PRESIDENT’S MESSAGE

Bringing Back the Summer Sun

It’s another cloudy, rainy day here as I sit down to write this, my first President’s Message. Despite the calendar saying “June,” it feels more like March. The Farmer’s Almanac predicted spring would be “wet and cool.” With snow in April and home heating still on in late May, it seems that the Farmer’s Almanac was spot on. The Almanac has been predicting weather patterns since its initial publication in 1818, two years following the Year Without a Summer. Many believe the three-degree global drop in temperature the world experienced in 1816 was due to the April 1815 volcanic eruption of Mount Tambora in Indonesia. New England was hit particularly hard — crop failures and widespread food shortages ensued, and religiosity increased. Migration west also increased, as people searched for a safer, more supportive, nurturing environment.

Thinking about the Year Without a Summer brings an eerie sense of déjà vu. Not only have two volcanoes erupted recently, but hunger, food insecurity, human migration for those fleeing hunger, violence, and religious intolerance are ever present. As pediatricians, we know these to be serious and pervasive threats to the health and well-being of children. Furthermore, as in 1816–1818, today’s political and social unrest have led to a serious weakening of our social fabric. Children, the most vulnerable among us, are paying the price for that weakened support. Perhaps the most egregious example of that price are the scores of children separated from their parents as families flee violence for the “freedom” the United States purportedly represents.

continued on page 3

Protecting Children from Firearm Injuries Requires Research: Without It, Our Politicians Are Legislating Blindly

The most recent Santa Fe school shooting left 10 people dead and many more physically injured or emotionally traumatized. Despite the renewed nationwide discussion on gun violence since the Marjory Stoneman Douglas shootings in Parkland, Florida, in February, there have been at least six school shootings. Very little has been done in Washington to curb gun violence at a national level. We must do continued on page 4
EDITOR'S NOTE

A Story about Team-Based Care: You (and Your Team) Just Never Know!

You just never know what impact your team may have. Like many of you, I practice in a NCQI-certified patient-centered medical home. We have been working in teams for years. In the beginning, our team meetings were stilted affairs, run by our planned care coordinator, and mostly consisted of “running the list” (i.e., who needed what well-child check or asthma control test or other indicator to meet our quality goals). The team consists of a planned care coordinator, two front desk staff, one medical assistant, one physician’s assistant, one nurse, one licensed practical nurse, and me.

We lost our planned care coordinator to a budget cut. For a few months, the team continued to try to replicate the above model. None of us felt very invested and staff participation was minimal. The lists did get run, and during their non-team time members of the team were very efficient at scheduling patients; we mostly met or exceeded our quality measures.

Then we revamped team time with input from all. I met with our patient care partner to review at-risk, depressed patients 18 years of age and older. When available, the nurse and physician’s assistant joined as well. It was the same structure for the complex care manager, and the rest of the team used the time for their outreach.

But our time with the whole team became richer, more interesting, and more patient-centered. The staff became much more invested and engaged. They began to bring families to the attention of the other team members. “Did you know the Smith family is going through a divorce?” “The Almeida family had a recent death in the family.” “The Joseph family lost their housing.”

Recently, we had the chance to tell a family story at an all-staff meeting that included many teams. One by one, staff members spoke about their touch points with the family. The family had two children, one of whom had a very tumultuous period with many interfaces with every aspect of the mental health system, and during this time we saw them frequently.

The front desk staff noted the parent was stressed and demanding. The medical assistant noted it was impossible to do simple things with this child, including weighing and measuring. Forget labs. And vaccinations had to be carefully, efficiently and safely executed with lots of help. Either parent was often unable to facilitate any interactions due to his or her own grief, sadness, and inability to act; eventually, we heard they were going through a divorce as well. We did our best to help them, but we worried about them all.

Time went by, and we started to see less of the family. When we did, we noted both children seemed better, and the parent who took over all medical appointments seemed better too. Gradually they eased into the roles of happy children, really extraordinarily so, with a content and at ease parent who was charming and gracious with all the staff.

continued on page 3

Pictured, left to right: Gevanie Thomas, PMR (practice medical receptionist); Suze Jean-Felix, MA (medical assistant); Lorraine Ward, RN; Melissa Odilon, PMR; Elvira Aronzon, PA; Lauren Gonzalez, LPN; Lisa Dobberteen, MD
Children are being detained in jail-like conditions along our border, and used as fodder for political ends, rather than human beings in need of safety and security.

The Farmer’s Almanac was started to help people prepare for and meet the challenges in their environment. It continues to fulfill that goal. It’s a goal we pediatricians know full well. Helping children grow and thrive, whatever their challenges, is what we do best. We do it through clinical practice; child health research; advocacy on behalf of the needs of children, families, and communities; and education of trainees, colleagues, and the community. The MCAAP has been working hard on all these fronts. I invite you to peruse the website or contact any of the committee chairs to learn more about the Chapter’s efforts.

I’m excited and honored to be taking the reins as president of the MCAAP from DeWayne Pursley, MD, who has so ably led our Chapter these past two years. Our Chapter has amazing strengths, from our dedicated and wonderful executive director, Cathleen Haggerty, to all of you. As I look forward, I hope to spend the next two years working collaboratively with you to support and promote the health and wellbeing of the children of our Commonwealth and our nation.

Please write and share with me your concerns, your priorities, your hopes and ideas for the Chapter. Come to a committee or Board meeting. Together we will shine a light on the needs of children and bring out the summer sun.

— Elizabeth Goodman, MD, MBA

Dr. Elizabeth Goodman is the incoming president of the MCAAP and can be reached at egoodman@mcaap.org.
Protecting Children from Firearm Injuries
continued from page 1

there is no research to support whether between 2004 and 2015.

US federal funding for gun violence re

School Public Safety Act allocates $400

people killed in each incident. Although media attention is keenly focused on these “shooter” events, they are a drop in the bucket: gun violence accounts for roughly 38,000 deaths annually in this country,1 and school shootings represent less than one percent of these deaths.

Data on firearm-related injuries is sparse. In 1993, a CDC-funded study examined whether gun ownership confers protection against crime or increases the risk of violent crime in the home. After examining three different counties across the country, the study concluded that “guns kept in the home are associated with an increase in risk of homicide by a family member or intimate acquaintance.”2

Reaction to this study led to intense lobbying by deep-pocketed special interest groups, and the eventual passage of the Dickey Amendment in 1996, which states that “none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention (CDC) may be used to advocate or promote gun control.”3 While, as recently clarified by Congress in its 2018 spending bill, this amendment does not in itself prohibit firearm injury research, it has created a chilling effect on federal funding, leaving the nation’s few firearm injury researchers scrambling for alternate sources of funding.

The lack of funding so far has led to a lack of objective data to either support or refute our current gun policies. For example, the Marjory Stoneman Douglas High School Public Safety Act allocates $400 million toward school safety and security measures, roughly 20 times the amount of US federal funding for gun violence research between 2004 and 2015.4 However, there is no research to support whether any of the suggested measures in this bill are in any way effective.

Gun violence is a public health crisis and needs to be treated as such. The United States has tackled many public health crises through rigorous, objective research. The classic example is traffic safety: despite the exponentially increasing number of cars on the roads and increasing numbers of vehicle miles traveled, the number of traffic fatalities per mile traveled has dramatically decreased as result of the implementation of evidence-based safety measures. The same public health approach must be used to address gun violence.

First, Congress must appropriate adequate funds to the CDC and the NIH. The American Academy of Pediatrics is urging Congress to provide $50 million to the CDC for public health research into firearm safety and injury prevention.

Second, we must create and allow researchers access to relevant epidemiologic data on which to base their research.

There is little data related to gun ownership at the local, state, and national levels. And unlike the national database available for fatalities related to motor vehicle crashes, there is little data collected on the details and circumstances of firearm-related injuries or deaths.

Third, we must consider state and philanthropy-funded initiatives to allow this research. Such initiatives already exist at the University of California at Davis, where $5 million in state funding is planned over five years. We must support nonpartisan research funding mechanisms such as the American Foundation for Firearm Injury Reduction in Medicine and the American Academy of Pediatrics’ own Gun Safety and Injury Prevention Research Initiative.

Good scientific research is neither Republican nor Democratic. It is neither pro-gun control nor pro-gun rights. This country desperately needs nonpartisan, objective research on firearm injury patterns that can allow for policies that both protect Americans’ second-amendment rights while decreasing firearm-related injury and mortality. Protecting our children from firearm-related injury must be a priority, and acting on the basis of good science is the only way to proceed.

— Erika Constantine, MD, FAAP

Erika Constantine, MD, FAAP, is associate professor of Emergency Medicine and Pediatrics at Alpert Medical School of Brown University. She can be reached at erika_constantine@brown.edu.

References

Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by August 31, 2018.
New Child Development Series for Young Parents Recently Launched

In May, UMASS Medical School-Eunice Kennedy Shriver LEND Program launched 1, 2, 3, Grow!, a new cable-TV show about early childhood development in eight languages and cultures on stations across Massachusetts.

Each show includes a local pediatrician and program host who speak the language of their particular audience from the same culture: English, Spanish, Portuguese, Mandarin, Haitian Creole, Arabic, and Vietnamese. There is also a show that focuses on African American needs. 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 to obtain translated materials and referral information to local providers if needed.

All eight shows are available on the 1, 2, 3, Grow! YouTube Channel (www.youtube.com/channel/UC9rrMooDiqHfRefqYoFzDOoA). The shows will also air on Boston Neighborhood Network Television (BNN-TV) every Wednesday night at 7:30 p.m. through August 15, with reruns throughout the week. In addition, an outreach campaign to air the shows on a variety of cable-TV stations across the state is currently underway.

For more information about 1, 2, 3, Grow! and to check back for show dates, please visit https://shriver.umassmed.edu/community-resources/cultural-resources/1-2-3-grow. For information and resources from the CDC “Learn the Signs. Act Early.” campaign, please visit www.cdc.gov/actearly.

— Elaine Gabovitch, MPA

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.

MCAAP Committees and Administrative Appointments

Send your email address to ldobberteen@mcaap.org for instant notification of issues important to the MCAAP membership.
Join the Immunization Initiative!

Who We Are
The Immunization Initiative of the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) is dedicated to fully immunizing Massachusetts children and adolescents against vaccine-preventable diseases through advocacy, communication, education, and networking activities. The Immunization Initiative works with MCAAP members and other stakeholders to identify and achieve goals related to improving vaccine access and delivery, awareness, and policy. Its membership includes MCAAP members and community partners, such as pediatric health care and public health professionals, community leaders, nonprofit organizations, vaccine manufacturers, and others who are interested in improving Massachusetts childhood immunization rates.

How We Accomplish Our Mission
- Developing educational programs, including conferences, Grand Rounds seminars, and webinars for health care professionals who administer pediatric immunizations. CME/CEU and Risk Management credit is often available for participating in these programs.
- Participating in collaborative partnerships and activities with organizations, such as the Immunization Program at the Massachusetts Department of Public Health (MDPH), and with individuals who share the Immunization Initiative’s mission. One current collaborative activity is the MCAAP/MDPH Vaccine Confidence Project. The project’s goal is to increase vaccine confidence throughout Massachusetts by engaging key constituents in areas of higher susceptibility to vaccine-preventable diseases in an effort to develop resources and training for health care professionals and outreach to the public.
- Supporting coalition building and networking opportunities through its Advisory Committee. The Advisory Committee meets three to four times per year to discuss current immunization information and strategies for addressing issues and barriers to immunization. The next meeting will be held on Wednesday, September 26, 2018, at 6:30 p.m. Meetings are held at the Massachusetts Medical Society, Waltham.
- Advocating for legislative and regulatory policies which optimize the immunization of Massachusetts children and adolescents by working closely with Massachusetts executive and legislative leadership, and with state agencies.
- Communicating current immunization information and resources through the Immunization Initiative list serve and website, monthly e-newsletter, quarterly MCAAP newsletter, and MCAAP social media outlets.

It’s Easy to Join!
Your participation is welcome and membership in the Immunization Initiative is free. To join, please contact Cynthia McReynolds, program manager, MCAAP Immunization Initiative at cmcreynolds@mms.org or (781) 895-9850. Already a member? Please pass this information on to a colleague who may be interested in joining the Immunization Initiative. — MCAAP Immunization Initiative

Elizabeth Mena Receives CDC Award
Elizabeth Mena, RN, BSN, OCN, CRNI, vaccine coordinator for St. Anne’s Free Medical Program, Shrewsbury, Massachusetts, has been named the Massachusetts recipient of the 2018 Centers for Disease Control and Prevention (CDC) Childhood Immunization Champion Award. Established in 2012 by the CDC, the Childhood Immunization Champion Award recognizes individuals who make a difference in the lives of children through their work in immunization. Ms. Mena was nominated for this award by the Immunization Program at the MDPH.

Since 1999, Ms. Mena has volunteered every Tuesday evening as vaccine coordinator for St. Anne’s Free Medical Program. This program provides vaccines to the most vulnerable populations in the Worcester area. Many of the program’s patients are young children from newborn to two years old, whose families are new to this country and are unable to or unfamiliar with how to access health care. Others are children who would not be able to enter school without up-to-date vaccinations. This free medical program serves approximately 45–60 patients every Tuesday evening.

Ms. Mena’s main goal is to provide vaccinations to children in the community to protect them from contracting vaccine-preventable diseases. She has been recognized for her dedication and has received several other awards for her outstanding work in immunization. Ms. Mena was nominated for this year’s CDC Childhood Immunization Champion Award by the Immunization Program at the MDPH.
diseases, without regard to their financial status.

Ms. Mena has established collaborations with high school students, nursing students from Becker College, medical students from the University of Massachusetts Medical School, and medical residents from St. Vincent’s Hospital. She has inspired many of the high school volunteers to seek careers in nursing and medicine. One of her volunteers will be completing medical school this year.

On a personal note, Ms. Mena’s mother contracted polio as a child, at a time when there was no vaccine available. This made her well aware of the importance of immunization to prevent vaccine-preventable diseases.

Jane Lochrie, MD, medical director, St. Anne’s Free Medical Program, says, “Beth has worked tirelessly volunteering over the past 20-plus years coordinating our immunization program for our free clinic. Her organization skills and meticulous attention to detail make her an ideal nurse for this position. Gracious, caring, and respectful of all, she relates extremely well to patients and their families.”

Pejman Talebian, MPH, MA, program director of the MDPH Immunization Program, noted that Ms. Mena “provides a vital service to her community to ensure that all children have access to recommended vaccinations.

We are lucky to have such a dedicated partner in Massachusetts because it truly takes a village to vaccinate.”

The CDC and the CDC Foundation launched this annual award program to honor immunization champions across the 50 US states and the District of Columbia during National Infant Immunization Week (NIIW). This year NI IW was held April 21–28.

— MCAAP Immunization Initiative

August Is National Immunization Awareness Month (#NIAM18)

National Immunization Awareness Month (NIAM) is an annual event held each August. NIAM provides an opportunity to promote the importance and value of immunization across the lifespan.

A different stage of the lifespan will be highlighted each week during NIAM. Check the NIAM web page for this year’s schedule: www.nphic.org/niam.

The NIAM web page also has a helpful toolkit which contains resources that can be utilized by providers throughout August, including key messages, vaccine information, sample news releases and articles, social media messages, web links from the CDC and other organizations, web banners, logos, and social media graphics.

Be on the lookout for #NIAM18 updates throughout August! Please contact Cynthia McReynolds (cmcreynolds@mms.org), if you are planning a specific NIAM activity, would like to partner with the Immunization Initiative on an activity, or if you have any questions.

Thank you, providers, for all that you do to keep Massachusetts’s children safe from vaccine preventable diseases!

— MCAAP Immunization Initiative

23rd Annual MIAP Pediatric Immunization Skills Building Conference

Note new location!

The Massachusetts Immunization Action Partnership (MIAP) is excited to announce the 23rd Annual Massachusetts Immunization Action Partnership Pediatric Immunization Skills Building Conference. The conference will be held on Thursday, October 18, 2018, at the Sheraton Hotel and Conference Center, Framingham, Massachusetts.

This year’s plenary speakers will be Anna-Lisa Farmar, MD, MPH, assistant professor of Pediatrics at Denver Health Medical...
Center, University of Colorado School of Medicine, Denver, Colorado; H. Cody Meissner, MD, FAAP, chief, Pediatric Infectious Disease Division, Tufts Medical Center, and professor of Pediatrics at Tufts University School of Medicine; Susan Lett, MD, MPH, medical director; Pejman Talebian, MA, MPH, director; and Rebecca Vanucci, MA, immunization outreach coordinator, Massachusetts Department of Public Health, Immunization Program.

Conference breakout sessions will include the following: How to Talk with Parents: Vaccine Conversations to Address Vaccine Confidence, Immunization “101,” Immunization “201,” Challenging Immunization Scenarios, Vaccine Preventable Disease Epidemiology, Vaccine Storage and Handling and VFC Compliance Training, and Massachusetts Immunization Information System (MIIS) updates.

Conference registration will open in August. Updated information will be posted as it becomes available on the MCAAP website at www.mcaap.org/immunization-cme and on the MDPH website at www.mass.gov/service-details/immunization-program-events.

In the meantime, if you have any questions, please contact Cynthia McReynolds at cmcreynolds@mms.org or (781) 895-9850.

— MCAAP Immunization Initiative

Call for 23rd Annual MIAP Conference Award Nominations

Submission Deadline: Friday, July 27, 2018

Each year, the Massachusetts Immunization Action Partnership (MIAP) recognizes Massachusetts individuals or groups that have made an outstanding contribution to pediatric immunization in Massachusetts. The recipient of this award is an individual or an organization that has demonstrated particular leadership, initiative, innovation, collaboration, and/or advocacy. The MIAP Conference Organizing Committee is seeking nominations for this year’s award.

The deadline to submit an award nomination is Friday, July 27, 2018. Nomination forms can be found at www.mcaap.org/immunization-cme.

The 2018 MIAP Conference Award will be presented on October 18, 2018, at the 23rd Annual MIAP Pediatric Immunization Skills Building Conference.

If you have any questions or need additional information, please contact Cynthia McReynolds at cmcreynolds@mms.org or (781) 895-9850. — MCAAP Immunization Initiative

Upcoming Events

National Immunization Awareness Month
August 2018
For more information, visit www.nphic.org/niam.

MCAAP Immunization Initiative Advisory Committee Meeting
September 26, 2018, 6:30–8:30 p.m.
Massachusetts Medical Society,
Waltham
For more information, contact Cynthia McReynolds (cmcreynolds@mms.org).

Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting
October 11, 2018, 4:00–6:00 p.m.
Massachusetts Medical Society,
Waltham, MA
For more information, visit www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html.

23rd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference
October 18, 2018
Sheraton Framingham Hotel and Conference Center – Note new location!

Updated information will be posted as it becomes available at www.mcaap.org/immunization-cme.

Advisory Committee on Immunization Practices (ACIP) Meeting
October 24–25, 2018
Atlanta, Georgia
ACIP meetings are open to the public (in-person and by telephone/webinar). Preregistration is required.

For more information, visit www.cdc.gov/vaccines/acip/index.html.

Provider Resource Spotlight: CDC Guidance Job Aids to Help with Vaccine Catch-Up

The Centers for Disease Control and Prevention recently published catch-up guidance job aids to assist health care professionals in interpreting figure 2 of the childhood/adolescent immunization schedule (see “U.S. Catch-Up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind” at www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html). The format of the job aids makes it easier for providers to determine what is needed for children who are behind schedule with DTap and/or Tdap, Hib and PCV13 vaccines. (See chart on next page.)

The job aids are free and can be downloaded from www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html#catchup.

— MCAAP Immunization Initiative

From the Massachusetts Department of Public Health — New MIIS Upgrade Coming Soon!

The Massachusetts Immunization Information System (MIIS) is undergoing a significant upgrade to its user interface (UI), navigation, some workflows, and performance. The improved MIIS will be available summer 2018. In addition, several new training opportunities and materials will be available for users. More information on trainings will be sent via email over the next few months. If you still need to register with the MIIS, visit the ContactMIIS Resource Center (www.contactmiis.info) for more information or call the MIIS Helpdesk at (617) 983-4335.

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

If you have any questions or need additional information, please contact Cynthia McReynolds at cmcreynolds@mms.org or (781) 895-9850. — MCAAP Immunization Initiative
# Catch-Up Guidance for Children 7 through 18 Years of Age

## Tetanus, Diphtheria, and Pertussis-Containing Vaccines: Tdap/Td

The table below provides guidance for children whose vaccinations have been delayed. Start with the child's age and information on previous doses (previous doses must be documented and must meet minimum age requirements and minimum intervals between doses). Use this table in conjunction with figure 2 of the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, found at [www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html](http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).

<table>
<thead>
<tr>
<th>IF current age is</th>
<th>AND # of previous doses of DTaP, DT, Td, or Tdap is</th>
<th>AND⁴</th>
<th>AND</th>
<th>AND⁵</th>
<th>THEN</th>
<th>Next dose due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown or 0</td>
<td>Give Dose 2 (Tdap) today</td>
<td></td>
<td></td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Dose 1 was given before 12 months of age</td>
<td></td>
<td></td>
<td>Give Dose 2 (Td) today</td>
<td>Give Dose 3 (Td) at least 4 weeks after Dose 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It has been at least 4 weeks since Dose 1</td>
<td></td>
<td></td>
<td>Give Dose 2 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
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<tr>
<td></td>
<td>Dose 1 was Tdap</td>
<td></td>
<td></td>
<td>Give Dose 2 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
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<tr>
<td></td>
<td>Dose 1 was not Tdap</td>
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<td></td>
<td>Give Dose 2 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
<td></td>
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<tr>
<td></td>
<td>It has not been 4 weeks since Dose 1</td>
<td></td>
<td></td>
<td>No dose today</td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
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</tr>
<tr>
<td></td>
<td>Dose 1 was Tdap</td>
<td></td>
<td></td>
<td>No dose today</td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose 1 was not Tdap</td>
<td></td>
<td></td>
<td>No dose today</td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
<td></td>
</tr>
<tr>
<td>7 through 18 years of age</td>
<td>Dose 1 was given before 12 months of age</td>
<td></td>
<td></td>
<td>Any dose was Tdap</td>
<td>Give Dose 4 (Td) at least 6 calendar months after Dose 3</td>
<td></td>
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<tr>
<td></td>
<td>It has been at least 4 weeks since Dose 2</td>
<td></td>
<td></td>
<td>Give Dose 3 (Td) today</td>
<td>Give Dose 3 (Td) at least 4 weeks after Dose 2</td>
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<tr>
<td></td>
<td>Any dose was Tdap</td>
<td></td>
<td></td>
<td>Give Dose 3 (Td) today</td>
<td>Give Dose 3 (Td) at least 4 weeks after Dose 2</td>
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<td></td>
<td>No dose was Tdap</td>
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<td>Give Dose 3 (Td) today</td>
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<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
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<td>Any dose was Tdap</td>
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<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
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<td></td>
<td>No dose was Tdap</td>
<td></td>
<td></td>
<td>No dose today</td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
<td></td>
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<tr>
<td>2</td>
<td>Dose 1 was given at 12 months of age or older</td>
<td></td>
<td></td>
<td>Any dose was Tdap</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
<td></td>
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<td>It has been at least 6 calendar months since Dose 2</td>
<td></td>
<td></td>
<td>Give Dose 2 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
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<td></td>
<td>Any dose was Tdap</td>
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<td>Give Dose 3 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
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<td>No dose was Tdap</td>
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<td>Give Dose 3 (Td) today</td>
<td>Give Dose 3 (Td) at least 6 calendar months after Dose 2</td>
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<td>It has not been 6 calendar months since Dose 2</td>
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<td>No dose was Tdap</td>
<td></td>
<td></td>
<td>No dose today</td>
<td>Give Dose 2 (Td) at least 4 weeks after Dose 2</td>
<td></td>
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</tbody>
</table>

1. Vaccine Information: Tdap: Administer to persons 7 years of age and older without a contraindication or precaution to tetanus, diphtheria, or pertussis-containing vaccine. Tdap products include Adacel® and Boostrix®. Td: Administer to persons 7 years of age and older previously vaccinated with Tdap or with a contraindication to pertussis vaccine.

2. Tdap or Td given as doses 1–3 prior to 7 years of age should not be counted.

3. Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.


Image courtesy of the Centers for Disease Control and Prevention.
Gastroesophageal Reflux in Infants: Physiological or Pathological?

More than 50 percent of infants regurgitate daily, even multiple times per day. Infant gastroesophageal reflux (GER), the passage of gastric contents into the esophagus, with or without regurgitation and vomiting is a constant concern for many families and a frequent topic of discussion with their health care provider.

Parents typically have these recurring questions in their well-child visits:

1. Is this a serious problem and should I be worried?
2. Is my baby getting enough calories or losing weight?
3. How common is reflux in infants?
4. What causes reflux?
5. Does it matter what my baby eats?

Providing answers to the above questions or solutions to help manage reflux can be reassuring to families.

Help parents to understand some of the behaviors that contribute to reflux, such as swallowing air while feeding. If baby is looking around and taking their mouth off the nipple, they may swallow air mid-feed, contributing to regurgitation. Drinking too much or too quickly is another common behavior that leads to reflux. Providers should also remind parents that laying baby down too soon after feeding is a contributing factor.

When it comes to what baby eats, the American Academy of Pediatrics recommends a diet of only breastmilk for the first six months of life. Studies have found infants who drink only breastmilk exhibit less reflux and spit-up behaviors than babies with a mixed diet including formula. Partially breastfed babies suffer from more frequent regurgitation.

While reflux will typically involve a dribble of spit-up after feeding, true reflux disease is much more impressive. These symptoms suggest GER is evolving into a bigger problem:

- Insufficient weight gain
- Fussiness and signs of pain, especially during regurgitation
- Frequent projectile vomiting
- Food refusal
- Respiratory symptoms such as wheezing or a chronic cough

These symptoms can signal gastroesophageal reflux disease, or GERD.

When discussing treatment options with parents, it is important to first discuss positioning. Some parents may already know to keep their baby upright for 30 minutes after feedings, but it is also important to tell them about other types of positioning techniques. In the supine position, the gastroesophageal junction is continually submerged in the consumed fluid, making reflux a common occurrence. Positioning the infant in a left-side lying or prone position clears the juncture of this fluid. If parents are not able to hold their child and keep them upright for 30 minutes after feeding, the left-side lying or prone position would be effective alternatives.

(Ed. note: Keep “back to sleep” in mind and suggest prone positioning only while infant is awake and observed by an adult.)

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Parents tend to put their baby in a car seat to keep them upright; however, this is counterproductive. It is important to not place a baby in a car seat for at least 30 minutes after feeding because the position of the infant in the carrier is one that increases pressure on the stomach. The baby’s position in the seat also causes the legs to flex, creating more pressure. Once the baby is sitting independently, the food will stay down more easily. Parents still worried about regurgitation or if their baby is still showing concerning symptoms should try feeding in smaller amounts and more frequently.

Often, health care providers turn to prescription medication after evaluating positioning strategies, particularly if the child is not yet eating solid food. Medication is commonly prescribed if the infant is in pain or is not taking in the proper quantity of formula/breastmilk per day. Recently, there has been a large increase in GERD diagnosed in infants under 12 months of age along with an increase in prescribing proton pump inhibitors (PPI).  

Once GERD is treated, the issue is not always solved. There can be the potential for long-term effects. Infants with a history of GERD may develop a habit of avoiding certain foods due to their frequent regurgitation and become picky eaters. Something as simple as picky eating can have lasting effects years after infancy. Without intervention, the habits developed while the infant has reflux can persist when they begin to eat solid foods. If a baby is a picky eater, he could be missing out on certain nutrients and vitamins essential to their growth and development.

For some infants and children, untreated reflux can contribute to tooth decay from loss of dental enamel due to stomach acid. Additionally, parents may shy away from putting their infant prone on their stomachs if their baby is showing signs of reflux, due to abdominal pressure and possible increased fussing. Unfortunately, this lack of tummy time can have significant effects on gross motor development and delay achievement of age appropriate milestones.

If reflux disease is unable to be successfully managed by the primary care provider, then the infant should be referred to a pediatric gastroenterologist for further evaluation and treatment. A pediatric gastroenterology specialist may perform further diagnostic testing, such as esophageal manometry, endoscopy, pH impedance test, or a BRAVO placement in order to assist them in creating an individualized treatment plan. Referral to a speech language pathologist is warranted if feeding and/or swallowing difficulties are noted, since this is a common occurrence in infants with GERD. Speech therapists can serve as an additional resource for families and are important partners in helping families become the best advocate for their child especially when navigating through early intervention services.

For more information about childhood development, please visit www.pathways.org or email 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
As your representative to the MMS HOD (Massachusetts Medical Society House of Delegates), I represent all MCAAP members at the biannual meeting of the policy-making body of the MMS. Delegates representing every district medical society and every specialty come together to discuss and debate numerous resolutions concerning health policy, medical practice, medical education, and public health.

The HOD met for the 2018 Annual Meeting on April 26–28. The full details of all resolutions and the final votes can be found at www.massmed.org/annual2018/hod/#final. Below is a summary of the resolutions that I felt would be of particular interest to our members.

1. **Opposition to concealed carry reciprocity** — This resolution, which was introduced by the Massachusetts Chapter of the AAP, addresses the issue of efforts at the federal level to require reciprocity of concealed carry permits across state lines. Currently, Massachusetts does not recognize concealed carry permits issued by other states, but there is concern that federal law would require all states to honor those permits issued by other states. The resolution was passed by the house to advocate that the MMS and the American Medical Association oppose any federal legislation that would require all states to recognize concealed carry permits granted by other states.

2. **Limiting the scope of involuntary civil commitment** — This resolution is an effort to limit the use of involuntarily committing people solely related to substance-use disorder without judicial intervention. Section 35 amended in 2016 of Massachusetts law does allow for involuntary commitments under specific situations, but there is a current bill before the Legislature to expand the use of this provision. It was felt by many that section 35 has a helpful tool in combating the opioid crisis, but there were concerns about the proposed expansion of the law. The resolution passed the HOD to limit the use of this provision.

3. **Food insecurity screening** — The house passed this resolution to encourage all health care providers to use a validated tool to screen for food insecurity of our patients on a routine basis. This is recommended by the American Academy of Pediatrics. The resolution also asked the MMS to disseminate resources for referrals to food and nutrition assistance to members.

4. **Ensuring prescription drug price transparency from retail pharmacies** — This resolution, which passed, addresses the issue of the challenges that patients and providers face in determining the patient’s out of pocket expenses for pharmaceuticals without first having the prescription filled.

5. **OpenNotes** — The OpenNotes movement aims to give patients direct electronic access to their entire medical records including the full text of all progress notes. While some organizations both in Massachusetts and nationwide have implemented this successfully, there were many concerns raised especially for specific populations such as children, victims of abuse, and those with mental health diagnoses. The existing literature on the benefits of OpenNotes compares it to no electronic access to the records. Rather than passing policy in support of OpenNotes, which the original resolution proposed, the version that the House passed states the MMS supports the concept that patients have access to their notes either via patient portals or other means (i.e., request through HIM) and will continue to monitor the OpenNotes movement.

6. **Health care is a basic human right** — There was significant discussion regarding this resolution, which initially asked for the MMS to state that “health care is a basic human right.” While all agree in concept that all people should have access to comprehensive health care, there were concerns regarding the implications of declaring health care a human right in terms of individual provider liability and obligation. The version that was passed calls for the

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Local Pediatrician Is Running for State Senate

Dr. Katie McBrine is a pediatrician in Scituate and fellow member of the American Academy of Pediatrics. She’s also a wife and mother who enrolls both of her kids in public school. Katie regularly gives talks on health and science to kids, teens, and adults at local libraries and schools.

Katie is running for State Senate in Plymouth and Norfolk (District 8).

For more information, you may email Dr. McBrine directly at katie@votemcbrine.com.

The Palfrey Advocacy Fund

The Palfrey Advocacy Fund provides funds for young pediatricians to start innovative initiatives to prevent adverse childhood events. This year, the recipients were Meghan Craven, MD, for her project entitled “Health Systems Strengthening of a Non-Communicable Disease Clinic in Haiti,” and Larissa Truschel, MD, for her project, “The effects of the Earned Income Tax Credit on asthma outcome, an innovative approach to improve asthma outcomes with federal anti-poverty program.”

For more information, contact Drs. Judy Palfrey or Sean Palfrey at jpalfrey@mcaap.org or spalfrey@mcaap.org.

MCAAP 2018 Election Results

- **President**
  Elizabeth Goodman, MD, MBA, FAAP

- **President-Elect/Vice President**
  Lloyd Fisher, MD, FAAP

- **Secretary**
  Brenda Anders Pring, MD, FAAP (re-election)

- **Treasurer**
  Mary Beth Miotto, MD, FAAP

- **District Representative Positions**
  - **District 1** — Stewart Mackie, MD, FAAP
  - **District 2** — Gina O’Brien, MD, FAAP
  - **District 3** — Laura Lee, MD, FAAP (re-election)
  - **District 5** — Daniel Slater, MD, FAAP (re-election)
  - **District 8** — Daniel Rauch, MD, FAAP

MMS to lead a conference to discuss the legal and ethical implications of such a declaration. Following that conference, recommendations would be made.

7. **Protecting the patient-physician relationship** — This resolution was introduced to address the issue regarding the disruption in the patient-physician relationships that have occurred due to the Medicaid ACO rollout. Many patients are being forced to choose between remaining with their primary care provider and continuing to see the specialists with whom they also have a relationship if their PCP and their specialist are not part of the same ACO. The resolution, which passed the House, asks the MMS to work with MassHealth to promote continuity of care and minimize disruptions in existing relationships. As we know this has been a significant concern in at pediatric patients. — **Lloyd Fisher, MD**

Lloyd Fisher, MD, is the MCAAP Delegate to the Massachusetts Medical Society.

Send your email address to ldobberteen@mcaap.org for instant notification of issues important to the MCAAP membership.
There is some compelling new evidence for the developmental benefits of reading an illustrated book to a child compared to a child listening to an audiobook or watching an animated version of the same story. It may sound silly that this would actually need to be studied at all, but it has, and it’s worth celebrating that the evidence supports what common sense already tells us: put down the device and read to your child on your lap. The format in which a child receives a story really does matter.

John Hutton, MD, a pediatrician and researcher at Cincinnati Children’s Hospital, conducted a study involving 27 children around the age of four (Hutton JS, et al. Shared Reading quality and brain activation during story listening in preschool children. J Pediatr 2017; 191:204-211.e1). Each child was placed in a functional MRI scanner while listening to an audiobook, watching an animated video, or looking at an illustrated book while being read to by a voice. Neural network connectivity in each of these scenarios was documented, and the results confirm that there are a lot more connections being made when a child has a visual guide to the story. Even without the benefit of dialogic reading, there are many more connections when an illustrated book is involved. Networks involving learning, visual imagery, and language are all more active when there is an actual print book in the picture.

The study further demonstrated that children experience stress while trying to understand an audiobook; they find it difficult to keep up with the language without a visual guide to go along. Compared to listening to the book being read, comprehension of audiobooks and animated video was reduced, and neural networks involving integration were less active.

As a pediatrician in an urban practice, I am still stymied about how to advise parents, especially when they are not convinced themselves that there is anything to be concerned about. A young mom of a 10-month-old recently told me that she bought a tablet for her daughter because she “needed it” for the plane trip to Florida. When I protested, she laughed and told me I was old-fashioned: every child she knows has a tablet or a phone. We started a conversation about my concerns. We will pick it up when they get back from vacation.

For now, we can have more confidence in promoting book reading to very young children and infants. We can honestly say that there is strong evidence that children will do better with their learning and vocabulary, have a higher likelihood of being ready for kindergarten, and be comfortable with books, if we start reading early and often. We can talk with parents at newborn visits about shared reading: the infant doesn’t have to understand. Just hearing the voice of a loving adult reading, hearing the cadence and expression and rhythm, while sitting closely and securely together, will enhance the child’s attachment and development. We have a lot of competition and marketing to cope with, but our message is simple and clear: read to your children. Thanks to Dr. Hutton, who also runs a children’s bookshop in Cincinnati, for this work. It’s comforting to all of us.

— Eileen Costello, MD

Dr. Costello is the medical director of ROR (Reach out and Read) in Massachusetts, and can be reached at eileen.costello@bmc.org for more information.

Editor’s note: the talented Dr. Hutton is not only a pediatrician, researcher, and local business owner, but the author of a number of wonderful children’s books, including my favorite, Fiona’s Feelings.
MCAAP Residents and Fellows Day at the State House (RFDASH) took place on May 3. Over 60 residents and fellows advocated for the following bills:

- House Bill 4109, An Act to Protect Youth from the Health Risks of Tobacco and Nicotine Addiction
- Senate Bill 2128, An Act Relative to Healthy Youth, which was related to sex education in MA public schools
- House Bill 3610, An Act Temporarily Preventing Firearm Access for Extremely Suicidal Individuals, which was related to gun violence prevention

Speakers and topics included the following:

- Chana Sacks, MD — Gun violence prevention and ERPO
- Jonathan Winickoff, MD — Prevention of youth tobacco and nicotine use
- Traci Brooks, MD — Youth sex education in schools
- Carole Allen, MD, MBA (Keynote Speaker) — Child health advocacy
- Ed Brennan, Esq. (MCAAP Legal Counsel) — Legislation highlights
- Alex Calcagno — How to Talk to Legislators 101

For more information about RFDASH 2018, visit https://rfdash.weebly.com.

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Full time BC/BE Pediatrician
Middleboro Pediatrics (Lakeville, MA) is a thriving private group practice with an opening starting as early as fall 2018. NCQA level 3 medical home with team-based approach to care. Affiliated with Partners Healthcare/MGH. No inpatient/hospital duties. Call 1:4. Competitive salary, full benefits, partnership opportunity. Convenient location in Southeastern MA with easy access to highways/commuter rail. Learn more about us at www.middleboropediatrics.com. Interested individuals: Please send CV and correspond with Aaron Bornstein, MD at abornstein@pchi.partners.org.

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Frisbie Memorial Hospital, Rochester, New Hampshire — We are currently seeking a Board Certified or Eligible Pediatrician to join our Women & Children’s Health Services team. This is a desirable position with a well-established practice that offers a 4-day work week and a 1-in-4 call schedule. Call includes inpatient coverage of the newborn nursery and pediatrics unit. For inquiries or to apply, please contact Jeanette Rowlinson, PHR, SHRM-CP, RACR; Office: (603) 330-7989; Email: J.Rowlinson@FMHospital.com.

Part-Time PCP BC/BE Pediatrician
Seeking part-time PCP BC/BE pediatrician for innovative Cambridge private practice starting July 2018. Please email CV and letter of interest to myogman@massmed.org. Dr. Yogman is the practice founder and chair of the Mental Health Task Force.

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Practice Name: Brockton Pediatrics, Inc. Board certified pediatrician for well-respected Brockton, MA, practice. Level 3 Medical Home; Epic EMR system. Nightly triage service, no hospital rounds. Availability: available now. Contact Person: Jan Appleby, RN, Nurse Manager — Fax: (508) 584-4949; Email: jappleby@brocktonpedi.com.

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