



PRESIDENT'S MESSAGE

How Fred Rogers and Robert Fulghum Guided Me as Chapter President

With my presidency winding down, I've been pondering my journey as a pediatrician, child health advocate, and Chapter officer. I came into the role of treasurer after decades of clinical practice, a recent degree in public health, experience planning Chapter education activities, and national AAP participation. My six years as a Chapter officer have been among the most satisfying of my career.

One of my greatest joys has been recruiting new Chapter leaders. An increasingly diverse group of pediatricians epitomizes the vision of our Chapter: "The MCAAP is a leading voice for child health advocacy and high-value equitable care for all youth in the Commonwealth of MA." Working alongside Chapter volunteers reinforces my belief that we all benefit when pediatricians "make some noise for kids".

Many members wonder if they are "meant to lead. Is there a quick "guidebook" to teach the basics to potential MCAAP leaders? Contemplating this question brought me to the greats: Fred Rogers, Robert Fulghum, and many more. While I can't really say that kindergarten is where I learned *everything* about being a pediatric leader, the basic rules still apply:

1. "Look for the helpers." (Fred Rogers). When faced with a challenge, I have been known to try to "go it alone," which is rarely the best approach. Fortunately, I usually start every project with "Who, What, How" and then remember that I can't be successful

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Flex Your Advocacy Muscle: Vote

I'm a political groupie. Over the years, I have gotten to know politicians at all levels of government, starting with school committee members when my children were young and select board members for my town of Arlington, all the way up to governor, attorney general, and congressional representatives and senators. I even took a course on how to run for

office, run by an organization called Emerge that focuses on Democratic women. One of my classmates was Michelle Wu, now mayor of Boston.

What I have understood from the beginning, decades ago, is that politicians produce policy, and it's policy that governs our communities, our family life,



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Photo by Lisa Dobberteen, MD, FAAP

EDITOR'S NOTE

A Fine Balance

There are many things that require a fine balance: ballet, making souffles, tying flies for fly fishing, and ophthalmological surgery, to mention a few. Sometimes, as pediatricians, we find ourselves treading a very fine balance between our patients and their parents. I recently found myself in just such a balancing act.

A parent sent an email asking to book an appointment for me to counsel the teen about risk-taking behaviors and prescribe for the problem as well. The parent was completely unaware that the teen was already getting confidential care for just this problem. (I'll describe this all in the abstract to protect the family's privacy.)

When the parent-teen pair came in, the parent jumped right in and said, "I want you to talk about X." The teen looked pale, and the parent was anxious. I suggested I have some private time with the teen, and then the three of us would talk. Fortunately, the parent agreed.

"You can't say anything. You promised it would be confidential!" The teen was adamant: no compromise, no discussion, no way. Even though I suggested the parent, although probably not thrilled that their teen was already engaging in risk-taking behaviors, might be relieved that their teen was being responsible? Still, no way!

We talk about confidentiality with teens and parents all the time, in the abstract. A

teen's right to confidential care and agency in making health care decisions is fundamental to adolescent care provided by pediatricians, family medicine doctors, and adolescent specialists. In reality, this rarely comes up in such a dramatically definitive fashion. Maybe the teen comes in on their own, maybe someone spills the beans, or there might be some drama, but the secret may eventually come to light in one way or another. Not so this time, at least for now!

I took a deep breath. "You have to promise to tell your parent some time," I said. The teen agreed, but stated emphatically, "only when I'm ready." I acquiesced, and then we had a very thoughtful discussion about teens and their right to confidential care, telling the truth, the Hippocratic oath, and ethics. "Well, what are you going to do now?" the teen demanded.

I said, "How about if we tell your parent two things? One, that you have discussed a confidential matter with me, and are not ready to share it with them. Two, that you do not need treatment now for this risk-taking behavior. (I did not add, "because you are already being treated for it.") The teen agreed, and so did the parent, fortunately.

The teen and I were both relieved, and we made a follow-up appointment. On to more balancing acts, with other families, other days. Wishing you success in your own balancing acts!

— *Lisa Dobberteen, MD, FAAP*

How Fred Rogers and Robert Fulghum Guided Me as Chapter President

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until I gather input from the smart people around me. That saves me a lot of frustration in the short and long run. I've leaned on a lot of "external" helpers as president. Some that come to mind are staff at the Department of Public Health, MassHealth, and the Department of Elementary and Secondary Education. I frequently reach out to allies in the Massachusetts Medical Society, the Massachusetts Academy of Family Physicians, and other specialty societies. Pooling our resources produces far better results.

2. **"When you go out into the world, watch out for traffic, hold hands, and stick together."** (Robert Fulghum). This is like quote #1, but here I picture a row of little children in the crosswalk. In addition to the helpers, do I stick together with those from my *own* team, i.e., those specifically dedicated to child health? No one chapter leader does it alone. Last fall, as the MCAAP worked to support the nirsevimab rollout and the shortage that followed, MCAAP Treasurer David Lyczkowski stepped up to create a dashboard of the birthing hospital nirsevimab rollout dates. This winter, in response to asthma controller prior authorization headaches, Secretary Michelle Trivedi brought information from pediatric pulmonologists and independently reached out to MassHealth while I advocated for the Chapter. Vice President Brenda Pring has been there at every turn, offering invaluable input on issues from gender-affirming care statements to legislative activity.

We've held hands with old friends, such as the national AAP, who offered guidance on an amicus brief regarding the use of electric shock devices for behavioral modification in autistic residents of a Massachusetts program. They've offered tips on getting *Boston Globe* op-eds published. We grabbed some new hands, including allies at the Massachusetts School Nurse Organization and the Massachusetts



Chapter of the National Association of Pediatric Nurse Practitioners (NAPNAP). We are more effective advocates and learners alongside fellow child health professionals with whom we routinely share patient care responsibilities. Why should we walk alone when we can hold hands and stick together?

We still have work to do. We have seen the benefits of pulling up more chairs beside us at the table, and we recently expanded our MCAAP Board to include medical student and pediatric trainee seats. As we explore bringing a family liaison to our board meetings, I personally hope the Chapter will continue to invite youth to more activities.

3. **Enjoy crayons and colors.** My favorite strategy is to put something on paper and let smart people draw all over it in red ink. We are a learning organization. We dedicate ourselves to equitable access and high-value child health care, but pediatric knowledge changes at an ever-accelerating pace.

Our Chapter tailors AAP policy statements to the Massachusetts environment, advocates for new AAP policies, and occasionally creates standalone MCAAP policies. We can't do this in a bubble. Strategic priorities must change over time.

Do we need to focus on the integration of climate change action into pediatric practices? Are primary care pediatricians ready and supported to diagnose and manage autism in their offices?

Our executive officers and board recently created a detailed Strategic Priorities document (<https://mcaap.org/about-mcaap>). We invite Chapter members to provide feedback on our strategic vision and priorities. Our volunteer organization needs to deliberately choose how we spend our resources. I've written a lot in the past two years. Please take your red pen and improve our plans.

4. **"We have two ears and one mouth so that we can listen twice as much as we speak."** (Epictetus). Uh huh, I am a broken record here. Your leaders are trying to hear you. Do you answer our "Back of the Envelope" monthly one-question surveys? Do you email us to demand our attention to issues of practice sustainability, physician burnout, or the increasing demands during office visits? Leaders listen twice as much as we speak.
5. **"People are always looking for the single magic bullet that will totally change everything. There is no single magic bullet."** (Temple Grandin).


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Caregiver to Caregiver Respite Network (C2C)

During her Public Policy class, while working on her Executive MBA at Suffolk University, Elizabeth (Beth) Bostic reflected on the many challenges she experienced as a caregiver of a child with special health needs. In particular, she remembered navigating complicated systems of care and struggling to balance the demands of her child's needs while staying employed and making ends meet. This was a long-standing challenge that was exacerbated during the COVID-19 pandemic. The direct service provider workforce crisis, in particular, made it next to impossible to find adequate skilled support and caregivers in the home. Out of the challenge came an epiphany: she realized there was a group of skilled direct service providers who were not being considered — *the caregivers of other children with special health care needs!* Why not create a network of caregivers to help care for each other's children with special needs and provide a break for each other?

From this idea, Ms. Bostic created the Caregiver to Caregiver Respite Network (C2C), a statewide network of families of children with special health needs that utilizes an untapped and fully trained workforce of caregivers. The C2C supports connections between caregivers who share similar experiences and have similar needs, creating a system for caregivers to provide and receive respite. Thanks to a \$1.2 million grant from the Respite Innovations Grant Program funded by the MA Executive Office of Health and Human Services, the Federation for Children with Special Needs is making the C2C a reality!

The entire C2C team is bilingual/bicultural, with project coordinators who speak English, Spanish, Portuguese, Haitian-Creole, Korean, and Chinese (other languages, including ASL, will be accommodated by other bilingual/bicultural Federation staff or through a language line). Through focus groups in a variety of culturally and linguistically diverse communities, they gained valuable insights into each community's unique strengths, needs, and concerns. They are using what they have learned to ensure they are culturally responsive to all



Caregiver to Caregiver Respite Network

A community of caregiving rooted in shared experience
Families of children and youth with disabilities and specialized support needs join the Caregiver to Caregiver Respite Network (C2C) to give and receive respite.

What is Respite?
"Respite" is the opportunity to take a break from caregiving. Time away creates space for taking care of yourself or other members of the family.

Who are Caregivers?
C2C welcomes anyone with primary responsibility for child-raising and support. This could be parents, foster parents, grandparents, or older siblings who have custody of a younger brother or sister.

How does C2C work?
You can apply to join. Then, we will match you with another family member based on:
• the child's medical and support needs
• where you live
• language and cultural identities and preferences

How can I get involved?
The C2C Respite Network is a program of the Federation for Children with Special Needs. It will launch in early 2024.
To join our mailing list or sign up for the program, please take our C2C Respite Network participation survey or scan the QR Code.

More Information:
Valeria Pedersen, Director - c2crespite@fcsn.org
Federation for Children with Special Needs - www.fcsn.org/c2c

caregivers who are interested in being part of the C2C. In addition to removing linguistic and cultural barriers, the C2C has removed financial barriers by including bartering as a method of compensation for caregivers (for example, each caregiver provides four hours of respite to each other).

The Caregiver to Caregiver Respite Network is building a community of caregiving rooted in shared experience. While it is currently only available in Massachusetts, Beth's ultimate vision for the C2C is to be available in every state, enabling caregivers to be on a family vacation in another state and access their local C2C so that they have the option to take a nap, read a book, walk on a beach, spend time with one of their other children, have a date night with their significant other, or just do NOTHING! Not surprisingly, other states are already very interested in replicating the program!

Massachusetts residents who are primary caregivers of children and youth with special health needs up to the age of 26 can access the Caregiver to Caregiver Respite Network at [C2C](https://www.fcsn.org/c2c).

— **Elizabeth (Beth) Bostic, MA, Assistant Director, Division for Children and Youth with Special Health Needs, MA Department of Public Health**

For those interested in contacting Ms. Bostic directly, feel free to email her at Elizabeth.E.Bostic@mass.gov.

How Fred Rogers and Robert Fulghum Guided Me as Chapter President

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Most of us have seen the surveys on burnout, and pediatricians have been climbing in these rankings. I get it. Those of us who enter pediatrics tend to have a bit of idealism entrenched in our souls. Some of that idealism has taken a beating. Change is going to happen. If we are not active participants, we run the risk of being devoured by it.

At my first board meeting as president, I went around the table and asked what brought each member to this work when they could be home relaxing. There were many answers, but almost all ended with something like, "I work hard for each child and Chapter work allows me to change systems that don't work." There are moments when we, as clinicians, feel like Sisyphus endlessly pushing our boulders up the hill. Most of my AAP leader colleagues report that our advocacy work "immunizes" us against burnout. MCAAP leaders don't get a stipend, but we get satisfaction from pushing the inevitable winds of change in the right direction for kids. We must voice our individual and specialty's vision for an equitable, just, health-driven society to raise healthy youth.

I embrace change. As immediate past president, I will support Brenda Pring, who will bring a unique perspective to the role of president. I will continue to serve as our AAP District 1 representative to the Chapter Forum Management Committee and will ask you to bring your best ideas forward into resolutions for the AAP Annual Leadership Conference. Chapter engagement can help us reclaim our hopeful aspirations for children and ensure our profession remains relevant and responsive. Consider stepping forward and raising your voice.
— **Mary Beth Miotto, MD, MPH, FAAP, outgoing President, MCAAP**

Flex Your Advocacy Muscle: Vote*continued from page 1*

and, importantly, health care and our practices. Policy can be good or bad, congruent with our values or at odds with them. In truth, public policy will never align completely with any one person's values. Nor should it. My father used to have a saying when people disagreed about something: "It is difference of opinion that makes horse races." But they should be fair horse races, not rigged ones, if we are to have honest discussions.

What does all this have to do with pediatrics? Plenty, as it turns out. Think of the Affordable Care Act, a.k.a. Obamacare. It took a presidential administration and congressional action to put together the framework and pass the law, and the action of a subsequent administration to preserve and expand it. This year alone, enrollment has increased substantially, although the ACA's future is in jeopardy if certain politicians win office in November. Our MassHealth 1115 waiver, which focuses more on pediatrics and behavioral health than in the past, was promoted by our state government and approved by CMS — agencies run by elected state and federal administrations.

Then, of course, there are the myriad of issues that directly impact children, adolescents, pregnant persons, and families: firearm injury, behavioral health, substance use, discrimination, reproductive health, poverty, racism, lack of housing, hunger, infections, climate, and war.

Because these issues are so visible to pediatricians, we are, by nature, advocates. Whether through the national AAP, our Massachusetts Chapter, other professional societies such as the Massachusetts Medical Society and the AMA, other affinity groups, or on our own initiative, pediatricians advocate. It's part of our identity. And organizations like AAP and MCAAP nurture our advocacy through education, collaborations, and visibility. They can be nonpartisan and still promote values in support of our patients and our practices.

All of this is to point out how important elections are. I have lived through many administrations, beginning with Truman (whom I don't remember because I was a child). All have made some mistakes, but thankfully, some have moved our nation forward through wise policy decisions. As I witness the actions of some governors to handicap women, racial and ethnic minorities, and the LGBTQ+ community and to undermine education and voting

rights, I am even more passionate in my determination to work to elect "the helpers," as Mr. Rogers used to say.

What can we do to move the needle toward fairness, health, and equity? Educate ourselves about candidates for all races. Challenge those who disseminate mistruths or advocate harmful policies. Consider supporting — financially or with sweat equity — grassroots organizations to advance our values. Make sure we are registered to vote. Urge patients and their parents to vote; consider helping them to register through our offices. If a particular issue resonates with you, don't let up on advocating for it. Most of all, commit to voting in every election, be it local, statewide, or, especially, national. And when your candidates win, celebrate them, communicate with them about the issues, and support them again.

Next November, I want to look back at our successes and say, "Yay! We did it. Now let's move forward."

— **Carole Allen, MD, MBA, FAAP**

Dr. Allen's pediatric career has centered on advocating for the health and well-being of children. To this end, she has been fortunate to attain many platforms including MCAAP president, AAP District I chair and Board member, and Massachusetts Medical Society president, where she hopes to have made a difference. Dr. Allen can be reached at carole@tomandcarole.org.

AAP/MCAAP Appointments, Chairs, and Expert Representatives

AAP/MCAAP Appointments

AAP DISASTER PREPAREDNESS CONTACTS
Sarita Chung, MD

AAP EARLY CHILDHOOD CHAMPION
Katherine Wu, MD

CATCH CO-COORDINATORS
Esther Kisseih, MD
Frinny Polcano, MD

MMS DELEGATE/HOUSE OF DELEGATES
Elisabeth Di Pietro, MD

PROS NETWORK COORDINATORS
David Norton, MD
Ben Scheindlin, MD

MCAAP Committees, Initiatives, and Task Forces

CHILDREN WITH SPECIAL HEALTH CARE NEEDS COMMITTEE
Jack Maypole, MD

CHILDREN'S MENTAL HEALTH TASK FORCE

Michael Tang, MD
Heather Forkey, MD

FOSTER CARE COMMITTEE
Linda Sagor, MD

IMMIGRANT HEALTH COMMITTEE
Julia Koehler, MD

IMMUNIZATION INITIATIVE
Everett Lamm, MD
David Norton, MD

LEGISLATIVE COMMITTEE
Eli Freiman, MD

MEDICAID ACO TASK FORCE
James Perrin, MD
Greg Hagan, MD

MEDICAL STUDENT COMMITTEE

Logan Beyer

PEDIATRIC COUNCIL
Peter Rappo, MD

COMMITTEE ON CHILD ABUSE AND NEGLECT
Sasha Svendsen, MD

MCAAP Appointments and Expert Representatives

FETUS AND NEWBORN
Munish Gupta, MD

INJURY PREVENTION
Michael Flaherty, DO
Greg Parkinson, MD

ORAL HEALTH
OPEN

SCHOOL HEALTH
OPEN

ShotClock

CDC Advisory: Stay Alert for Measles Cases

Between December 1, 2023, and January 23, 2024, the Centers for Disease Control and Prevention (CDC) was notified of twenty-three (23) confirmed US cases of measles, including seven direct importations of measles by international travelers and two outbreaks with more than five (5) cases each. Most of these cases were among children and adolescents who had not received a measles-containing vaccine (MMR or MMRV), even if eligible.

As of this writing, a total of 35 measles cases have been [reported](#) by 15 US jurisdictions: Arizona, California, Florida, Georgia, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Pennsylvania, Virginia, and Washington.

In response to the increase in measles cases, the CDC published a Clinician Outreach and Communication Activity (COCA) communication advising health care providers to remain on alert for measles cases.

The article reviews the following recommendations for health care providers:

1. **Isolate** patients with suspected measles.
2. **Notify** local or state health departments about any suspected measles case to ensure rapid testing and investigation.



Photo Courtesy of Centers for Disease Control and Prevention

3. **Test** following the CDC's testing recommendations and collect either a nasopharyngeal swab or throat swab for reverse transcription polymerase chain reaction (RT-PCR), as well as a blood specimen for serology from all patients with clinical features compatible with measles.
4. **Provide**, in coordination with local or state health departments, appropriate measles post-exposure prophylaxis (PEP) to close contacts without evidence of immunity, either MMR or immunoglobulin.
5. **Make sure** that all your patients are **up to date on measles vaccine**, especially before international travel.

The CDC [recommends](#) that international travelers be vaccinated against measles at least two weeks before travel, regardless of the international destination. Providers should also advise patients to watch for signs of measles upon their return from international travel.

Additional Resources

- [Think Measles Handout](#), American Academy of Pediatrics (AAP)
 - [For Healthcare Professionals — Diagnosing and Treating Measles](#), CDC
 - [Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings](#), CDC
 - [Measles — Vaccine Preventable Diseases Surveillance Manual](#), CDC
 - [Plan for Travel — Measles](#), CDC
 - [Measles Lab Tools](#), CDC
 - [Measles Serology](#), CDC
 - [Measles Specimen Collection, Storage, and Shipment](#), CDC
 - [Measles webpage](#), MDPH
 - [Measles reporting guidance](#), MDPH
- **MCAAP Immunization Initiative**

Reference

CDC COCA News (1/25/24)

AAP Clinical Report: “Strategies for Improving Vaccine Communication and Uptake”

The American Academy of Pediatrics' (AAP) Committee on Infectious Diseases, the Committee on Practice and Ambulatory Medicine, and the Committee on Bioethics recently published an updated clinical report, [“Strategies for Improving Vaccine Communication and Uptake.”](#)¹

The clinical report reviews the concepts and underlying determinants of vaccine uptake and vaccine hesitancy, describes the relationship between vaccine hesitancy and costs of preventable medical care, and provides resources for addressing specific vaccine concerns.

The clinical report includes detailed information and tables that pediatric health care providers can use to review their knowledge of the recommended immunization schedule and vaccine safety. It provides tools that can support pediatric health care providers in their vaccine communication and immunization delivery and includes the following:

- A summary of vaccine safety monitoring systems
- Facts and messages to debunk common vaccine myths
- A flowchart showing when and how to apply specific communication techniques during a vaccine conversation
- Links to websites with detailed information to address common vaccine concerns

The clinical report also reviews a variety of approaches that pediatric practices and individual pediatricians have taken to address families who choose to refuse or delay vaccinations for their children.

The clinical report was published in the March 2024 issue of *Pediatrics*.

— **MCAAP Immunization Initiative**

Reference

¹O'Leary ST, Opel DJ, Cataldi JR, Hackell JM; American Academy of Pediatrics, Committee on Infectious Diseases, Committee on Practice and Ambulatory Medicine, Committee on Bioethics. Strategies for Improving Vaccine Communication and Uptake. *Pediatrics*. 2024;153(3):e2023065483.

Using Standing Orders for Administering Vaccines

As noted on MDPH's Vaccine Model Standing Orders [webpage](#),

“Implementing standing orders in your practice can empower other health care personnel to administer vaccines and increase vaccination rates.”

Standing orders are written protocols, approved by a physician or other authorized practitioner, that authorize nurses, pharmacists, or other health care personnel (where allowed by state law) to do the following:

1. Assess a patient's need for vaccination
2. Administer the vaccine without a clinician's direct involvement with the individual patient at the time of the interaction

[Immunize.org](#) has resources that can be utilized for implementing standing orders in your practice. [Using Standing Orders for Administering Vaccines: What You Should Know](#) provides answers to frequently asked questions about standing orders. [Steps to Implementing Standing Orders for Immunization in Your Practice Setting](#) describes the basic principles for implementing standing orders procedures for immunization.

Standing orders templates for vaccines, which are routinely recommended for children and adults, can be found here. The templates are reviewed for technical accuracy by immunization experts and are updated as appropriate. — *MCAAP Immunization Initiative*

Resources

- Vaccine Model Standing Orders [webpage](#), MDPH
- Clinical Resources: Standing Orders [webpage](#), Immunize.org

Massachusetts Vaccine Confidence Project Update



The Massachusetts Vaccine Confidence Project (MVCP) is a collaboration of the Immunization Division, Massachusetts Department of Public Health (MDPH); the Massachusetts Adult Immunization Coalition (MAIC); and the Massachusetts Chapter, American Academy of Pediatrics (MCAAP).

The MVCP is committed to increasing vaccine confidence and ensuring that all Massachusetts residents are protected against vaccine preventable diseases. To accomplish its

mission, the MVCP develops educational activities, communicates science-based resources and training materials for health care providers and the public, and collaborates with organizations that support immunization.

The MVCP has exhibited recently at the 28th Annual MIAP Pediatric Immunization Skills Building Conference (October 2023), the Massachusetts School Nurse Organization (MSNO) Spring 2024 Conference (March 2024), and the 29th Annual Massachusetts Adult Immunization Conference (April 2024).

Upcoming MVCP exhibits include the MDPH Office of Oral Health's "Oral Health in the Commonwealth Conference" and the 26th Annual Massachusetts Association of Public Health Nurses Conference.

Are you interested in joining the MVCP? Your participation is welcome! Please contact Cynthia McReynolds, Program Manager, MCAAP Immunization Initiative (cmcreynolds@mcaap.org) for more information. — *MCAAP Immunization Initiative*

2024 MDPH Immunization Updates

The Massachusetts Department of Public Health's (MDPH) Immunization Division presents updates on immunization-related topics for health care providers every spring. This series of one-hour webinars takes place on Wednesdays in May and June, from noon to 1:00 p.m.

2024 Immunization Updates Schedule

May 8 **Immunization Schedule Updates**
Angela Fowler, MD, MPH, Associate Medical Director for Vaccine Preventable Diseases

May 15 **Immunization 101**
Laurie Courtney, MSN, RN, Immunization Nurse Manager & Perinatal Hepatitis B Coordinator

May 22 **Epidemiology of Vaccine-Preventable Diseases in Massachusetts**
Juliana Jacoboski Duncan, MPH, Epidemiologist, MDPH

May 29 **Vaccine Confidence — Improving the Vaccination Experience to Reduce Anxiety-Related Vaccine Hesitancy**
Kelly Moore, MD, MPH, President & CEO, [Immunize.org](#)

June 5 **Massachusetts Immunization Information System (MIIS)**
Michelle Holmes, MPH, MIIS Interoperability Coordinator and Trainer

June 12 VFC Compliance and Vaccine Storage and Handling Training*

Dylan Kirby, MPH, Vaccine Management Unit Operations Coordinator VFC

**Vaccine coordinators and backups can earn their VFC Certificate.*

All sessions are free and will be held via webinar (no in-person sessions). Registration will open in April. You will find updates on the following web page, including information about continuing education credits and the "on demand" VFC webinar, at mass.gov/service-details/immunization-division-events.

For questions about the Immunization Updates, please contact Ted Clark, Outreach Coordinator, MDPH Immunization Division, at ted.f.clark@mass.gov.

— *MCAAP Immunization Initiative*

Upcoming Conferences and Meetings

National Infant Immunization Week (NIIW)

April 22–29, 2024

MCAAP Annual CME and Business Meeting "Adolescent Wellness in the 21st Century"

May 8, 2024, 4:00 p.m.

The meeting will be virtual.

2024 MDPH Immunization Updates

May and June 2024

The Immunization Updates will be held as one-hour webinars.

Massachusetts Vaccine Purchasing Advisory Council Meeting

June 13, 2024, 4:00 p.m.

The meeting will be hybrid.

Advisory Committee on Immunization Practices (ACIP) Meeting

June 26–27, 2024

The meeting will be virtual. Pre-registration is not needed to attend the meeting.

An Active Way to Get to School



There are many factors that impact absenteeism, but all students have to travel to school. In Massachusetts, more than 900,000 students commute to school on a daily basis. Sustainable active transportation, like biking and walking, is actively promoted and supported by the MassDOT (Department of Transportation) Safe Routes to School program. This encourages physical activity and safety, as well as the social and emotional benefits of student independence, while helping to foster a sense of community and resilience.

Working since 2005 to bridge the gap between health and transportation, the Massachusetts Department of Transportation's Safe Routes to School program is a free, federally funded K–12 program that works to increase safe biking and walking to school by using a collaborative, community-focused approach. The program has a public health

foundation that involves 1,100+ MA Partner Schools and 225+ Alliance Partners (non-schools).

A cornerstone of the MA Safe Routes to School program is promoting the life skills of DESE-accredited pedestrian and bike safety education. Understanding how to be a safe walker and biker, even if the journey is to a bus stop, is complemented through our work with family engagement, policy, and planning. In addition, our [website](#) offers numerous

multilingual safety resources to help engage students, drivers, and schools.

Getting to and from school safely and in an enjoyable and active fashion is important for all our students in the Commonwealth. — *Judy Crocker, MBA, MA Statewide Safe Routes to School Coordinator*

For more information about the program, our free materials, and our involvement in your school district, please contact Judy Crocker at judy.crocker@aecom.com.



MassHealth and the MCAAP Medicaid ACO Task Force

The MCAAP Medicaid ACO Task Force and the closely-associated Massachusetts Child and Adolescent Health Initiative (CAHI) continue to work on enhancing MassHealth (Medicaid) support for children, youth, and families. The Initiative recommended a wide variety of enhancements for the recent (2022) MassHealth 1115 waiver — the Commonwealth's request for funding to implement innovations in the state's Medicaid program. These recommendations included support for an enhanced, team-based primary care program, along with more investment in the population under age 21 and better use of funds for health-related social needs for younger populations.

The large majority of the CAHI recommendations were included in the 2022 waiver, which started implementation in April 2023. Among the key advances that MassHealth has put into place are

increased funding for primary care practices, including pediatric practices. The increase for pediatrics exceeded those for adult practices, and MassHealth plans additional increases in base primary care funding for the coming year. The waiver also supports enhanced payment (through an increased per member per month rate) to practices that expand their behavioral health and care coordination services, for example, with integrated mental/behavioral health providers, community health workers, school liaisons, and others. Practices that make upfront investments to provide more services get higher-level payments. MassHealth has also innovated in paying for primary care through a partial capitation program, i.e., moving substantially away from a predominantly fee-for-service model. The fee-for-service model still supports certain services that MassHealth, the pediatric community,

and parents thought merited clear incentives for performance.

The waiver also calls for increased use of health-related social needs funding for younger families. It also expands support for coordination of care across the spectrum of needs, from limited coordination needs to children and youth with complex clinical and social needs. This latter work also comes with enhanced payments. Nemours recently published a report — “Advancing the Key Elements of Whole Child Health” — from their Whole Child Health Alliance, including Massachusetts as one of three case studies ([Whole Child Health Alliance Advancing the Key Elements of Whole Child Health](#)).

CAHI continues to convene pediatric practice leaders from across the Commonwealth to share experiences in implementation and to identify issues that the CAHI leadership can bring to the

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MassHealth and the MCAAP Medicaid ACO Task Force

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MassHealth leadership for resolution. So far, we are hearing that practices at the higher payment levels have seen real increases in practice income with the changes, along with support for practice enhancements. Most practices note real problems in staff recruitment, especially for mental and behavioral health practitioners — a statewide (really nationwide) problem! Given the 17 ACOs in Massachusetts, internal arrangements and the way funds flow vary a good deal

among the practices. Having the opportunity to learn from other ACO leaders and to share issues with MassHealth leadership is one of the strengths of the ongoing efforts.

CAHI plans to continue collaboration among these practices and help spread best practices. We encourage MCAAP members to contact CAHI leadership with questions or recommendations for the best strategies to make Medicaid work for our families.

— **James M. Perrin, MD, FAAP, Co-chair, MCAAP Medicaid ACO Task Force**

Reach CAHI through Charlie Homer, MD, MPH, executive director of CAHI, Charlie.homer@gmail.com.

TEACHING OPPORTUNITY

Tufts University School of Medicine is delighted to offer the opportunity for pediatricians in Eastern Massachusetts to host a clinical rotation for students in pediatrics!

The benefits of hosting students include the following:

- Personal and professional satisfaction from teaching the physicians and PAs of tomorrow
- Faculty Appointment at Tufts University; access to robust online and library resources
- Honorarium per student hosted
- Continuing Medical Education (CME) opportunities and faculty development

- Connecting with a broad network of colleagues in Boston and across New England
- Fringe benefits such as Apple Store discounts and free digital newspaper subscriptions
- Recruitment to your practice: PA students are only a few months away from graduation and, in many cases, have taken jobs at sites where they completed their rotations!

For more information, please visit acrobat.adobe.com/id/urn:aaid:sc:US:04bd603d-3001-4c5b-88f8-4cc497702020.

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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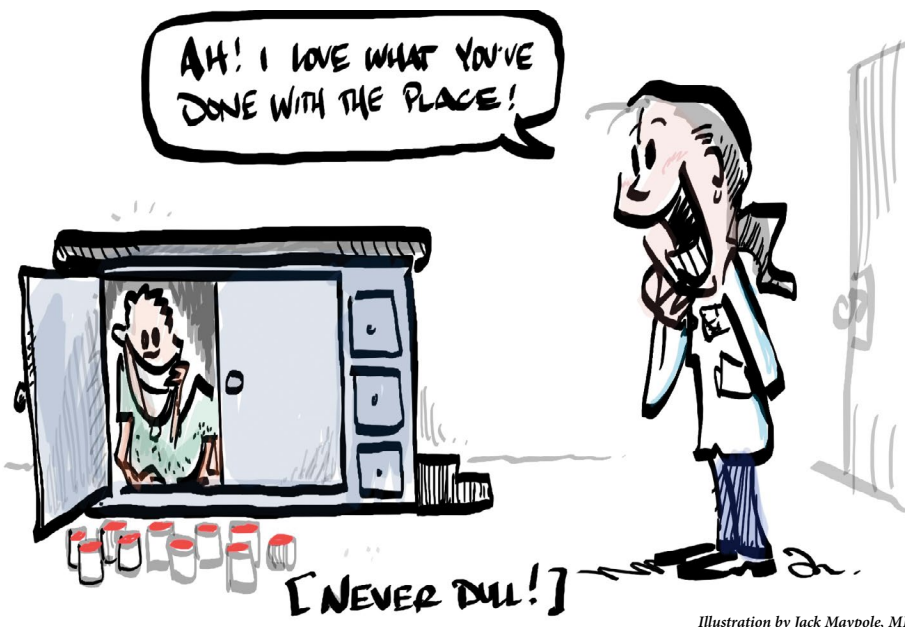


Illustration by Jack Maypole, MD



The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) presents its

MCAAP 2024 Annual CME Meeting and Business Meeting

Adolescent Wellness in the 21st Century

May 8, 2024
4:00 p.m. to 6:35 p.m.
Virtual

Overall Goal

This program is targeted toward pediatricians and multi-disciplinary pediatric health care provider teams to learn how to mitigate threats to adolescents by reviewing screening tools and ways to refer to new and commonly used resources.

Schedule

4:00–4:05 p.m. WELCOME

4:05–5:05 p.m. “Confronting the Adolescent Social Media Danger Paradigm”

Erin L. Belfort, MD, DFAACAP, Child & Adolescent Psychiatry Fellowship Training, Director, Psychiatrist for The Gender Clinic at Barbara Bush Children’s Hospital, Maine Medical Center, Associate Professor of Psychiatry, Tufts University School of Medicine

Goals/Learning Objectives

- Understand overall trends in youth social media use and the differential impacts on mental health based on underlying strengths and vulnerabilities of adolescents
- Effectively screen for social media use and its impacts on youth
- Be able to counsel youth and caregivers in order to mitigate risk and promote healthy social media use

5:05–5:35 p.m. MCAAP BUSINESS MEETING AND BREAK

Mary Beth Miotto, MD, MPH, FAAP, MCAAP President

5:35–6:35 p.m. PANEL

“Pearls for Pediatricians: Screening Methods and Resources for Risky Behaviors in Adolescents”

Pediatric ED Evaluation for Risk of Substances (PEERS) Program — Boston University Chobanian & Avedisian School of Medicine

Panelists

- Alexis Bauer, School of Public Health Student, Boston University
- Kiran Maypole, 3rd year Medical Student, Boston University
- Rachel Thompson, MD, Assistant Professor of Pediatrics, Boston University Chobanian and Avedisian School of Medicine
- Lilin Tong, 4th year Medical Student, Boston University

Goals/Learning Objectives

- Understand the importance of social drivers of health (SDOH) in caring for the adolescent population
- Identify commonly used resources for adolescents and how to refer them to these resources (e.g., housing, education/job services, food access)
- Learn how the technique of brief negotiated interviews (BNI) can be applied to supporting adolescents in reducing high-risk behaviors

6:35 p.m. ADJOURNMENT

Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Academy of Pediatrics (AAP) and the Massachusetts Chapter of the AAP. The American Academy of Pediatrics is accredited by the ACCME to provide continuing medical education for physicians.

- *AAP designates this live activity for a maximum of 2 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.*
- *This activity is acceptable for a maximum of 2 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.*
- *PAs may claim a maximum of 2 Category 1 credits for completing this activity. NCCPA accepts AMA PRA Category 1 Credit(s)[™] from organizations accredited by the ACCME or a recognized state medical society.*
- *This program is accredited for 2 NAPNAP CE contact hours of which 0 hrs contain pharmacology (Rx) content, (0 related to psychopharmacology) (0 hours related to controlled substances), per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.*



READING CORNER

What Is the Doctor's Role in Promoting Literacy?

In the preceptor room of my continuity clinic during my general pediatrics training, there was always a shelf stocked with books for various ages as part of the Reach Out and Read program. At the end of my well-child visits, I would hand a book to the family to take home; at least, that was the goal. Sometimes, particularly early on, I would forget to do this. If the well-child visit became a sick visit or if there were social complications, I found that literacy promotion was often the first to fall out of my mental framework, as it was crowded out by other issues.

On reflection, the fact that this would happen is not surprising. In my role as a resident physician, I would often prioritize illness, mental health, or social/economic circumstances over literacy promotion. One thing that I appreciate now that I didn't so much a few years ago is that doctors are often the main source of guidance on this. In fact, the American Academy of Pediatrics makes it clear that literacy promotion is very much the role of the pediatrician, particularly for children before they reach the age of 3, when schools take over services.

A study from late 2022 in *Academic Pediatrics* looked at the perceptions of both pediatric faculty and residents from 42 training programs concerning literacy promotion. Four hundred and seventy-three faculty and 1,216 residents filled out an anonymous online survey, and there were notable differences in the opinions of each group. For example, a majority of faculty (65.3%) but not of residents (44.3%) completely agreed that it is their job to assess and promote reading. A similar discrepancy was seen in those who completely agreed with the statement “discussing sharing books with children at health supervision visits can be an effective early intervention strategy” (65.8% vs. 46.6% for faculty and residents, respectively). Interestingly, more residents than faculty felt that parents with low literacy would resent the topic being broached. Unsurprisingly, a majority of both groups (but more so residents) felt that there wasn't enough time during the visit to discuss reading.

The authors of this study acknowledge that any explanation of these differences is speculative and state that this should

be further studied. I similarly find it hard to draw conclusions, as there are many unknowns. For example, was the discrepancy between residents and faculty different, say, 30 years ago than it is today? Regardless, I imagine time is generally the limiting factor, and as a resident, I certainly had to learn to use my time efficiently.

Regardless of the underlying causes, it is important to discuss literacy with our patients' families, and we should make an effort to incorporate it into our visit. I have started asking about reading as part of language milestones — a sort of “family milestone,” if you will — but other providers may choose other techniques. As pediatricians, we have a unique role to play in promoting wellness in the developing child, and literacy is a large part of that.

— **Rajapillai Pillai, MD, PhD Fellow,**
Neurodevelopmental Disabilities,
Boston Children's Hospital

References

<https://www.aap.org/en/patient-care/early-childhood/early-childhood-health-and-development/early-literacy>

Erickson E, et al. Clinician perceptions on literacy promotion in pediatric continuity clinics. *Acad Pediatr.* 2022;22(7):1192-1199.

JOB CORNER

Pediatrician

Garden City Pediatrics Associates is seeking a BC/BE pediatrician to join our practice in Beverly, MA, just 20 miles north of Boston and with easy access to both beaches and mountains. We are a group of eight pediatricians (six full-time and two part-time) who, along with our four advanced practice providers and exceptional nursing staff, are dedicated to providing high-quality, evidence-based care to children in our community 365 days a year. This 0.75 FTE position would entail three office days/week and a share in holiday/weekend coverage, which includes newborn nursery rounds at Beverly Hospital and sick visits at our office on the Beverly Hospital campus. Our proximity to the hospital allows for close collaboration with our Boston Children's and BIDMC colleagues, who provide neonatal, emergency, and inpatient care on site. Generous compensation is based on revenue. Please contact Steve Brickman, Practice Manager, at ofcmgr@gardencitypediatrics.com for more information.

Outpatient Pediatrician

Beth Israel Lahey Health Primary Care practice is affiliated with Mount Auburn Hospital. The office has two busy physicians, with room for a third physician to grow a panel. Call is shared with our colleagues at the Mount Auburn Pediatrics Cambridge location and is rotated among the physicians in both groups (approximately 1 in 7). We utilize a nurse triage service for nights, weekends, and holidays. To apply and learn more about this opportunity, please reach out to Janet DaCosta at janet.dacosta@mah.org.

Neonatologist

Mount Auburn Hospital is seeking a BE/BC neonatologist to join a team of five core neonatologists, who provide 24/7 in-house coverage to support a 2200 birth OB/CNM service. Job responsibilities include providing inpatient care at Mount Auburn Hospital's newly renovated 10-bed Level IIB nursery and caring for infants on CPAP with a GA of 32+ weeks. The team of neonatologists is supported by RTs and Level 2 dedicated nurses.

To apply and learn more about this opportunity, please reach out to Physician Recruiter Janet Waters at jwaters2@mah.harvard.org.

Chief of Pediatric Hospital Medicine

Tufts Medicine Pediatrics with Boston Children's Hospital (BCH) seeks a chief of pediatric hospital medicine to provide academic and innovative leadership for our Division of Pediatric Hospital Medicine. Available ASAP. Should you have any questions regarding the position or any complications submitting an application with us, please feel free to reach out to Kaitlyn Buckley, Sr. Physician Recruiter, at kaitlyn.buckley@tuftsmedicine.org. To apply directly online, please visit careers.tuftsmedicine.org/us/en/job/R5595/Chief-of-Pediatric-Hospitalist-Medicine

General Pediatrician

Tufts Medical Center located in Boston, MA, is looking for general pediatricians to see ambulatory patients in one of the Tufts ambulatory locations. Available ASAP. Should you have any questions regarding the position or any complications submitting an application with us, please feel free to reach out to Kaitlyn Buckley, Sr. Physician Recruiter, at kaitlyn.buckley@tuftsmedicine.org. To apply directly online, please visit careers.tuftsmedicine.org/us/en/job/R230/General-Pediatrician.

Pediatrician

Centre Pediatric Associates is looking to hire a new full-time (8 sessions) or part-time (6 sessions) MD in 2024. Centre Pediatrics is a reputable and established pediatric practice located in Brookline, MA, near the Longwood Medical Area. The practice includes six MDs and six NPs and we treat a diverse group of patients from the surrounding communities. We highly value forming strong relationships with our patients by offering 30-minute well visits to our patients. We are affiliated with Mass General Brigham, and all MDs have Harvard Medical School appointments; we have many opportunities to be involved in teaching and mentoring. We round on newborn babies at BWH and BIDMC, and our schedules are set up to include dedicated time for this. If interested, please reach out to Caitlin King at csking@mgb.org or Laura DeGirolami at ldegirolami@mgb.org.

Developmental Behavioral Pediatrician

Tufts Medical Center is looking for a developmental behavioral pediatrician to see ambulatory patients in one of the Tufts ambulatory locations. Full-time position available now. Please contact Kaitlyn Buckley, Sr. Physician Recruiter, at kaitlyn.buckley@tuftsmedicine.org for more information. To apply directly online, please visit clinicalcareers.tuftsmedicine.org/careers.

