Continuing the Fight

In my last President’s Message, I highlighted the importance of renewing and reawakening our sense of urgency regarding vaccinations and urged us all to continue fighting so that our communities are protected from diseases that should be vanquished. On May 21, Kim Schreier, the first pediatrician in Congress, introduced the VACCINES Act, bipartisan legislation to increase public awareness of the safety and effectiveness of vaccines and enable the CDC to address vaccine hesitancy.

Religious exemptions for vaccines are one of the most widely used mechanisms employed by parents who are vaccine-hesitant. Religious freedom is foundational to American society. It is frightening to me to see that freedom now being weaponized to erode and destroy important gains we have made in both individual and social health and to promote widespread dissemination of misinformation. A Boston Globe editorial in February noted that the rate of religious exemptions from vaccination among Massachusetts school children has risen more than five-fold in the past decade, ranging from 0% to 25% depending on the school. This dramatic increase in religious exemptions has occurred despite the fact that no theological doctrine specifically opposes vaccination and there has been no shift in the state’s religious demographics during that time.1

So what is driving these increases? With the rise of the Internet and social media, it’s easier than ever before to spread misinformation and have those misperceptions and lies reverberate and strengthen over time. Research published in the journal Vaccine notes that most religious exemptions reflect personal viewpoints and it was developed with the input of middle and high school students across the state.

Featuring online and social media ads on Instagram, Snapchat, Spotify, and YouTube, the campaign sends youth to mass.gov/vaping for basic information and resources on the dangers of vaping and resources on the dangers of vaping.

Youth Vaping — New Resources

The Massachusetts Department of Public Health (MDPH) recently launched a public information campaign for middle and high school aged youth titled “Different Products. Same Dangers.” (www.mass.gov/news/baker-polito-administration-launches-campaign-to-combat-teen-vaping).

The campaign links the dangers of vaping to cigarette smoking for young people,
EDITOR’S NOTE

Some Thoughts about the “D Word”

As pediatricians, most of us are in the fortunate position of rarely experiencing the deaths of our patients. Most of our patients grow up knowing how to read, wear their seatbelts and bicycle helmets, eat in a healthy fashion, are well protected by vaccines against infectious diseases, and are off to productive lives as adults. We transfer their care to our adult medicine colleagues in what for me feels almost like a graduation. I’m proud of the young adults they’ve become and wish them well on their journey of life. Some of us are lucky enough to care for the children and even the grandchildren of our former patients.

Death does touch us as pediatricians. Maybe not often with our patients, but it may be the deaths of the parents of our patients from cancer, heart disease, opioid overdoses, and more. Lately, I have been reflecting on a number of moving interactions with families at events in memory of their now-deceased family members.

I attended the funeral of my infant patient, lost to SUID (sudden unexplained infant death). A tiny white coffin sat in the middle of the funeral home, surrounded by flowers and toys. We all felt the visceral grief of the parents. “They have other children” was said by many in attendance, in hopes that it would lessen their pain, but of course everyone knew it would not.

A young adult died of a rare but known complication of a usually well controlled chronic disease. The deceased and siblings had all been my patients and were now cared for by my internal medicine colleagues. I had known the family for over two decades. We didn’t imagine we would all see each again, this way, at the funeral of one of their young adult family members. Obrigada, Doutora por vistor.

The parent of a patient died suddenly. Cancer went undetected until it was widely metastatic. Heroic treatment was attempted and failed. Hospice care helped this parent spend the little time remaining with the family. Relatives arrived from four continents to mourn at an incredible multilingual, musical funeral that was an incredible tribute to an amazing soul, whom I was privileged to know as an exceptional parent. After the service I went to pay my respects to the family, including my five-year-old patient. “Why are you here?” the child demanded as only children can. “Because I loved your parent, too,” I replied, and the child, resilient in the way that only children can be, ran off to play with the other children at the service. Mes en pil, Doktee pou vini.

At times like this, we have only our presence to offer families. Support later, for all family members is key as well. I’m grateful that pediatrics is an upbeat, mostly very happy specialty focused on growth, development and prevention. But when the “d word” appears, we need to do the right thing, and be present for those who mourn. — Lisa Dobberteen, MD, FAAP
President’s Message

couched as religious beliefs. These beliefs often reflect those held “among a social network of people organized around a faith community.” This is how social conservatives and the religious right are reaching parents who want only to protect their children. That is also the mission of every pediatrician — to keep children safe from harm and help them thrive. That is why we vaccinate children — to protect them and promote healthy development for them and their communities.

Today I’d like to call your attention to another area targeted by the religious groups and social conservatives for misinformation campaigns: sex education for our young people. Development of a healthy sexual identity is one of the core tasks of adolescence. Unlike cigarette smoking, alcohol, or other drug use, sex is a basic human drive. We should want all young people to develop the capacity to enjoy a healthy sex life; education is key to achieving that. However, only 24 states plus the District of Columbia mandate sex education in schools and Massachusetts is not one of them. A slightly higher number of states (27) mandate that, when sex or HIV education is taught, it meets certain general requirements. Shockingly, only 48% of these states (N=13) require that the information be medically accurate.

Pushed more aggressively than age-appropriate, medically accurate sex education by the current administration are “sexual risk avoidance programs.” These are the decades-old “abstinence only” education programs that push abstinence until marriage rebranded using public health language to make them seem evidence-based. These programs have been widely shown to be ineffective, to promote stigma and inequities, and to violate ethical principles for both health care providers and educators. As of May 1, 2019, 37 states require that information on abstinence be taught if sex education is offered and 73% require that abstinence be stressed. Eighteen states require that instruction of the importance of engaging in sexual activity only in the confines of marriage be provided.

Here in the Commonwealth, the only mandate is that if a school district is teaching sex ed, parents be notified and given the opportunity to opt out. There is no requirement to provide young people with comprehensive sex education, nor are there general requirements that sex education, when taught, be medically accurate. This is unacceptable, especially for a state which is a health care leader.

Currently, Massachusetts fails its young people. As pediatricians, we serve as a source of non-judgmental, medically accurate, age-appropriate information for our patients and their families, but young people need access to such information outside the doctors’ offices. The Healthy Youth Act, legislation that has languished in the legislature for the past several years, would help provide such information in schools. Under S.263 and H.410, sexual health education in school districts that choose to offer it would be comprehensive, age-appropriate, and medically accurate. The curriculum would teach young people how to develop safe and respectful relationships, the benefits of delaying sex, and how to prevent STIs and pregnancy when they become sexually active. Such comprehensive sex education would improve young people’s understanding of themselves, their friends, peers, and our culture and promote healthy decision making and healthy lives.

Mandating that sex education be comprehensive, age-appropriate, and medically accurate is a start. Last year, the Healthy Youth Act passed both the Senate and the House but the session expired before it could be signed into law. It was re-filed in January and was discussed by the Education Committee in June. MCAAP wrote testimony both last year and this year in strong support of the Healthy Youth Act. Last year, it was one of the RFDASH bills. Let’s get this legislation over the line and passed into law. I urge you to contact your legislators to support S.263 and H.410.

— Elizabeth Goodman, MD, MBA

References

3. Ibid.
6. Ibid.
7. Ibid.

Youth Vaping

and encourages them to follow the campaign on Instagram (@GetTheVapeFacts).

Detailed guidance on how schools and organizations who work with youth can utilize the campaign and its resources is available through a toolkit for schools and community-based organizations at www.GetOutraged.org. If you are already familiar with the toolkit from the MDPH’s first campaign, “The New Look of Nicotine Addiction,” to educate parents and adults about the dangers of youth vaping, we encourage you to take another look as the toolkit has been updated with new resources and information.

The campaign also includes posters, handouts, and mirror clings for schools, organizations, and provider offices. Materials are available free of charge at the Massachusetts Health Promotion Clearinghouse (https://massclearinghouse.ehs.state.ma.us).

In addition, communicating about youth-focused resources is also a great time to reinforce information for adults at www.GetOutraged.org.

If you have questions or comments about the campaign and related materials, feel free to contact Patti Henley at Patricia.Henley@state.ma.us.

— Rachel Cohen, MPH, Senior Health Communication Specialist, Division of Prevention and Wellness, Massachusetts Department of Public Health
Nilda Gabin knows how terrifying it is to rush to the hospital with a child who is having trouble breathing. Fortunately, that hasn’t happened to her in two years. “The scariest part is to see your child struggling to breathe and you can’t do anything to help them at home,” says Nilda, who recalls racing to Boston Children’s Hospital in an ambulance in the middle of the night with her daughter, Kailisa.

At the hospital, Nilda learned about the Community Asthma Initiative (CAI) and enrolled in the program. CAI was created in 2005 to address the issues contributing to high asthma rates. It is designed to help families in Boston who have children with poorly controlled asthma. Nilda, who has four children with asthma, says CAI helped her learn to better manage their asthma medications and create a more asthma-friendly home.

Once a family enrolls, a community health worker (CHW) visits them at home. “When you walk into these families’ lives you are there for asthma, but you really are not there just for asthma,” says Margie Lorenzi, CAI’s CHW for the past 11 years. “You also help them with their immediate needs like housing or transportation to their next medical appointment.”

**Boosting Health Literacy**

Lorenzi provides case management, support, and education about asthma. “We are serving a community that sometimes can be forgotten. Providing them with this knowledge is very important,” says Lorenzi.

Another important part of CAI is to help families reduce triggers in their home, such as pests, dust, or harsh cleaning products. Lorenzi showed Nilda how to make homemade cleaning products that won’t irritate her daughter’s airways like store-bought cleaning products. Nilda says she used to sweep her hardwood floors until she learned that vacuuming was more asthma-friendly. “There are a lot of things that can trigger asthma that you wouldn’t even know,” she says.

**On the MAP**

CAI has helped many health care organizations in Massachusetts and beyond to create similar asthma programs. The Medical Home Asthma Program (MAP), modeled after CAI, is now being offered to practices in the Pediatric Physician’s Organization at Children’s (PPOC).

MAP is the largest replication effort of CAI so far. It began in 2016, when the CAI team and the PPOC began working together to develop the program. MAP helps providers leverage electronic tools to identify at-risk children and provides CHWs who can visit patients’ homes to address the social determinants of health that can aggravate asthma.

MAP uses the electronic health record in pediatricians’ offices to look for patients who may need help with their asthma. Additionally, the MAP analytics team mines claims data and examines utilization patterns to try to predict and prevent an emergency department visit or hospitalization for asthma. MAP CHWs can access the electronic health record of their patients to identify those who might benefit from the program and communicate directly with primary care offices.

“We wanted an opportunity to prevent that first hospitalization by identifying kids through their primary care provider,” says Dr. Jon Hatoun, medical director of MAP.

To identify higher-risk patients, MAP created a risk score that looks at prescription filling patterns, the number of outpatient visits for asthma and the occurrence of asthma exacerbations. The MAP team runs a report for each practice monthly to identify patients who may be at increased risk for uncontrolled asthma. They also have a registry of all patients with persistent asthma.

“With a couple of clicks, our providers and CHWs can look for all patients who had an asthma exacerbation in the last seven days,” says Hatoun, who is also associate medical director for Research, Safety, and Quality for the PPOC.

“We give full credit to CAI for sharing with us everything from how the CHW assists families to where and how we

continued on page 5
The CHWs who conduct home visits and help families are located right in the pediatrician's office and often meet with family members after they see their pediatrician. "If they meet a new patient in the pediatrician's office (rather than through a phone call), there is a better chance of the family enrolling in MAP," says Hatoun.

**More Expansions Ahead**

The South Coast MAP has been so successful that the program recently expanded into the PPOC’s Western Massachusetts offices, where they have hired two CHWs. Going forward, asthma home visiting programs in the PPOC will be integrated with other supports for practices and families. Regional support teams will not only carry out MAP programming but will also be designed to handle more than just asthma. They will have a case manager and licensed clinical social worker to help families with behavioral and mental health issues as well.

As the focus in health care shifts from a fee-for-service model toward value-based care, there could be increased interest in programs like CAI and MAP that reduce costs by improving care coordination and addressing social determinants of health. In an article published in the *Journal of Asthma*, new research using actual claims data shows CAI generates a positive return on investment after two years and actually saves money after three years.

"It’s not only about helping some children in Boston with asthma, but it’s also about creating systemic change where we can really have a broader impact and reach many more children," says one of the article’s authors, Susan Sommer, MSN, WHNP-BC, AE-C. — Erin Moriarty Wade and Kyra Shreeve, BS

This project was supported in part by HRSA/MCHB of the US Department of Health and Human Services through the Boston Children’s Hospital Healthy Tomorrows grant H17MC21584 and Leadership Education in Adolescent Health training grant T71MC00009.

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Send your email address to ldobberteen@mcaap.org for instant notification of issues important to the MCAAP membership.
Massachusetts Medical Society Annual Meeting of the House of Delegates

As your representative to the Massachusetts Medical Society (MMS) House of Delegates (HOD), I represent all MCAAP members at the bi-annual meeting of the policy-making body of the MMS. Delegates representing every district medical society and specialty come together to discuss and debate numerous resolutions concerning health policy, medical practice, medical education, and public health.

In May, the HOD met for the 2019 Annual Meeting. Below is a brief summary of the resolutions that I felt would be of particular interest to our members. The full details of all resolutions and the final votes can be found at www.massmed.org/Annual-Meeting/House-of-Delegates/House-of-Delegates/#final.

1. Establishing a special committee on mental health and substance: This resolution written by MCAAP member Dr. Michelle Dalal and passed by the HOD directs the MMS to establish a new committee to look into the many important issues in the mental health realm, including early detection, screening, prevention, and treatment.

2. Regulation to limit sales of liquid nicotine delivery products: This resolution, co-authored by Dr. Mary Beth Miotto and me, and sponsored by the MCAAP, addresses the recent crisis of e-cigarettes, vaping, and flavored nicotine products that are negatively affecting our youth. The resolution, which the HOD passed, asks the MMS to advocate for improved licensing and regulation of these products, including limiting sales at retail tobacco establishments to people age 21 and over.

3. Banning tobacco flavors in combustible and electronic cigarettes and other nicotine products: An important resolution written by past MCAAP President and current MMS Vice President Dr. Carol Allen was successfully passed by the HOD. The resolution asked the MMS to advocate to the state legislature to ban the sale or distribution of any flavored tobacco products. In addition the resolution encourages banning the sale or distribution of these products.

4. Ending nonmedical exemption to public school entry: This resolution was written by Dr. Eli Freiman, a pediatric resident at Boston Children’s Hospital, and was passed by the HOD. It charges the MMS to advocate for legislation to end non-medical vaccine exemptions for school attendance in Massachusetts.

5. Social determinants of health in MassHealth ACOs: With the recent implementation of the Medicaid ACO program in the Commonwealth, the MassHealth program has made a commitment to address the social determinants of health, which we know are a critical factor in providing quality care to our patients. There have been concerns raised by the MMS Committee on the Quality of Medical Practice, which submitted this report to assess some of these concerns. Specifically, the report attempted to tackle the issue regarding inconsistency in the screening tools and data collection processes used by each ACO, which makes any data analysis and comparison challenging. In addition, there is alarm about the burden on individual practices to conduct an increasing number of screenings for all ACO patients without adequate available resources. Most importantly, the matter of pay for performance of outcomes being imposed upon physicians without any data on the validity of such a program is of significant concern. The report advocated for continuing with pay for implementation and pay for reporting but delay the implementation of pay for outcomes until better and more complete data are available. The report contained six different recommendations and passed by the HOD.

6. Promoting communication, apology, and resolutions programs: There has been significant evidence that disclosure, apology, and offer programs are beneficial to both patients and physicians compared with addressing unexpected outcomes through the tort system. This successful resolution asks the MMS to advocate for communication, apology, and resolution programs to be implemented at hospitals, health care organizations, and medical practices across Massachusetts as the preferred approach to address adverse events.

7. Lack of savings generated by hospital-led ACOs: So far ACOs that are run by hospital-integrated systems have not shown cost savings where those that are physician-run have. This resolution, which asked the MMS to research the root causes of this variation in success, was passed by the HOD.

8. Conference and report on telemedicine: The HOD allocated resources for the MMS to hold a conference on telemedicine and to provide a report at the 2020 Annual Meeting regarding a vision for the future of telemedicine with a focus on how the technology can contribute to value-driven health care, decrease physician burnout, and be effectively regulated.

This was my last meeting as your representative to the MMS House of Delegates. I will continue to be a delegate representing the Worcester district, but will be passing along the MCAAP delegate position to Dr. Michelle Dalal, starting with the fall 2019 Interim Meeting.

— Lloyd Fisher, MD, FAAP

Lloyd Fisher, MD, FAAP, is the outgoing MCAAP delegate to the Massachusetts Medical Society House of Delegates.

Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by August 30, 2019.
During my 30 years in primary care pediatrics, I regularly counseled parents on safety. I discussed car seats, cribs, foods, and toys that were choking risks and the strangulation risks of hoodie strings. Later as the babies began to explore, I discussed securing medicine and cleaning supply cabinets, bolting dressers to the wall, and safety issues of climbing structures, bikes, and ATVs. I told them all to give their guns to some childless friend to keep for them until their youngest child turned 18.

When my own children arrived, I was astonished by their ingenuity and determination to find the most dangerous way to use all toys and found objects, and I redoubled my efforts to keep my patients safe. Although I was vaguely concerned about balloons, my own children loved them, particularly in the summer for water balloon wars, and I even occasionally blew up a latex glove and drew a face on it to coax a smile from a reluctant patient.

Everything changed when a three-year-old boy arrived on the 20-bed pediatric ward of the local nursing home. My partners and I took care of the children there. They had a variety of neurologic disorders due to accidents, illness, genetic disorders, and prematurity. “Tim” had bitten into a balloon a year earlier at his six-year-old brother’s birthday party, and a piece of latex had blown into his pharynx, wrapping itself over his larynx. No amount of effort by his parents could dislodge it, and by the time the paramedics arrived and performed an emergency tracheotomy, it was too late. Tim was resuscitated at the hospital and lived another 18 years in a persistent vegetative state.

After meeting Tim and his family I became an anti-balloon crusader. In researching choking deaths due to balloons, I found that the AAP Policy Statement on Prevention of Choking Among Children contains statistics from an article published in JAMA on December 13, 1995. In “Characteristics of Objects That Cause Choking in Children,” Frank L. Rimel et al. reviewed 449 cases of children who died due to choking on artificial objects between 1972 and 1992 as reported by the Consumer Product Safety Commission (CPSC). They found that balloons caused 29% of choking deaths overall. Moreover, the deaths were not clustered in children under three years of age. The risk of choking to death on a balloon was much higher in children ages three to eight years of age. Sixty percent of all choking deaths in this age group were due to balloons while only 33% of the fatalities occurred in children three years or under. Notably, two of the deaths, one in a 20-month-old and one in an eight-year-old were due to balloons made of latex exam gloves given to them by physicians. Dr. Rimel concluded, “Balloons pose a high risk of asphyxiation to children of any age.”

More recent data found in the yearly reports of the CPSC show that though the absolute number of deaths due to choking on balloons is relatively small, the percentage of choking deaths attributable to balloons has remained stable. Between 2009 and 2017, 20 children died due to choking on latex balloons. In 2011, balloons accounted for 23% of fatalities due to choking, and between 2001 and 2014, about 38% of all toy-related choking deaths involved balloons. Those children who survived but were left in a persistent vegetative state are not included in the statistics.

Balloons, along with the stuffing from diapers are what are categorized by the CPSC as “conforming objects.” As such, they are nearly impossible to remove with finger sweeps or back blows once they have been aspirated. Children of all ages love chewing on inflated balloons, and when they pop, the rush of air can force a piece of the latex deep into the pharynx, beyond the reach of the parent. The child’s attempts to inhale suck the fragment firmly over the larynx, and the child’s cough is often not strong enough to dislodge it. Balloon fragments also cause asphyxiation. When children put them in their mouths and chew on them, their slippery consistency can cause them to slide to the pharynx with subsequent choking and asphyxiation.

Although latex balloons are ubiquitous and deeply entwined in the culture of our celebrations, I feel it is time to explain the dangers of latex balloons to parents and recommend that they buy only mylar balloons for children under 10. I realize this may sound like overkill; perhaps instead latex balloons could be used with great caution. However, balloon deaths are often particularly tragic. As in Tim’s case, many of the balloon-choking deaths occur during a celebration for either the victim or a sibling. The family mourns the loss of the child, and the sibling’s birthdate forever carries a shadow. At a party, no parent can watch every balloon and every balloon fragment, let alone the ones the guests take home. The time has come for latex balloons to go. — Catherine Bartlett, MD
David Norton, MD, FAAP, Recipient of the CDC Childhood Immunization Champion Award

In April, David P. Norton, MD, FAAP, pediatrician at Holyoke Pediatric Associates, Holyoke, and Assistant Clinical Professor of Pediatrics at the University of Massachusetts Medical School — Baystate, was named the Massachusetts recipient of the 2019 Centers for Disease Control and Prevention (CDC) Childhood Immunization Champion Award.Each year, during National Infant Immunization Week (NIIW), the CDC and the Association of Immunization Managers (AIM) honor health professionals and community leaders from around the country with the CDC Childhood Immunization Champion awards. These awards acknowledge the outstanding efforts of those individuals who strive to ensure that children in their communities are fully immunized against 14 preventable diseases before the age of two. Dr. Norton was nominated for this award by the Immunization Division at the Massachusetts Department of Public Health (MDPH).

Dr. Norton is a pediatrician and immunization expert at Holyoke Pediatric Associates, a large pediatric practice in Western Massachusetts that provides service for more than 50,000 patient visits annually. As a long-time member and current chair of the MCAAP’s Immunization Initiative Advisory Committee and a voting member of the MDPH-sponsored Massachusetts Vaccine Purchasing Advisory Council since 2012, Dr. Norton has been a longstanding and vocal champion for practices that ensure optimal immunization of the children of Massachusetts.

In addition to his domestic work, Dr. Norton has volunteered annually for more than 25 years in the developing world. He has seen dozens of children suffering from vaccine-preventable diseases and entire wards of children with measles. Families and providers with whom he has spoken felt they could not prevent disease, but could only treat it because of lack of access to vaccines.

The selection of Dr. Norton was praised by his colleagues. MCAAP President Dr. Elizabeth Goodman, MD, MBA, FAAP, said, “Dr. Norton’s passion for public health and prevention make him a natural advocate. He is tireless in promoting the utility and importance of vaccines to parents and to helping the Commonwealth’s medical community educate patients and parents so that our children’s health can be optimized.”

Pejman Talebian, MA, MPH, director of the Immunization Division at the Massachusetts Department of Public Health, noted that “Dr. Norton has been a close partner, working with the Immunization Program over the years to promote complete and timely vaccination of the Commonwealth’s children.”

National Infant Immunization Week is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases and to celebrate the achievements of immunization programs in promoting healthy communities throughout the United States. Each year, during NIWW, communities across the United States celebrate the CDC Childhood Immunization Champions. These award recipients are being recognized for the important contributions they have made to public health through their work in childhood immunization.

The 2019 CDC Childhood Immunization Champion Awardee profiles can be found at www.cdc.gov/vaccines/events/niww/champions/profiles-2019.html. Congratulations, Dr. Norton!

Vaccine Confidence Project

Over the past year, the MCAAP Immunization Initiative and the Immunization Division at the Massachusetts Department of Public Health have been collaborating on a project focused on increasing vaccine confidence in selected communities across Massachusetts. We have been focusing on areas of Massachusetts which may be more 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 the MDPH’s School Immunizations webpage: www.mass.gov/service-details/school-immunizations.

The overall project goal is to develop vaccine confidence-focused education and resources that can be utilized with health care professionals and for future outreach to the general public. Our initial step has been to meet with key constituencies about common concerns and issues specific to Western Massachusetts. Over the past year, meetings have been held with key constituencies.

Project updates will be communicated as they become available through the Immunization Initiative monthly e-newsletter and The Forum. For more information, you also can visit the Vaccine Confidence webpage, https://mcaap.org/immunization-initiative/vaccine-confidence-project. If you are interested in participating in this project, please contact Cynthia McReynolds, program manager, MCAAP Immunization Initiative at cmcreynolds@mms.org or (781) 895-9850.

August Is National Immunization Awareness Month (#ivaxtoprotect)

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.

The NIAM webpage (www.cdc.gov/vaccines/events/niam.html) 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 NIAM 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 for all that you do to keep children of Massachusetts safe from vaccine-preventable diseases!

24th Annual MIAP Pediatric Immunization Skills Building Conference

The Massachusetts Immunization Action Partnership (MIAP) is excited to announce the 24th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference. The conference will be held on Thursday, October 17, 2019, at the Sheraton Hotel and Conference Center, Framingham, Massachusetts.

This year’s plenary speakers will be JoEllen Wolicki, BSN, RN, nurse educator, Centers for Disease Control and Prevention (CDC); Ronald C. Samuels, MD, MPH, associate director of the Primary Care Center, Boston Children’s Hospital, and president, Massachusetts Immunization Action Partnership; Susan Lett, MD, MPH, medical director; and Pejman Talebian, MA, MPH, director, Immunization Division, Massachusetts Department of Public Health.

Conference breakout sessions will include the following:

- Pediatric Immunization Challenges in Immigrant and Refugee Populations
- Immunization “101”
- Vaccine Preventable Disease Epidemiology
- Vaccine Storage and Handling and VFC Compliance Training
- Massachusetts Immunization Information System (MIIS) Updates
- 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-division-events.

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

Call for 24th Annual MIAP Conference Award Nominations

Nomination Deadline: Friday, July 26, 2019

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 26, 2019. Nomination forms can be found at https://mcaap.org/immunization-initiative/immunization-cme.

The 2019 MIAP Conference Award will be presented on October 17, 2019, at the 24th Annual MIAP Pediatric Immunization Skills Building Conference.

If you have any questions or need additional information, please contact Cynthia McReynolds at cmcreynolds@mms.org at (781) 895-9850.
Provider Resource Spotlight: There’s an “App” for That!

Mobile devices and software applications, commonly known as “apps,” can be used by pediatric health care professionals in their daily practice. Apps can provide easily accessible, accurate, and current immunization information. Some of the apps also include online continuing education.

The Immunization Action Coalition (IAC) has developed a list of helpful apps for health care professionals and their patients. Most of the apps are free to download on iPhones or Android devices (www.immunize.org/resources/apps.asp). One of the apps is the Centers for Disease Control and Prevention (CDC) Vaccines Schedules App for Healthcare Providers. You can easily access all CDC-recommended immunization schedules and footnotes from your mobile device. Optimized for smartphones, the app shows child, adolescent, and adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). It also visually mimics the printed immunization schedules.

Another helpful app is the HPV Vaccine: Same Day, Same Way™ app, developed by the American Academy of Pediatrics, Academic Pediatric Association, and Kognito (a health simulation company). This app is a brief, interactive role-play simulation designed to enhance health care providers’ ability to introduce the HPV vaccine and to address HPV vaccine hesitant parents’ concerns. The app is ideal for immunization education (residency training, quality improvement collaboratives, or office in-service training). It is free and can be downloaded from the App Store or Google Play.

Do you use immunization apps in your daily work? If yes, we would love to learn more about your experience. Please contact Cynthia McReynolds at cmcreynolds@mms.org.

Upcoming Events and Meetings

National Immunization Awareness Month
August 2019
For more information, visit www.nphi.org/niam

Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting
October 10, 2019, 4:00–6:00 p.m.
Massachusetts Medical Society, Waltham, MA
For more information, visit www.mass.gov/eohhs/programs/idd/immunization/mvpac.html

24th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference
October 17, 2019
Sheraton Framingham Hotel and Conference Center, Framingham, MA
Updated information will be posted as it becomes available at https://mcaap.org/immunization-initiative/immunization-cme.

Advisory Committee on Immunization Practices (ACIP) Meeting
October 23–24, 2019
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.

Join the Immunization Initiative!

Who We Are

The Immunization Initiative of the Massachusetts Chapter of the American Academy of Pediatrics 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 Division at the Massachusetts Department of Public Health, and with individuals, who share the Immunization Initiative’s mission.
- Supporting coalition building and networking opportunities through its Advisory Committee. The Advisory Committee usually meets three to four times per year to discuss current immunization information and strategies for addressing issues and barriers to immunization.
- 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.

All ShotClock articles were written by the MCAAP Immunization Initiative
Five-year-old Laura and her mother had come to the hospital for another battery of tests to prepare for bone marrow transplantation (all identifying information changed). She was playful that day, and many hospital staff waved to her or came over to greet her, as she had spent so much time at the hospital since falling gravely ill two years before. Yet her mother, Sarah, and I knew that she would go through many hard moments soon. The awareness of what was ahead for Laura’s next few months was weighing heavily on Sarah. But she said to me, “I was afraid driving here today. You know what might happen.”

Sarah, with tens of thousands of parents like her in Massachusetts, was afraid of being pulled over by police, because as an undocumented immigrant, she cannot obtain a driver’s license. From her small town, she had no other way to bring Laura to the hospital.

I know many parents who, like Laura’s parents, have been hard-working members of our communities for 10 or 20 years, yet cannot obtain a driver’s license. This situation leads to profiling in some towns, arrests for driving without a license, and turning parents over to ICE for deportation. I have spoken with many parents who face the choice of risking arrest and deportation for driving their child to the hospital, or of failing to get needed medical care for their child.

Most of the children struggling with having lost a parent to deportation are United States citizens. The lasting scars of losing a parent remain not only with the directly affected child, but also their cousins, classmates, and neighbors — again, most of them US citizens. They all feel the same constant fear, whether they are old enough to understand their parents’ dread of family breakup, or they sense only that the world is a very frightening place.

I followed Laura during her bone marrow transplant. She initially did very well. One of her parents was always at her bedside, while the other worked and then prepared home-cooked food. Her parents took turns bringing a meal they had cooked at home, to her in the hospital every day. To do this, they had to drive from their home, 30 miles away, to Boston every day. Then Laura developed an extremely serious complication from her transplant.

One day, as Laura was in the hospital struggling for her life, Sarah left the house with freshly cooked dishes of food. Not far from her home, she was stopped by police. They asked her for her license. With a pounding heart, Sarah asked the policemen to let her go to her child in the hospital. They did not arrest her, but they had her car towed despite her pleas to let her pastor pick it up. Had they arrested her, she may have been turned over to ICE. This was under the previous administration in Washington — this event may have ended much worse today.

Laura recovered from her bone marrow transplant. She still had weekly clinic visits. Sarah drove her to Boston every week without a driver’s license.

How are public safety — and Laura’s safety — served by denying Sarah the opportunity to go through the standard process of obtaining a license — the written test, the driving test, the fee payments — which she desperately wants to do?

All the undocumented parents I know, who drive without drivers’ licenses, wish nothing more than the opportunity to take the driving test, pay the fee, and pass through all the requirements to obtain a license just like their documented family members, friends, and neighbors can.

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Society is rapidly evolving in many ways; the most obvious is that in the shift in jobs from manufacturing to service industries the roles of men and women will continue to shift. These significant shifts have occurred quickly, leaving little time for women and men to adjust to their new roles. As roles change, stereotypes need to give way to new ways of thinking about roles of caretakers and wage earners for families. The stay-at-home parent taking care of the children and home can be either parent; the mother or father may choose to be the wage earner. And often, in today’s economy, both parents may combine some amount of paid work and time caring for young children to achieve what is best for their particular father.

Both parents are important! Studies have shown that fathers, as well as mothers, have significant impact on their children’s lives. In same sex couples, both parents also have significant impact on the lives of their children. Parents who stay at home may feel they have stepped out of their career pathway. Parents who are the primary wage earners may experience work-family conflicts and strive to lessen their workload in order to be home more and strengthen the relationship with their children.

Dads have a different parenting style than moms and their input is significant. Children with a close relationship to their dad are less likely to act out in school and less likely to get expelled from preschool. They are more likely to start their school education in a positive way. With a strong start to their education, children are twice as likely to go to college. In general, boys who experience less bonding with their dads are more likely to have lower life satisfaction. Girls, with dads who are interested in their academics and are nurturing in their relationships, are more likely to be in a relationship with a kind and understanding partner and to complete college and enter a challenging career.

Many dads may not know about the hormonal changes they undergo during their partner’s pregnancy that continue after delivery. The changes are all related to helping fathers become more nurturing parents, although some of the associated changes affect male aggression, loss of muscle mass, and weight gain. Bodily changes may be perceived but the underlying cause may not be understood. With society’s obsession with appearance and looking fit, these body changes can only lead to further self-esteem problems for the new dad.

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

A dad may start to worry about his role in caring for his newborn child. He could feel stressed about financially supporting his family or have concerns about the new family and how it will be structured. A dad may feel left out of the intense relationship between a nursing mother and her baby, as well as feeling his partner is totally focused on the baby. All of these issues can contribute to depression after birth and this can severely impact both parents and child. The situation is exacerbated if both parents experience PPD. Both parents will need help.

The rate of male PPD varies between 6% and 10%. It is more likely to occur if there is a past history of depression or if the other parent is also depressed. PPD cannot be detected without screening. Since the effect of PPD can result in at least four adverse childhood experiences in some home situations (parents getting physically aggressive with each other, substance use, separation, and depression), it is imperative to try and find those dads who are depressed and offer them counseling. Dads, who do get depressed and are not offered help, may turn to substance use or violence against their partner, which will create a very unsafe and frightening home environment. There is no harm in screening for depression according to the US Preventive Services Taskforce as long as there is evidence based effective treatment available.

The screening tool, which is the same survey of 10 questions used for moms, is the well-validated Edinburgh Postpartum Depression screening tool. The pediatric office is the best place for screening because the pediatrician is seen by about 75% of dads. Many dads have not yet connected with a physician for themselves because they are still relatively young. A particular family visit or a visit for dad alone can become routine for every newborn at a certain age. This will ensure that dads get screened at the most likely time to pick up paternal depression. The best time to screen is at three and six months postpartum.

In conclusion, implementing screening for dads can be done with very little extra effort, since moms are already being screened with the same tool. There is a need to have trained providers to treat these dads in a therapeutic environment that is caring and supportive. The goal is to support both parents, and help them begin their new life as a family in the best way possible. — Mark Friedman, MD

Mark Friedman, MD, can be reached at mfriedman@communitycatalyst.org or markrichardfriedman@gmail.com.

References
Father’s brain is sensitive to childcare experiences. Proceedings

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Immigrant Children

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as a Commonwealth should provide that opportunity, lift a heavy cloud of fear from their children’s shoulders, and improve everyone’s safety in the process.

Three quarters of Massachusetts employees use a car to get to work. In many areas, 80–100% of workers drive. Fifty-three thousand children in Massachusetts have an undocumented parent and fear every day that their father or mother will not come home. Twelve states, including our neighbors Connecticut and Vermont, plus the District of Columbia, have unlinked accessibility of a driver’s license from immigration status. This change in the law had positive impacts in Connecticut after its implementation in 2015.

“An Act Relative to Work and Family Mobility,” H.3012 (Reps. Farley-Bouvier and Barber) and S.2061 (Sen. Crighton), is a bill to separate driver’s license eligibility from immigration status in Massachusetts. Children’s safety and protection from disastrous life events is well served by this bill: it will protect thousands of children from losing a parent to deportation. Additionally, it will improve road safety when all drivers have taken a test.

The deeply deleterious effects on children of detention and deportation of a parent, and of the constant fear of children with an undocumented parent, have been widely documented at this point. There are illnesses and injuries that we cannot avert — as pediatricians we try to heal them when they occur. Laura was healed from an immunodeficiency by her bone marrow transplant. Other health disasters for a child, like intentional injuries, can be averted. The disaster to a child, of loss of a parent because that parent could not get a driver’s license, is completely avertable. Laura should not have to fear that her mother will not reach the hospital because she was taken by ICE. Advocating for the Family Mobility Bill can be our contribution to avert such a disaster for Laura and for tens of thousands of Massachusetts children. — Julia Koehler, MD

Editor’s Note: The views expressed in this piece are Dr. Koehler’s. The Chapter has decided not to take a formal position on this issue.

References


Dads

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of the National Academy of Sciences. www.pnas.org/content/111/20/792.full.


Send your email address to ldobberteen@mcaap.org for instant notification of issues important to the MCAAP membership.
RFDASH 2019

Residents and Fellows Day at the State House (RFDASH) took place on May 30 at the Massachusetts State House. Approximately 60 participants advocated for the following bills:

- S.1279 “An Act Regulating Flavored Tobacco”
- S.677 “An Act to Ensure Equitable Health Coverage for Children”
- S.588 “An Act Relative to Mental Health Parity Implementation”

Speakers and topics included the following:

**Youth Vaping and E-cigarette Usage**  
Nicholas Chadi, MD, MPH

**Covering All Kids: Expanding Healthcare for All**  
Fiona Danaher, MD, MPH

**A Shot in the Dark**  
Michael Hirsh, MD (Keynote Speaker)

**Improving Child Mental Health: The Best Investment in Our Future**  
Michael Yogman, MD

Legislation Highlights

Ed Brennan, Esq., MCAAP Legal Counsel

**How to Talk to Legislators 101**  
Alex Calcagno, Director of Legislative Relations for the MMS

Advocacy Tips

Dr. Anna Rosenquist, RFDASH Founder, Pediatrician

RFDASH was founded in 2005 by residents in the Massachusetts General Hospital for Children Pediatrics residency program, and it is now organized through a collaboration of all the Massachusetts pediatrics residencies. It was established as a time for the pediatric trainees of our state to come together as advocates for the children of our shared community. Since then, we have advocated for over 30 bills, many of which have been passed and are current Massachusetts law.

During this yearly event, pediatric residents, fellows, and medical students (from all over Massachusetts) pick 2–3 state bills that they want to advocate for, learn about bills/themes from pediatric advocates, have official lobby training, and then meet with legislation and advocate for the bills at the Massachusetts State House. — Cathleen Haggerty

For more information about RFDASH 2019, visit http://rfdash.weebly.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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Native files or other file formats will not be accepted. Fonts must be embedded and TrueType fonts should be avoided.

Please remember to double check that your ad is the correct size and contains the most up-to-date information.

Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by August 30, 2019.
I recently attended an event coordinated by Write Boston (www.writeboston.org), a literacy organization that promotes the teaching of writing and gives opportunities for teens in the Commonwealth of Massachusetts to write. Several students spoke about their experiences writing for a newspaper, Teens in Print, and of learning to write persuasive essays for their college applications as well as cover letters for jobs. As I was listening to their poignant stories of learning to write properly, and the degree to which this was changing their trajectories, I reflected that Reach Out and Read is the beginning of the literacy experience for many of the kids we serve, and it’s a social justice intervention for children growing up in poverty who have lower literacy levels and subsequently fewer options in adult life.

Over the years of my primary care practice of pediatrics, I’ve shifted the message that I give to parents about the value of books for infants and very young children. It isn’t really about reading; at least not early in life — it’s about talking, listening, asking questions, expanding on a story, singing, counting, serve and return, dialogic reading, and keeping a conversation alive using the book as a tool. Parents and caregivers expressed frustration that their babies wouldn’t let them read the book. Now parents will tell me their children love to be read to and have favorite books they want to look at over and over, and this is a source of pride for them.

Speaking with parents who have low literacy themselves can be a challenge in primary care. The Foundation for Child Development reported that children of mothers with less than a high school education were only one-third as likely to be reading proficiently in eighth grade as children of mothers with college degrees. No surprise there. Talking with parents about their wishes for their own children’s future, however, almost all of them express a desire for their children to go to college, have a good life, and not make the mistakes that they made. How we help make this possible for kids in early life depends, at least in part, on supporting their literacy development, which starts with reading and talking with them early in life, fostering their understanding of the written word and promoting writing clearly as a life skill.

I’ll admit to having spent little time talking about writing with parents of my patients. Reading on grade level is something parents often report as a sign their child is doing well in school, yet few mention their child’s ability to write. Marilyn Augustyn, chief of Developmental and Behavioral Pediatrics at Boston Medical Center (and the previous author of this column), encourages primary care pediatric providers to incorporate the report card into well-child visits, as a window into how a child is doing at school. Occasionally I do get to see a report card, and learn so much more than asking about how things are going in school.

The ability to write clearly in English should not be out-of-reach for our patients. There is a movement to support financial literacy for our low-income families, yet this requires basic proficiency in literacy first. Children of non-English speaking parents are at particular risk, and programs like Write Boston exist for precisely this reason, promoting clear writing to children who are the first generation to master spoken English or children of low-literacy parents in general.

We can play a role here, talking about reading and writing at primary care visits, encouraging older kids to participate in the various literacy development programs after they “age out” of Reach Out and Read, as a clear next step in their progression toward the life their parents want for them. — Eileen Costello, MD
JOB CORNER

Wilmington Pediatrics

Wilmington Pediatrics, a primary care pediatric group 20 minutes north of Boston, is seeking a board-certified/board-eligible general pediatrician for outpatient care, starting in the fall of 2019. The position is currently part-time with full-time potential and includes participation in shared call with weekend and holiday coverage. If you are interested, please email your resume and cover letter to Gabriela Biasini at Gbiasini@wilmingtonpedi.com.

Pediatrician for Cambridge Practice

Seeking part-time PCP BC/BE pediatrician for unique Cambridge private practice with a developmental focus, starting summer or fall 2019. Please email CV and letter of interest to Dr Michael Yogman, practice founder, at myogman@massmed.org.

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.

OPENPediatrics Presents the Pediatric Pain and Opioid Education Curriculum

Opioid prescription for pediatric patients presents unique challenges. In addition, abuse of prescription pain medication in the pediatric population is a growing problem. To help address these concerns, OPENPediatrics (www.openpediatrics.org) developed the Pediatric Pain & Opioid Education Curriculum (www.openpediatrics.org/course/pediatric-pain-and-opioid-education-0).

The curriculum provides training in acute and chronic pain management for pediatric patients, with an emphasis on safe and effective opioid use. It is approved by the Massachusetts Board of Registration in Medicine and offers 5.5 physician, nurse, pharmacy, risk management, and MOC part II credits and satisfies the required 3 credits in pain management training for licensure renewal in Massachusetts. If interested, visit www.openpediatrics.org/user/register to register on OPENPediatrics and enroll. — OPENPediatrics Staff and Boston Children’s Hospital

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Submissions for the next issue of The Forum should be sent to ldobberteen@mcaap.org by August 30, 2019.