Children of Dreamers and of Temporary Protected Status (TPS) Holders

A young woman with chubby cheeks and long brown pinned-back hair held her four-month old baby for me to examine, while her three- and five-year-old children were racing around the room. The baby, Valeria (patient and parent names are changed), was referred to Infectious Disease clinic for hepatosplenomegaly and thrombocytopenia. She had CMV infection, presumably congenital, and needed to be treated with a medication that required close monitoring for toxicities.

Disease clinic for hepatosplenomegaly and thrombocytopenia. She had CMV infection, presumably congenital, and needed to be treated with a medication that required close monitoring for toxicities. While her pediatrician would do the lab
EDITOR’S NOTE

The Boys Are Not All Right, but Neither Are the Girls

As a pediatrician and parent, I think about children every day, and read with interest Michael Black’s recent op-ed in the New York Times, “The Boys Are Not All Right.” (www.nytimes.com/2018/02/21/opinion/boys-violence-shootings-guns.html) Everyone in the US, irrespective of profession or politics, should care about our children. Sometimes, it seems to me, we have lost the village it takes to raise a child.

We know children and youth need positive outlets for friendship, safe play, and physical activity. But opportunities to participate in group activities are less available for a whole host of complicated reasons. For example, according to the Sports and Fitness Industry Association and the Aspen Institute (2017 data) participation in youth sports for kids ages 6–12 has dropped 8 percent over the last decade. Low-income kids are even less likely to participate due to cost and access. Participation in faith-based organizations and other organized activities as well as youth paid employment are also dropping. And we all are painfully aware of the increased rates of obesity and obesity-related complications in our patients.

When they aren’t able to choose positive role models and mentors, children and youth gravitate to others who take them under their wing personally, even if it means gangs, violence, and weapons. Another route for these young people at loose ends is to self-isolate and live in an unreal cyber world, on-line, planning events such as school shootings and bombings. I’m heartbroken to note that patients of mine, of both sexes, have recently come to appointments wearing GPS monitoring devices.

We need to sustain and strengthen our commitment to support families and children. On a positive note, it is heartwarming to see how the teens of Parkland, FL, have challenged us; now it’s up to us to exceed their expectations. These remarkable young people have fired up activism in a way that has inspired young people all over the country, including Massachusetts. In our offices, communities, and state legislatures we need to continue to advocate for family-friendly policies, living wages, better access to mental health care, gun safety legislation, long-term fiscal support of CHIP, SNAP, WIC, and other programs. Most of all, grownups need to take an interest in and care about the youth in their communities. We must reinvigorate the village, and return to caring for all our children and youth.

— Lisa Dobberteen, MD, FAAP
Striving for Diversity and Inclusion
continued from page 1

AAP medical education, leadership education, membership, and workforce activities; and recommending priorities for outreach/inclusion activities in the AAP leadership pipeline and making recommendations for tracking measures.

We took a broad view of diversity to include not only race and ethnicity but also religion, gender, sexual orientation, gender identity/expression, immigration status, career phase, and other characteristics. We looked at available data, and among other observations found that the race/ethnicity of physicians, pediatricians, and AAP members didn’t reflect the diversity of US children. That mismatch was somewhat mitigated by the presence of international medical graduates (IMGs) who make up about a quarter of US residency trainees. They are much more diverse and are more likely to provide care in underserved areas. IMGs, racial/ethnic minorities, and pediatric subspecialists are among the underrepresented groups within the AAP. Even for those of Asian descent and women, who are overrepresented (relative to the overall population) among pediatricians and AAP members, there is underrepresentation in leadership positions.

We presented our findings in November and made four recommendations: one on organizational structure, one on specific initiatives for AAP membership, one on promoting/sustaining a diverse pool of leaders in the AAP structure, and one on measurement.

All of these recommendations are relevant to our Chapter. As we move forward into the implementation phase, we will rely on your input to ensure that our Chapter reflects the diverse perspectives of its members and is doing everything we can to meet the needs of all Massachusetts children.

— DeWayne Pursley, MD, MPH, FAAP

Trouble Getting Your Patients to a Dentist?

From the First Tooth, a DentaQuest grant funded initiative, helps pediatric and family practice primary care offices formalize relationships with local dental offices serving both Medicaid and other insurers. Every child deserves a medical home and a dental home to improve and maintain overall health. Unfortunately, more than 50 percent of children did not see a dentist last year. Pediatricians and other primary care providers who see children can help change this situation.

Our goal is to help medical and dental offices establish better relationships with one another in order to improve patient referrals and communication.

We have funding to conduct regional meetings of medical and dental professionals that include the following for FREE:

- Dinner meeting with CME/CE for both professions related to oral health and HPV
- Examples of referral processes that are working
- “Speed Dating” component of the evening to meet and greet professionals to strengthen referral patterns and improve collaboration

From the First Tooth staff will make all the arrangements for a Meet & Greet event. If you or your regional AAP society is interested in having a Meet & Greet, please contact Ellen Sachs Leicher at eslassoc61@aol.com or call (508) 572-4002.

— Ellen Sachs Leicher
Speaking Out to Prevent Tragedy

After yet another school tragedy, this time in Parkland, Florida, my colleagues and we felt we needed to do something. The statistics speak for themselves: firearm-related mortality is among the top four causes of death in children and teens. Every three hours a child dies of a firearm injury. How many children is this in the course of our pediatric careers? We all have felt helpless in facing this problem, especially when it is so entrenched in partisan politics.

Each time an unthinkable tragedy has occurred, we have watched the loved ones of victims who have striven to turn their sorrow into action, to make sure another family did not suffer the same trauma. Sadly, the voices of these families faded with time, and little has been done to make the changes needed to prevent further tragedies.

Gun-related morbidity and mortality are national public health crises and need to be recognized as such. Our families trust us to do right by their kids. We have both the credibility as well as the responsibility to reach out about this critical issue and advocate for change in our homes, in our communities, and with our state and national leaders.

As pediatric primary care providers, safety, including gun safety, is certainly not a new topic. We have spent many hours encouraging folks to keep their homes safe. Given the scope of the problem and the lack of action to date, we feel compelled to speak up, which is why we sent the following letter to the Taunton Gazette. Action to keep children safe from gun-related violence should not wait any longer.

To the Editor:

Do assault-style weapons and equipment (bump stocks) belong in the hands of an 18-year-old? Do we have adequate gun control laws to protect our children? Is there a strong mental health system to help those at risk for violence? The answer to all of these questions is a resounding NO.

The issue of gun control is multifaceted. As pediatric health care providers and parents, we want to be reasonably assured that when we put our children on the bus they will be safe at school. But what can we do? We have seen passionate calls for reform with each tragedy, yet not much has changed. We need to arm our teachers and guidance counselors with knowledge, not weapons. The staff in every school across the nation needs to be knowledgeable about identifying children at risk for violence. But that is not enough. They need the support of a mental health system that can provide assessment and treatment for these children and adolescents. Because troubled students often come from homes that may not follow through with mental health treatment, we need to be sure they can receive help and support and do not “fall through the cracks.”

What can we do? There are many people who are cautious, law-abiding gun owners. They can teach their children about gun safety. They should never assume that a child does not know there is a gun in the home. Guns and ammunition should always be locked and secured. Statistics clearly show us that firearm related injuries and fatalities are a reality in this country. In the United States, the fatality rate for 15- to 24-year-olds killed by firearms is 49 percent higher than in other high-income countries (Pediatric Firearm-Related Injuries in the United States. Hospital Pediatrics, May 23, 2017). Inertia and complacency are also our enemies. People and organizations with strong voices are influencing lawmakers. Our legislators are our voices. We need to contact them and voice our positions. We are fortunate to live in Massachusetts, which has some of the toughest gun laws in the country.

We also need to stay alert. In hindsight, many of the tragedies that have unfolded — shootings as well as suicides — have involved people who have known histories of mental illness. Warning signs have often existed on social media. An extreme risk petitioning order (ERPO) is before the Massachusetts legislature. H.3081 would allow family members and the police to petition the courts to temporarily remove firearms from those who pose a risk to others or themselves. However, this bill has not received full support from our state legislature.

Things to consider: National laws are needed to make our country safer for our children. Read about these issues and make legislators aware of your concerns.

1. Commonsense gun laws that ban assault weapons, equipment, and high-capacity magazines
2. Background checks
3. Mandatory waiting periods to “cool off” before purchasing a gun
4. Increase age requirements to age 21 for gun purchase
5. Buy-back programs for illegal weapons
6. Regulation of firearm use (require training, certification, liability coverage)
7. Mandate microstamping (ballistic identification of all new guns)
8. Gun safety features (biometric trigger locks so only the legal owner can use it)
9. Mental health access (funding for improved mental health access and substance abuse treatment)
10. Violence prevention and intervention programs (developing programs in schools across the country to deescalate violence and address warning signs)

One of our most basic instincts is to protect our children. We have an opportunity to do that by being their voice.

Sincerely,

The Taunton pediatric community: your pediatricians and pediatric nurse practitioners

— Elizabeth McQuaid, MD, and Elizabeth Tomase, PNP

Dr. McQuaid can be reached at emcquaid@pcpo.partners.org.
DEVELOPMENTAL CORNER

What to Know about Toe Walking

Toe walking can be a commonly observed movement pattern that many young children display during their development. We know that many children will give up idiopathic toe walking (ITW) without specific intervention. Research within the scientific community suggests that ITW is sometimes a causal symptom related to other conditions. Toe walking may be a symptom of a physical condition such as spinal dysraphism or injury, myopathy, or neuropathy. Children may also toe walk because of low muscle tone. When children’s abdominal muscles are weak, they depend on toe walking to feel secure while moving. If the underlying etiology of toe walking is not one of the physical conditions noted, it can be an indication of motor, visual motor, and gross motor delays that are associated with neurological conditions such as cerebral palsy, autism, and sensory processing issues.

Children who toe walk may have an increased or decreased sensitivity to sensory information. They process information differently, through the vestibular, tactile, and proprioception systems, which may make it difficult to coordinate body movements. The body’s vestibular system controls our sense of movement and balance. Children with sensory issues related to the vestibular system have a different awareness of their body position and feel more stable while toe walking. Our sense of touch, pain, and temperature is part of the tactile system. Some studies conclude that children with differences in vestibular processing can also have tactile sensations that exacerbate their toe walking. They may not like the feeling of the floor touching their feet, and toe walking minimizes this contact. Children seeking proprioceptive input toe walk, because the gait prolongs stimulation of joint receptors and causes their muscles to tighten. The movement provides a calming input sensation for the child.

Parents should consult their pediatrician if they notice that their child continues toe walking beyond the age of two. They should also be aware of other behaviors that may require additional evaluation such as language delays, poor eye contact, repetitive behaviors, tightness in other muscles, and delays in meeting milestones.

There is a wide range of treatment options available for ITW and methods of treatment vary based on the underlying cause of toe walking. Stretching and physical therapy are usually suggested as the first treatments to be implemented because they are minimally invasive. Casting, ankle foot orthosis (AFOs), and Botox injections are other options that can be effective. Specialists may suggest surgery for children who do not respond to more conservative treatments. Children with autism or other developmental conditions can be referred for consultation and specialized treatment given by a pediatric physical or occupational therapist.

Doctors and parents can receive more information about early childhood development and milestones at www.pathways.org or through email at friends@pathways.org. Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on children’s motor, sensory, and communication development. — Pathways.org

For more developmental resources, see www.pathways.org

References

“Tide Pod Challenge” Easily Combatted with Facts

It has been argued that the reason adolescent brains are impulsive is to allow them to embrace, without hesitation, the many challenges and adventures that this time of transition brings. Some risks, however, are downright ill-advised. The “Tide Pod Challenge,” where young people try to bite into the laundry product, is a clear example of a bad and dangerous risk. A little knowledge can help pediatric caregivers prevent these ingestions.

Let’s begin with the ingredients. A pod has an outer membrane that dissolves in water. Inside the pod is polyvinyl alcohol, a polymer related to Elmer’s Glue, which holds the other ingredients together. Fatty acid salts and alcohol ethoxy sulfate are the soap-like agents. Mannanase, Amylase, and Sutilisin are enzymes that break down stains, while Diethylenetriamine pentaacetate is a metal chelant, a specialized molecule to bind positively charged ions. Calcium formate keeps enzymes “folded” until the product is in use. Finally, in 2015, Tide added denatonium benzoate, a bittering agent, to discourage accidental ingestion by young children.

Pods are more concentrated than regular detergent, therefore more toxic. The main adverse reactions are either due to aspiration, effects on heart rate and blood pressure, or through central nervous system toxicity, which can cause seizures and depressed levels of consciousness in a minority of cases. As a result, these agents are poisonous if ingested.

Fortunately, this practice has quickly come to the attention of health providers and parents. It is also safe to say that most adolescents are shocked to hear that the practice has developed notoriety. “That’s just stupid” is a common teenage response when the issue is raised. Apparently, some teens have not gotten the message soon enough, as the incidence of ingestion has spiked in early 2018.

Many of the subjects that pediatricians advise parents and teens in relation to safety are nuanced and challenging. This is not one of them. Raised awareness and an explanation of the risks associated with ingestion of a pod will hopefully make this a fad that disappears quicker than a ground-in stain.

— Greg Parkinson, MD, FAAP

Greg Parkinson, MD, FAAP, practices in Falmouth at Falmouth Pediatric Associates, and is chair of the Injury, Violence and Poison Prevention Committee of the MCAAP. He can be reached at gregorywparkinson@gmail.com.

Advertise in The Forum

We would like to invite you and your organization to advertise your services in upcoming editions of The Forum. The Forum is mailed to 1,700 pediatricians and is available online at no charge. If you would like more information about rates and submissions, please contact Cathleen Haggerty at chaggerty@mcaap.org.

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Children of Dreamers and of Temporary Protected Status (TPS) Holders  
continued from page 1

studies in a Massachusetts town about an hour away, Valeria also needed a brain MRI and a hearing test, for which she would have to come back to Boston.

Months later we found a normal brain MRI but severe bilateral hearing loss, treated baby Valeria for many weeks, monitored weekly labs, found improving hearing, treated longer, and confirmed normal hearing — and I had come to know the baby’s mother, Maria, well. She never missed an appointment or a blood-work check. She brought a binder with all the appointments and results to each clinic visit. She asked me what to do about her older children’s eczema. She told me about her progress and setbacks in getting her GRE. And she confided in me that when she drove up to Boston from her hometown, she was always scared, because she did not have a driver’s license. She was undocumented and hence could not get a license.

More months later, I had met more family and community members at Valeria’s tremendous, deeply moving first birthday party in a church basement in her hometown. I learned that many of her community members are uncertain Spanish speakers since their mother tongue is an indigenous language. And Maria told me that she now had a driver’s license, because she had been treated with DACA, but that her husband, Valeria’s father, could not apply for DACA because he was already 17 years old when he came here undocumented.

On September 5, 2017, Donald Trump announced he was ending DACA as of March 5, 2018. DACA recipients would become subject to deportation, which was easy for ICE because they had provided all their personal information as a condition of their application. ICE knows where they live. DACA has numerous other stringent conditions, like age limits, limitations of the date of arrival in the United States, being in or completing high school or receiving an honorable military discharge, and absence of a criminal conviction. Approximately 800,000 young people have been approved for DACA since the beginning of the program in June 2012. Many eligible youth did not apply, possibly fearing what has now happened: that they would give all their personal information to US authorities, and that these authorities would turn against them. Many others were ineligible because they had not finished high school, or because of the age and date-of-entry cutoffs.

On September 8, 2017, Science magazine published a study of the effect of DACA on the children of its recipients, entitled “Protecting unauthorized immigrant mothers improves their children’s mental health” (Hainmueller et al., Science 357, 1041–1044). The authors wrote the following:

“We provide causal evidence of the intergenerational impact of parental immigration status on children’s health. … An estimated 200,000 children had parents who were eligible for DACA at the time the policy was announced. … We found that mothers’ eligibility for DACA protection led to a significant improvement in their children’s mental health. Specifically, mothers’ DACA eligibility reduced adjustment and anxiety disorder diagnoses in their children by 4.3 percentage points \( (P = 0.023) \) from a baseline rate of 7.9% among children of ineligible mothers at the threshold. This represents more than a 50% drop in the rate of these disorders.”

In other words, the mothers’ fear of deportation, which was alleviated by DACA, doubled the incidence of adjustment and anxiety disorders in their children. The children studied by these researchers were all US citizens, because they entered the study through Medicaid databases.

Now that Maria is about to lose her driver’s license and her work permit if the Trump administration prevails in court with their intention to end DACA, what will happen to Valeria and her older brother and sister? Will they lose their parents? Will they ask their mother why she ever trusted an American government enough to hand over her address and phone number? Will they blame her for the fear they are living in?

I would like to introduce another young girl, who wants to become a pediatrician and asked me excitedly about volunteering at Children’s Hospital. We had to take a few breaths and think about how else she can start preparing for her dream profession, because she is only 12 years old, and to volunteer there she will need to be 16. She is the middle daughter of my Salvadoran friend, José Palma, whose real name I am using because he is speaking out publicly about his family’s situation. José co-founded the Comité TPS Massachusetts (see www.savetps.com/committees), and is organizing with others to try to protect his daughter from the impact of having an undocumented father, who could be taken away at any moment.

The news site The Hill headlined a January 1, 2018, opinion piece by a Catholic bishop (at http://thehill.com/opinion/immigration/366777-but-what-about-the-children-what-happens-to-the-192000-us-citizen). “But what about the children? What happens to the 192,000 US citizen children of Salvadoran TPS parents?” This was because the Trump administration has announced that they will end Temporary Protected Status (TPS) for US residents from Haiti, El Salvador, Honduras, and other countries not viewed as favorably by Donald Trump as Norway. Like those of DACA recipients, the children of TPS holders will fear that their parents will be forcibly taken away, and that they may be harmed or killed by the cartels and gangs that are rampant in Honduras and El Salvador.

For us as pediatricians, TPS is as big an issue as DACA, because its loss will impact our patients as dramatically. But it isn’t as well known as DACA is, and it lacks advocates. TPS is even not well known within our Academy. We can inform ourselves more, with simple facts as available here: http://cmsny.org/publications/jmhs-tps-elsalvador-honduras-haiti. We can talk to our friends and colleagues in the Academy. And we can call our federal congressmen and senators, because our legislators do pay much more attention to issues about which they hear from constituents. We can help protect Maria’s and José’s children, and hundreds of thousands of others who are at risk for losing a parent, and for mental illness because of that risk.

— Julia Koehler, MD

Julia Koehler, MD, is chair of the Immigrant Health Committee, and can be reached at Julia.Koehler@childrens.harvard.edu
MCAAP Immunization Initiative/MDPH Immunization Program Vaccine Confidence Project

The MCAAP Immunization Initiative and the MDPH Immunization Program are in the initial planning stages of a Vaccine Confidence Project focused on increasing vaccine confidence in selected communities across Massachusetts.

What is Vaccine Confidence?

Vaccine confidence is the trust that parents, patients, or providers have in:

- Recommended vaccines
- Providers who administer vaccines
- Processes and policies that lead to vaccine development, licensure, manufacturing, and recommendations for use

Reference
HHS.gov

We are targeting Western Massachusetts as one area susceptible to vaccine-preventable diseases as a result of higher than state average school exemption rates. You can find more information about school immunization and exemption rates on MDPH’s School Immunizations web page at www.mass.gov/service-details/school-immunizations.

The overall project goal is to develop a vaccine confidence training module that we will bring back to the region for more comprehensive training with both health care professionals and the general public. Our initial step is to get feedback from key constituencies about common concerns and issues specific to Western Massachusetts. We are planning to hold an in-person meeting in the area with providers, local public health, school nurses, parent advocates, and other partners who are interested in increasing vaccine confidence. We plan to meet in May and more details will follow for interested parties. If you are interested in participating in this project or have any questions, please contact Rebecca Vanucci, immunization outreach coordinator, MDPH Immunization Program (rebecca.vanucci@state.ma.us; (617) 983-6534); or Cynthia McReynolds, program manager, MCAAP Immunization Initiative (cmcreynolds@mms.org; (781) 895-9850).

— Rebecca Vanucci, MA, immunization outreach coordinator, MDPH Immunization Program; Cynthia McReynolds, MBA, program manager, MCAAP Immunization Initiative

CDC Publishes 2018 Immunization Schedules

The Centers for Disease Control and Prevention (CDC) has published the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018, and the Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States 2018. Visit www.cdc.gov/vaccines/schedules/hcp to download and print the schedules.

The February 6, 2018, issue of Morbidity and Mortality Weekly Report (MMWR) includes comprehensive summaries of the ACIP recommended changes to the 2018 child and adolescent immunization schedule and the 2018 adult immunization schedule.

Easy-to-Read Immunization Schedules

Easy-to-read schedules that you can print to give to your patients are available at www.cdc.gov/vaccines/schedules/easy-to-read/index.html. Easy-to-read schedules are available as follows:

- Immunization Schedule for Infants and Children (birth through 6 years)
- Immunization Schedule for Preteens and Teens (7 through 18 years)
- Immunization Schedule for Adults (19 years of age and older)

— MCAAP Immunization Initiative

The Forum Spring 2018

Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by June 4, 2018.
National Infant Immunization Week Is April 21–28, 2018

National Infant Immunization Week (NIIW) is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases and to celebrate the achievements of immunization programs and their partners in promoting healthy communities.

When the NIIW observance was established in 1994, immunization programs were facing significant challenges. The nation was in the midst of a serious measles outbreak and communities across the US were seeing decreasing immunization rates among children. NIIW provided an opportunity to draw attention to these issues and to focus on solutions. Communities have continued to use the week each year to raise awareness about the importance of ensuring all children are fully protected from vaccine preventable diseases through immunization. Today, many immunization programs, partners, and communities can celebrate high infant immunization rates.

During NIIW, communities across the 50 US states, eight US Territories, and the District of Columbia celebrate the CDC Childhood Immunization Champions. The CDC Childhood Immunization Champion Award is an annual award given jointly by the CDC Foundation and CDC to recognize individuals who make a significant contribution toward improving public health through their work in childhood immunization. Young children rely on these champions in their lives to keep them safe and healthy. Past Massachusetts awardees include the following MCAAP members: Bill Adams, MD, FAAP; H. Cody Meissner, MD, FAAP; Richard Moriarty, MD, FAAP; Sean Palfrey, MD, FAAP; and Ronald Samuels, MD, MPH, FAAP. Thank you to these previous Champions!

The award will be announced during NIIW. Be on the lookout for an announcement about this year’s Massachusetts CDC Childhood Immunization Champion Awardee!

The award will be announced during NIIW. Be on the lookout for an announcement about this year’s Massachusetts CDC Childhood Immunization Champion Awardee!

The CDC has a number of resources that you can use during NIIW to promote vaccination in your practice. Among these resources are: print ads and posters, web banners and buttons, public service announcements (PSAs) that you can post on your website, articles for your newsletter, and even coloring sheets that you can print for your patients. To access these materials, visit: www.cdc.gov/vaccines/events/niiw/promotional.html.

Health care professionals remain parents’ most trusted source of information about vaccines for their children, by playing a critical role in supporting parents in understanding and choosing vaccinations. Thanks for all that you do to protect Massachusetts children against vaccine preventable diseases!

— MCAAP Immunization Initiative

Immunization Action Coalition Updates VIS Staff Education Materials

To reflect the new date (2/12/18) of the most recently released MMR, MMRV, varicella, zoster (RZV) and zoster (RZL) Vaccine Information Statements (VISs), the Immunization Action Coalition (IAC) recently revised the following VIS staff education materials, “Current Dates of Vaccine Information Statements” (www.immunize.org/catg.d/p2029.pdf) and “You Must Give Your Patients Current Vaccine Information Statements — It’s Federal Law!” (www.immunize.org/catg.d/p2027.pdf). Visit the following websites to review updated VIS information:

- IAC’s web page at www.immunize.org/vis for VISs, including VISs in multiple languages
- CDC’s “What’s New” section with VISs web page at www.cdc.gov/vaccines/hcp/vis/what-is-new.html
- CDC’s VIS web page at www.cdc.gov/vaccines/hcp/vis/current-vis.html

— MCAAP Immunization Initiative

CDC Updates Its Vaccine Storage and Handling Toolkit

In January 2018, the CDC updated its Vaccine Storage and Handling Toolkit, which can be found at www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Updates to the Vaccine Storage and Handling Toolkit include:

- A reorganized table of contents to better navigate the toolkit
- Revised recommendations for monitoring and recording storage unit temperature
- A new document on how to handle a temperature excursion in your vaccine storage unit
- Updated content which reflects current vaccine products on the market

The CDC also redesigned its training module, “You Call the Shots: Storage and Handling,” at www2a.cdc.gov/nip/isd/ycts/
From the Massachusetts Department of Public Health

MDPH Announces 2018 Immunization Updates

The Massachusetts Department of Public Health (MDPH) is pleased to announce the 2018 Immunization Updates.

Conference topics will include:

- MIIS updates, including ways to improve data quality and bi-directionality
- VFC compliance/vaccine storage and handling (meets the annual VFC training requirement)
- Updates to the 2018 childhood and adult immunization schedules
- School immunization data
- Strategies to build vaccine confidence
- Current trends in the epidemiology of vaccine preventable diseases
- And more

Registration for the Immunization Updates will open in early April.

All Immunization Update programs are scheduled from 8:00 a.m.–noon, with the exception of the webinars, which will start at noon. Registration starts at 7:30 a.m. for the In-Person Meetings.

For up-to-date information, please visit the "Events" section on the Immunization Program website at www.mass.gov/service-details/immunization-program-events. For questions about the updates, call or email Denise Henry at (508) 752-7313 or denise@adcare-educational.org.

Hepatitis B Update

On January 12, 2018, the CDC released an issue of MMWR updating hepatitis B vaccine recommendations. The CDC outlines strategies for the identification and management of HBV-infected pregnant women. Recommendations include testing all pregnant women for HBsAg during an early prenatal visit (e.g., first trimester) in each pregnancy, even if they have been vaccinated or tested previously. All pregnant women found to be HBsAg positive should also be tested for HBV DNA to guide the use of maternal antiviral therapy during pregnancy. For more information on the testing and management of HBsAg positive pregnant women, see pages 13–14 of this report. Also included in this MMWR is an updated recommendation of universal hepatitis B vaccination within 24 hours of birth for medically stable infants weighing ≥2,000 grams. Please read the entire MMWR for additional guidance regarding postexposure prophylaxis and health care worker vaccination. The article can be found at www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

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

Post-Secondary Student Meningococcal Requirement

The meningococcal requirement for post-secondary students will be changing for the 2018–19 school year. The new meningococcal requirement is as follows: All newly enrolled full-time students 21 years of age and younger must have received a dose of quadrivalent meningococcal vaccine (MenACWY) on or after the 16th birthday.

Students may submit a medical or religious exemption to meningococcal vaccine, or sign a waiver indicating they reviewed the meningococcal information sheet and choose to waive receipt of meningococcal vaccine. The waiver form on our website, www.mass.gov/service-details/school-immunization-information-for-school-nurses, has been updated to reflect the new requirement and the latest recommendations on meningococcal vaccine.

Please note that meningococcal B vaccine does not fulfill the meningococcal requirement.

If you have any questions about the new meningococcal requirement, please contact the Immunization Assessment Unit at (617) 983-4330 or immunassessmentunit@state.ma.us. — Rebecca Vanucci, MA, Immunization Outreach Coordinator, MDPH Immunization Program
Upcoming Immunization Conferences and Meetings

23rd Annual Massachusetts Adult Immunization Conference
April 10, 2018
Best Western Royal Plaza Hotel, Marlborough
For more information and to register, visit http://maic.jsi.com/2017-massachusetts-adult-immunization-conference.

MCAAP Immunization Initiative Webinar Series
April 19, 2018, Noon–1:00 p.m.
2018 Childhood Immunization Schedule Review; MDPH Vaccine Update
Susan Lett, MD, MPH
For more information and to register, visit http://mcaap.org/immunization-cme/#webinars.

National Infant Immunization Week (NIIW)
April 21–28, 2018
For more information, visit www.cdc.gov/vaccines/events/niiw/index.html.

MCAAP Immunization Initiative Advisory Committee Meeting
April 23, 2018, 6:30–8:30 p.m.
Massachusetts Medical Society, Waltham
For more information, contact Cynthia McReynolds at cmcreynolds@mms.org.

Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting
June 14, 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.

Advisory Committee on Immunization Practices (ACIP) Meeting
June 20–21, 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.

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 at cmcreynolds@mms.org.

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). Pre-registration is required.
For more information, visit www.cdc.gov/vaccines/acip/index.html.

23rd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference
October 18, 2018
Sheraton Framingham Hotel and Conference Center — Please note the 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 11, 2018, 4:00–6:00 p.m.
Massachusetts Medical Society, Waltham, MA
For more information, visit www.mcaap.org/immunization-cme.

Send your email address to ldobberteen@mcaap.org for instant notification of issues important to the MCAAP membership.
The Massachusetts Chapter of the American Academy of Pediatrics presents its

Annual CME Edward Penn
Lecture and Business Meeting

Wednesday, May 9, 2018
9:30 AM to 4:00 PM
Massachusetts Medical Society
860 Winter Street, Waltham, MA

Schools and Health Care Providers Working Together
To Promote the Health and Wellbeing of Children and Youth

Schedule

9:30 AM REGISTRATION

9:55 AM Welcome
Chair of School Health Committee: Lisa Dobberteen, MD, Co-chair, MCAAP School Health Committee, Pediatrician, Cambridge Health Alliance, Medical Director of School Health and Public Health Services, Cambridge Public Health Department, and Karen Sadler, MD, Co-chair, MCAAP School Health Committee, School Health Physician for Framingham Public Schools

10:00–11:00 AM “Bending the Curve; The Power of Early Identification and Treatment in Neurodevelopmental Disorders”
Edward Penn Memorial Lecturer: Leonard Rappaport, MD, MS, Senior Associate in Medicine, Boston Children's Hospital; and Mary Deming Scott, Professor of Pediatrics, Harvard Medical School

11:00 AM–NOON Identifying and Intervening in Substance and Alcohol Issues
Nicolas Chadi, MD, Pediatric Addiction Medicine Fellow at Boston Children's Hospital, Boston Children's Hospital, Harvard T.H. Chan School of Public Health

NOON–1:30 PM BUSINESS MEETING AND LUNCH

1:30–2:00 PM State of School Health and High-Quality Initiatives for Children and Youth with Special Health Care Needs (CYSHCN)
Judy Palfrey, MD, Chair of the MCAAP CYSHCN Committee; Pediatrician; Director, Global Pediatrics Program, Boston Children’s Hospital; Past President of the American Academy of Pediatrics; Professor of Society and Human Development, Harvard Medical School
Aubry Threlkeld, EdD, Education Leader/Consultant/Professor, Van Loan School, Endicott College, Harvard University School of Education
Workshops (2:00–4:00 p.m.)

WORKSHOP 1 (CHOOSE ONE): 2:00–3:00 PM

• School Health Communication 101 — Regulations, models, documentation (including concussion and immunization documentation), HIPAA/FERPPA, IEPs and more!
  Lisa Dobberteen, MD, Co-chair, MCAAP School Health Committee, Pediatrician, Cambridge Health Alliance, Assistant Professor in Pediatrics at Harvard Medical School
  Rick Moriarty, MD, Co–Program Director, MCAAP Immunization Initiative
  Michael Posner, MD, School Health Physician, Paulo Freire Social Justice Charter School
  Tracy Rose-Tynes, BSN, RN, School Nurse Manager, Cambridge Public Schools and Cambridge Health Alliance

• Mental Health Resources in Schools
  Julie Love, MSN, APRN, PMHNP-BC, PPCNP-BC, Director, McLean School Nurse Liaison Project, McLean SouthEast

• Immigrant Health Services in Schools
  Celeste Atallah-Gutierrez, PhD, Instructor of Psychiatry, Harvard Medical School, Staff Psychologist, Boston Children's Hospital
  Ivys Fernandez-Pastrana, JD, Manager, Lead Family Navigator at Boston Medical Center
  Lara Jirmanus, MD, MPH, Primary Care Physician, Cambridge Health Alliance, Clinical Instructor, Harvard Medical School, Fellow, FXB Center for Health and Human Rights, Harvard School of Public Health
  Julia Koeblere, MD, Chair, MCAAP Immigrant Health Committee, Associate Physician in Medicine, Boston Children’s Hospital, Assistant Professor of Pediatrics, Harvard Medical School

WORKSHOP 2 (CHOOSE ONE): 3:00–4:00 PM

• School Health Communication 101 — Regulations, models, documentation (including concussion and immunization documentation), HIPAA/FERPPA, IEPs
  Karen Sadler, MD, Co-chair, MCAAP School Health Committee, School Health Physician for Framingham Public Schools
  Judith Styer, BSN, RN, BA, NCSN, Director of Health and Wellness, Framingham Public Schools
  Michael Posner, MD, School Health Physician, Paulo Freire Social Justice Charter School
  Rick Moriarty, MD, Co–Program Director, MCAAP Immunization Initiative

• Supportive Programs for LGBTQ Youth in the Schools
  Valerie Frias, Executive Director, Greater Boston PFLAG

• Bullying Prevention in Schools
  Elizabeth Englander, PhD, Director and Founder of the Massachusetts Aggression Reduction Center, Professor of Psychology at Bridgewater State University

In support of improving patient care, Baystate Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Baystate Health designates this live activity for a maximum of 4.5 AMA PRA Category 1 Credits™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Faculty Disclosure
The design and content of Baystate Continuing Interprofessional Education (CE) activities support quality improvement in healthcare and provide fair and balanced views of therapeutic options. Faculty or planner conflicts of interest are resolved before the educational activity.

The presenters have no commercial relationship with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

The program cost is $80 and is free for medical students and residents.

For more information or to register, contact Cathleen Haggerty at chaggerty@mcaap.org.
BOOK CORNER

Reach Out and Read® Empowers Parents

What a lovely opportunity for a longtime primary care pediatrician to opine about the virtues of reading to children! I am delighted to join the ranks of the Book Corner authors who preceded me, most especially my long-time colleague, Marilyn Augustyn, MD. She has been a tireless advocate for children in our community and has done so much to strengthen Reach Out and Read in Massachusetts and nationally. Marilyn will be a hard act to follow.

Reach Out and Read was in its infancy in the 1980s when I was a resident at Boston City Hospital. To witness the growth of this program in the intervening years has been one of the joys of my clinical practice and career. Seeing the continued commitment of our faculty and residents to the program is inspiring, and hearing children asking for books when they come to clinic because they associate going to the doctor with talking about reading is also a testament that a small group of people with a great idea can really make a difference. There is a certain urgency to promoting reading and literacy now, in this age of screens and social media, which I feel with my patients now — even more than I did decades ago. Parents, reading still matters!

My clinical practice is in a large urban safety hospital (Boston Medical Center, the former Boston City Hospital) where Reach Out and Read was born, in the same primary care clinic I now direct. My current clinical practice includes a new clinic for infants and children with in-utero substance exposure. Every one of these children, and almost all their parents, have experienced toxic stress and have very high Adverse Childhood Experiences (ACE) scores.

As I read "What’s the Punchline?: Promoting Child and Teacher Resilience through Pediatrician-Teacher Partnerships,” I thought about the many other professionals who interact with families, and who may have more time than we do to impress the message of resilience and promoting healthy relationships and development. It’s time we reach out to them more regularly.

Kavaitha Selvarag, MD, MPH, MEd, writes about her experience as a middle school teacher prior to becoming a pediatrician, and about learning that the toxic stresses of the students in her classrooms were at the root of many of their behavioral difficulties. In our new clinic, we are seeing the effects of toxic stresses that can shape early life: parents in recovery who relapse, foster care, parental incarceration, frequent moves, neglect, food and material insecurity, and homelessness. Many of the parents we care for experienced similar stresses early in their own lives. They are not well positioned to provide nurturing and safety to their kids, as a result of what was missing from their own childhoods. It’s so hard to do for your children what no one did for you.

A concept that was new to me as I started working alongside addiction-trained providers is that of distress tolerance. Learning how to tolerate an everyday stress or disappointment is a good life skill, and children can start learning it early. Asking parents how they manage their own stress and helping them reduce behaviors which transmit stress to their infants and children is something we can work on together as pediatricians, childcare providers, and teachers of children of all ages. If we can collaborate and share the same messages we can best help parents shelter their children, as they want to, and help them ameliorate toxic stresses and the damaging stress reactions they can engender.

One of my favorite books to give to families in the office is Feelings, the Reading Rainbow book by Aliki. I love showing the pictures of angry or sad kids to my patients and explaining that these are normal, though uncomfortable feelings that we all have, and that we learn to cope with them in different ways. Parents sometimes make rueful comments about this, “If only I had known there was any other way!” In my experience, most of our parents are extremely motivated to help their children do better. Being a consistent and positive adult presence in a young child’s life is one of the gifts of teaching and doctoring. Teachers have more of a chance to sit down and read to young children, but as pediatricians we can convey to parents the

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importance of reading together. We can remind them how much it means to devote the time to cuddling, reading, and talking about stories with their children, just as we can help them understand their own protective power in their children’s lives. And finally, we can help them see that by reading to their children, they can strengthen their children’s sense of security and of being loved, as well as their cognitive skills. — Eileen Costello, MD

Eileen Costello, MD, is chief of ambulatory pediatrics, Boston Medical Center, clinical professor of pediatrics, Boston Medical Center, and the new Massachusetts medical director for Reach Out and Read. She can be reached at eileen.costello@reachoutandread.org.

Reference
JOB CORNER

Pediatrician (Inpatient and Outpatient)
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 four-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.

Looking to Hire or Be Hired?

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

To submit a listing, email chaggerty@mcaap.org. Please include the following information:
• Contact information
• Practice name/residency program
• Position title
• Description (25-word limit)
• Availability (e.g., available now)

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

SAVE THE DATE

2018 RFDASH Residents and Fellows Day at the State House!

Who: Pediatrics — interested medical students, pediatrics residents and fellows across MA
What: An annual gathering of pediatric trainees from across MA to learn about 2–3 bills related to child health, to learn how to lobby effectively, and to meet with state legislators/aides to advocate for the bills selected.
When: Thursday, May 3, 2018
Where: Massachusetts State House, Beacon Hill, Boston, MA
More information: https://rfdash.weebly.com

Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by June 4, 2018.