has some of the highest immunization rates in the country, local data can vary widely. There are pockets of higher exemption rates in areas of Massachusetts, including the western part of the state as well as the southeast, particularly the Cape and the Islands. Areas with higher exemption rates may be more susceptible to disease outbreaks as these students are not fully protected. The MDPH is working with many partners to target education to address the “exemption hot spots” and increase vaccine confidence. If you are interested in participating in this educational effort, please contact Rebecca Vanucci ([rebecca.vanucci@state.ma.us](mailto:rebecca.vanucci@state.ma.us)) or Cynthia McReynolds ([cmcreynolds@mms.org](mailto:cmcreynolds@mms.org)).

Thank you for all that you do to ensure the children of Massachusetts are protected against vaccine-preventable diseases.

— **Kathleen Shattuck, MPH, Assessment Coordinator, and Rebecca Vanucci, MA, Immunization Outreach Coordinator, MDPH Immunization Program**

## 22nd Annual MIAP Pediatric Immunization Skills Building Conference

Almost 400 health care professionals attended the 22nd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference, held on October 12, 2017. The conference included both plenary sessions and breakout sessions, and viewings of immunization-themed videos.

The MIAP Conference Organizing Committee would like to thank the following speakers for their outstanding presentations: “Plenary Sessions” by Susan Lett, MD, MPH, Rebecca Perkins, MD, MSc, Pejman Talebian, MA, MPH, and JoEllen Wolicki, BSN, RN; “Breakout Sessions” by Tricia Charles, BA, Rebecca Perkins, MD, MSc, Marija PopStefanija, MPH, Katie Reilly, MPH, MSN, RN, PHNA-BC, Tabitha Rohrer, MA, Ronald Samuels, MD, MPH, Pejman Talebian, MA, MPH, and Rebecca Vanucci, MA. Conference presentations have been archived and can be downloaded at <http://mcaap.org/immunization-cme/#Conferences>.

MIAP Conference Awards were presented to Eileen Duffey-Lind, RN, MSN, CPNP, Dana-Farber Cancer Institute/Team Maureen, and Cynthia McReynolds, MBA, MCAAP Immunization Initiative.

Through the organization which she founded, Team Maureen, Ms. Duffey-Lind has developed a variety of innovative activities to educate people about the importance of human papillomavirus (HPV) vaccination as a cancer prevention tool, and the importance of early detection of HPV-related cancers. Ms. Duffey-Lind practices in the pediatric oncology clinic at Dana-Farber and has worked with the public health/community outreach office to initiate programs that engage multiple stakeholders in an effort to increase HPV vaccination rates and reduce HPV-related cancers.

Ms. McReynolds was recognized for her work as program manager of the MCAAP Immunization Initiative. In that role, Ms. McReynolds manages immunization advocacy, collaboration, communication, education, and grant activities. She works with the Chapter’s 1,800 pediatricians, and also pediatric health care, public health professionals, and policy advocates, creating partnerships to keep Massachusetts a national immunization leader.

Ms. Duffey-Lind and Ms. McReynolds also serve as co-chairs of the Massachusetts HPV/Cervical Cancer Work Group.

H. Cody Meissner, MD, MPH, FAAP, was also recognized as the 2017 Massachusetts recipient of the CDC's Childhood Immunization Champion Award.

The MIAP Conference Organizing Committee would like to thank Sanofi-Pasteur for an unrestricted educational grant in support of the conference.

— *MCAAP Immunization Initiative*

## 2018 Immunization Initiative Webinar Series

The goal of the Immunization Initiative Webinar Series, which was initiated in 2012, is to improve Massachusetts childhood and adolescent immunization rates through continuing education for health care professionals. The webinars are appropriate for health care

professionals who provide immunizations to children and adolescents in Massachusetts, including Chapter pediatricians and family practice physicians, nurse practitioners, nurses, physician assistants, medical assistants, public health workers, community health center staff, and office staff who work in pediatric health care settings.

The one-hour webinars are free and attendees receive a CME/CEU activity award certificate for their participation.

Recent webinar topics include the following:

- 2017 Minnesota Measles Outbreak
- 2017–2018 Influenza Season Update; MDPH Vaccine Update
- Improving Human Papillomavirus (HPV) Vaccination Rates Through A Local Partnership
- 2017 Childhood Immunization Schedule Review; MDPH Vaccine Update

- Vaccine Storage and Handling and VFC Compliance Training
- You Are the Key to HPV Cancer Prevention: Strategies for Raising HPV Vaccination Rates
- 2017 HPV Vaccination Update
- Are Alternative Vaccine Schedules a Reasonable Alternative?

To view a list of upcoming webinars, visit <http://mcaap.org/immunization-cme/#webinars>.

Archived webinars from previous years can be found at <http://mcaap.org/immunization-cme-archives>.

If you have any questions about the webinar series, please contact Cynthia McReynolds at [cmcreynolds@mms.org](mailto:cmcreynolds@mms.org) or (781) 895-9850. — *MCAAP Immunization Initiative*

## Upcoming Conferences and Meetings

### MCAAP Immunization Initiative Advisory Committee Meeting

January 31, 2018, 6:30 p.m.

Massachusetts Medical Society, Waltham

For more information, 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, 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).

### 23rd Annual Massachusetts Adult Immunization Conference

April 10, 2018, Best Western Royal Plaza Hotel, Marlborough

Updated information will be posted as it becomes available at <http://maic.jsi.com>.

### National Infant Immunization Week (NIIW)

April 21–28, 2018

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

## SAVE THE DATE

# The 2018 MCAAP Annual Meeting

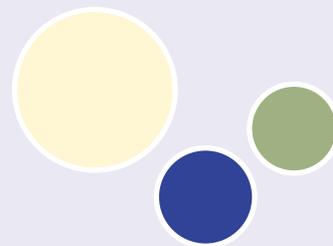
## School Health in Massachusetts

### Schools and Health Care Providers Working Together to Promote the Health and Well-Being of Children and Youth

The Annual MCAAP Edward Penn Memorial CME Lecture and Business Meeting will take place on May 9 at the Massachusetts Medical Society from 9:30 a.m. until 4 p.m. The program will focus entirely on a variety of issues that

affect children in schools, and CME credits will be offered. The program cost is \$80 for members and is free for medical students and residents.

For more information or to pre-register, please contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).



## MDPH Changes Lead Regulation for Pediatric Health Care Providers

The Massachusetts Department of Public Health's (MDPH) Childhood Lead Poisoning Prevention Program (CLPPP) has amended its Lead Poisoning Prevention and Control Regulation, which will go into effect December 1, 2017. The amended version of the regulation lowers the blood lead level in the regulatory definition of *lead poisoning*, establishes a new blood lead Level of Concern category, and institutes additional screening guidelines for these blood lead levels. Details of these and other changes are found below. Please refer to our website or contact CLPPP at (800) 532-9571 with any questions.

Changes that will affect your practice include the following:

- Lead Poisoning: Venous Blood Levels  $\geq 10$   $\mu\text{g}/\text{dL}$  (reduced from 25  $\mu\text{g}/\text{dL}$ )
- Blood Lead Level of Concern: Venous Blood Levels 5 to  $<10$   $\mu\text{g}/\text{dL}$  (new regulatory category)
- Mandatory Screening Schedule remains the same
- Screen all children at 9–12 months and again at ages 2 and 3
- Continue to screen children 4 and over if high risk
- Lives in a High Risk Community: A list of these communities can be found at [mass.gov/dph/clppp](http://mass.gov/dph/clppp) (Lead Research and Statistics)
- Lives in a High Risk Environment: Other poisoned children in the same home or pre-1978 homes under renovation
- Changes to Regulatory Blood Lead Level Categories
- Changes to Screening and Reporting Thresholds
- Capillary tests  $\geq 5$   $\mu\text{g}/\text{dL}$  now require venous confirmatory re-screening (recommended within two months)
- Continue to report all Blood Levels to CLPPP
- BLL 10  $\mu\text{g}/\text{dL}$  or greater (reduced from 25  $\mu\text{g}/\text{dL}$ ): Report within three business days of testing
- BLL  $< 10$   $\mu\text{g}/\text{dL}$ : Report within seven business days of testing
- Provide parents/guardians with proof of screening for entry into daycare and pre-K programs in addition to kindergarten — *Massachusetts Department of Public Health*

For more information, call (617) 624-5757 or the TTY number at (617) 624-5286 or fax (617) 624-5183, or visit [www.mass.gov/dph/environmental\\_health](http://www.mass.gov/dph/environmental_health).

## New Child Development Series for Young Parents Coming in 2018

Massachusetts Act Early, the state affiliate of the CDC's national public awareness campaign about the importance of developmental monitoring in young children, announced that it will launch its *1, 2, 3... Grow!* cable-TV series about early childhood development in eight languages and cultures across Massachusetts in early 2018.

Each of the eight shows will include a local pediatrician and program host from the same culture who speak the language of their particular audience: English, Spanish, Brazilian Portuguese, Mandarin Chinese, Haitian Creole, Arabic, and Vietnamese, as well as an African American show. The shows will present video examples of healthy development and signs of concerns, as well as interviews with parents of children with developmental disorders from diverse cultures. At the end of each show, viewers will receive contact information to local resources for translated developmental materials and referrals to local pediatric providers for further evaluation, if needed.

*1, 2, 3...Grow!* is scheduled to be aired on Boston Neighborhood Network

Television (BNN-TV) in early 2018 (dates TBA). In addition, an outreach campaign to cable-TV stations across Massachusetts is planned for late 2017/early 2018 to request airing the shows locally. All eight shows and the individual parent interview clips will also be available on YouTube.

For more information about *1, 2, 3... Grow!* and to check back for show dates, please visit [www.maactearly.org](http://www.maactearly.org). For information and resources from the CDC "Learn the Signs. Act Early." campaign, please visit [www.cdc.org/actearly](http://www.cdc.org/actearly).

— *Elaine Gabovitch, MPA*

Massachusetts Act Early is the state coalition for the national CDC's "Learn the Signs. Act Early." public health campaign. The campaign aims to educate parents and professionals about healthy childhood development, early warning signs of developmental disorders including autism spectrum disorder, the importance of routine developmental screening, and timely early intervention whenever there is a concern. MA Act Early is a cross-organization collaborative comprised of state team members who represent families and caregivers, university centers of excellence, health care, public health, early education, day care, elementary and secondary education, disability agencies, family support agencies, advocacy groups, and research centers.

For more information, contact Elaine Gabovitch, MPA, project director, Adjunct Faculty, UMass Medical School-E.K. Shriver Center LEND Program, at (617) 893-4439 or [Elaine.Gabovitch@umassmed.edu](mailto:Elaine.Gabovitch@umassmed.edu).





### BOOK CORNER

## Get Devices Out of Children's Hands

There were probably very few surprised pediatric clinicians when Common Sense Media released their latest media usage report in October 2017 ([www.common-sense-media.org/research/the-common-sense-census-media-use-by-kids-age-zero-to-eight-2017](http://www.common-sense-media.org/research/the-common-sense-census-media-use-by-kids-age-zero-to-eight-2017)). Recently, we all have seen more tablets and smartphones clutched in toddler's hands in our exam rooms instead of beloved stuffed animals or action figures. These reports, which have been released since 2011, reflect a large, nationally representative sample of respondents across the United States and track the use of media and technology from birth to age 8. This report presents the results of a nationally representative, probability-based online survey of 1,454 parents of children age 8 or under, conducted from January 20 to February 10, 2017.

The 2017 data reflected the spike in the number of young children who have their own tablet device (now 42%, up from 1% in 2011) and the amount of time children age 0 to 8 are spending with mobile devices (48 minutes, up from just 5 minutes in 2011). When looking at high-risk children, those from lower-income homes spend an average of 1:39 more time with screen media each day than those from higher-income homes (3:29 vs. 1:50). Children from homes with lower parent education consume more screen media than children from homes with higher parent education (2:50 vs. 1:37).

You might easily throw up your hands and give in to a digital world, perhaps

trying to air drop your image onto their screen to get the patient's attention, but two recent studies show there is hope on the horizon. The first was a review in the *Journal of Developmental and Behavioral Pediatrics*, which compared the educational value of reading on tablets versus print books for young children's learning via a qualitative synthesis of the research to date (Reich SM, Yau JC, Warschauer M. Tablet based eBooks for young children: what does the research say?, *J Dev Behav Pediatr* 2016;37:585–591). They found that when e-books are designed well, preschool-aged children learn equally and sometimes more than from print books. At the same time, enhanced e-books with sounds, animation, and other distractions can reduce learning. They also noted that when parents engage with their child during e-reading, it is often about the platform. When parents and children engage in reading a print book, the conversation is more about the content.

A second study published this month in the *Journal of Pediatrics* explored the relationship between maternal shared reading quality (verbal interactivity and engagement) and brain function during story listening in at-risk, preschool-age children (Hutton JS, et al. Shared reading quality and brain activation during story listening in preschool children. *J Pediatr* 2017;191:204–211.e1). This study had a twist on prior work from this group. In addition to functional magnetic resonance imaging using an established story listening task, the dyad was then directed to a private waiting room and encouraged

to relax. A high-definition webcam was unobtrusively mounted, and arranged on a table were popular magazines, a sign with a WiFi password, and a children's picture book. If the mother or child did not spontaneously choose the book within 3 minutes, a research coordinator advised them that it was theirs to take home and encouraged them to read it together, with no further coaching.

The good news first: scores were positively correlated with activation in left-sided brain areas supporting expressive and complex language, social-emotional integration, and working memory. The not-so-good news: shared reading quality scores were generally low and negatively correlated with maternal distraction by smartphones. Thus, in this high-risk cohort, being read to showed positive brain activation in communication areas but maternal distraction by smartphone use impacted how often children receive this positive boost.

What should we do as pediatric clinicians? Can we really overcome the 48 minutes/day that children younger than 8 years of age spend on a mobile phone? The data tell us we must try — it is too important! As you all do, every day, encourage parents and caregivers to put down their phones and pick up a book to read to their child! — **Marilyn Augustyn, MD, FAAP**

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

## Two New Resources for Depression Available

At the October meeting of the MCAAP Mental Health Task Force, Bill Beardslee and Lauren Thomann, from the Baer Prevention Initiatives, presented information about FAMpod.org. The website offers two free training programs: Family Talk, a training course designed for clinicians helping these families, and Parent Talk, Baer's latest resource developed for parents facing depression within the family.

Family Talk, which is based on an approach to parental depression developed by Dr. Beardslee, Dr. Gladstone, and associates over many years, is a preventive, psychoeducational approach for families that is evidence-based and clinician-facilitated. Designed to strengthen positive interactions between parents and children, it reduces risk factors and reinforces protective factors, increases understanding of parental illness and self-awareness, and decreases depressive symptomatology in children. The six sessions begin by taking a history from both parents (if present) and educating them about depression, its treatment, and resilience in children. Then for four sessions, clinicians work with the parents to plan a family meeting. A family meeting is held in the fifth session and a follow-up in the sixth. (Please note that credit can be received from the National Association of Social Workers for completing the Family Talk training.)

Family Talk is supported by strong evidence, is based on a 10-year National Institute of Mental Health-supported randomized trial, and has received high rankings in the National Registry of Effective Programs. The original intervention has been adopted for country wide use in Finland, Holland, several other European countries, Australia, and Costa Rica, and for different populations in this country. After these experiences, Dr. Beardslee and Dr. Gladstone and their colleagues developed Family Talk.

Inspired by parents' concerns about adolescent and parental depression, the team developed a second course, Parent Talk, designed specifically to address them. This information comes from extensive experience working with families using the Family Talk intervention, and from

use of a parent-focused internet depression prevention approach in pediatric practices, developed by Dr. Gladstone (the CATCH-IT parent program). Parent Talk is designed to not only enhance the lives of youth potentially experiencing depression, but also to help parents learn about depression, and learn how to maintain a positive influence on their child's functioning even if they are coping with depressive symptoms themselves.

The course consists of four separate modules: Introduction to Parent Talk, Adolescent Depression, Preventing Depression in Adolescents, and Parental/Adult Depression. The Introduction section provides an overview of how to use the Parent Talk print and online resources for families. The Adolescent Depression module presents information about symptoms, risks and resilience, and treatment strategies for youth depression. In the section on Preventing Depression in Adolescents, evidence-based depression prevention programs are outlined. The Parental/Adult Depression module mirrors the module on Adolescent Depression and highlights the differences in symptom expression and diagnosis. The developers' hope is that through this resource, parents will be able to both learn what adolescent depression is and how to recognize depressive symptoms in their children, understand risk and resilience in teens, learn about treatment and prevention programs, identify effective steps that they can take as parents to strengthen family bonds, and discover available resources.

Ultimately, the FAMpod website represents a resource developed by researchers at Boston Children's Hospital, Judge Baker Children's Center, and the Stone Primary Prevention Initiatives at the Wellesley Centers for Women, Wellesley College to distill what has been learned from years of research, practice, and advocacy into programs to help individuals better understand depression. This effort has culminated in the creation of Family Talk and Parent Talk. — **Bill Beardslee**

Please visit <http://fampod.org> in order to explore Parent Talk and Family Talk further.

Questions? Please contact Bill Beardslee at [William.beardslee@childrens.harvard.edu](mailto:William.beardslee@childrens.harvard.edu).

### MCAAP Committees and Administrative Appointments

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**SUSPECTED CHILD ABUSE AND NEGLECT**  
Stephen Boos, MD, [sboos@mcaap.org](mailto:sboos@mcaap.org)

## JOB CORNER

### Academic Pediatric Gastroenterologist

**Description:** Dedicated pediatric gastroenterologist looking to join an academic practice and provide patient-centered care with the options for clinical/translational research.

**Contact info:**

Timothy Menz, 9 Kiberd Dr.,  
North Chelmsford, MA 01863.  
Email: tmenz@lifespan.org,  
tim.menz@gmail.com.  
Work: (401) 444-8306,  
Cell: (617) 997-2689,  
Fax: (401) 444-8748.

**Practice name/Fellowship**

**Program:** Pediatric Gastroenterology, Hasbro Children's Hospital, Warren Alpert Medical School of Brown University.

**Position title:** Third-year fellow.

**Availability:** Available after August 30th, 2018.

### 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](mailto: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](mailto:chaggerty@mcaap.org) for rate and payment information.



## 2018 MCAAP Call for Nominations: Here's Your Chance to Get Involved and Serve the Chapter!

The MCAAP 2018 election will fill vacancies on the Executive Board for vice president, secretary, treasurer, and district representatives in districts 1, 2, 3, 5, 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](mailto: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 Monday, February 26, 2018.

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

