



### PRESIDENT'S MESSAGE

## I Know Things Now

My wife and I love musical theater. I was always involved in shows in my youth, and I loved being on stage, being part of a cast, and sharing the magic that performing in a show creates with the audience. Even now, my wife and I can often be found humming bits from shows, and life events will frequently trigger her into singing lines from some song — she has said for years that there is usually a lyric that can fit these scenarios. As I was thinking about writing my final President's Message, the lyrics that seemed to best fit are from a song from Stephen Sondheim's *Into the Woods* called "I Know Things Now." In the song, Little Red Riding Hood is speaking to the audience about her encounter with the Big Bad Wolf. She starts, "Mother said, 'Straight ahead!' Not to delay or be misled."

As I began my presidency of the MCAAP, things were incredibly chaotic as we were still in the early stages of the pandemic, but the first goal seemed clear: advocate for our children around efforts to reopen schools. I was asked by my predecessor, Dr. Elizabeth Goodman, to take the lead in working with state governmental leaders in advocating for our children in the efforts to reopen schools. I had the opportunity to join Gov. Baker at a press conference when he announced our state's plan for return to in-person learning for the fall of 2020. I spoke on behalf of children and their families about the detrimental effects of prolonged remote education on both learning and mental health as well as the concern about the widening of the educational gap based on race and socioeconomic status. I spoke about the various mitigation efforts that were necessary to ensure safe in-person

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## Turning 18 Checklist

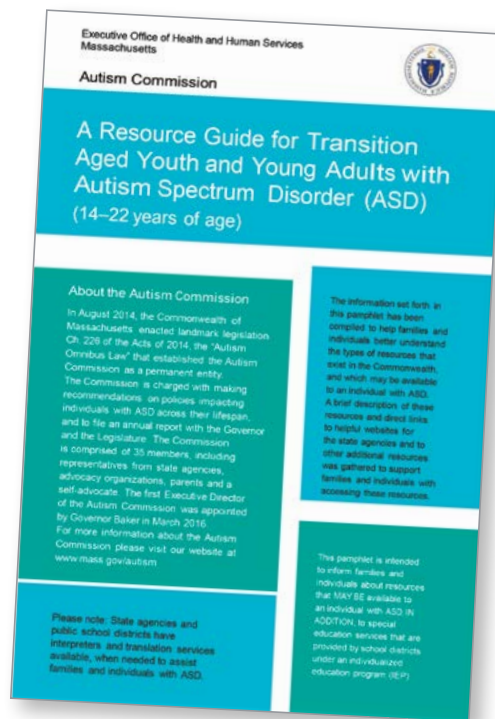
Are you caring for a young adult close to 17 years old who has an intellectual disability with or without autism? Are you, the trusted pediatric provider, comfortable discussing the Turning 18 Checklist with families? Many will need to consider and complete most of these items. Plan to have this list completed before transitioning these patients to an adult provider. You may understand this process better that their future provider.

Here is short paragraph on many of the list elements with appropriate websites. Websites with the word *Mass* are available in several languages.

The Massachusetts Autism Commission handout on transition is one I often print and give to families. It offers detail and many resources: [www.mass.gov/files/documents/2018/02/15/resource-guide-transition-aged-youth-and-young-adults-14-22-years-with-autism-spectrum-disorder.pdf?ga=2.256510219.1681103166.1569881424-348089828.1567826225](http://www.mass.gov/files/documents/2018/02/15/resource-guide-transition-aged-youth-and-young-adults-14-22-years-with-autism-spectrum-disorder.pdf?ga=2.256510219.1681103166.1569881424-348089828.1567826225)

Here are 10 items worth discussing with families from the Turning 18 Checklist:

- Guardianship:** As your patient approaches 18 years, will they be competent to make medical or financial



decisions? If they aren't, parents will need to apply through the state probate and family court for guardianship or conservatorship. School will often take the lead in starting to fill out the Clinical Team Report (CTR)

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**Massachusetts Chapter  
American Academy of Pediatrics**  
860 Winter Street  
Waltham, MA 02451

**EXECUTIVE DIRECTOR**

**Cathleen Haggerty**  
chaggerty@mcaap.org

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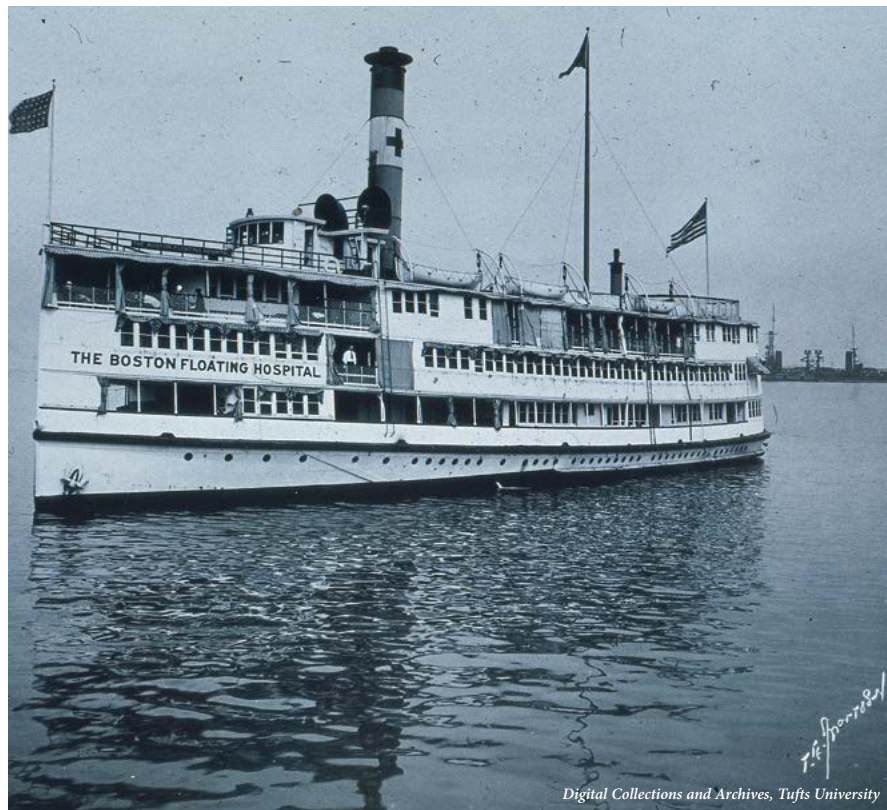
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**EDITOR'S NOTE**

## And the Ship Set Sail, for the Very Last Time

Several of my fellow alumnae of the pediatric residency at Boston's Floating Hospital for Children shared a moment recently. We, along with many other former residents, fellows, and medical students, were saddened to read the announcement of January 20, 2022, that its 41 pediatric beds will be used as adult medical, surgical, and intensive care beds. Now known as Tufts Children's Hospital since its name change in 2020, the pediatric inpatient service is destined to close, along with many specialty services. A letter of agreement is to be negotiated and signed with Boston Children's Hospital. A few services will remain, notably primary care and the neonatal ICU, at least for now.

Founded in 1894 by the Reverend Rufus B. Tobey as a charitable endeavor, the Floating Hospital has a unique place in the history of the Boston medical community. It had its origins on the water, naturally: a ship was purchased to take ailing children and their mothers out for daily sailing trips on the harbor for fresh air and sunshine during the summer months.

Children were fed healthy meals and allowed to play and run on the ship while their mothers were given instruction about health, nutrition, and hygiene.

The ship developed close ties with Tufts Medical School, founded in 1893. It was the second medical school in New England to admit women, and its first class had eight women students (the first was the New England Female Medical College, which merged with Boston University School of Medicine in 1873). Medical students provided much of the care for the children on the ship, under the supervision of attending physicians. Long before the founding of the American Academy of Pediatrics in 1930, the staff and students on the ship practiced pediatrics before the specialty was recognized. The Floating and Tufts Medical School became formally affiliated in 1929.

The ship burned down in 1927; fortunately, no patients, families, or staff

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## I Know Things Now

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learning for children, their teachers, and their family members. I was quite proud of what I said, felt my recommendations were sound and based on the most up-to-date information and data that we had at the time, and were generally aligned with what the governor and the Department of Education leaders were saying.

*“When he said ‘Come in!’ with that sickening grin, How could I know what was in store?”*

Much to my surprise and disappointment, my views, which I expected would have been shared by most pediatricians, parents, teachers, and anybody else who is concerned with the health and well-being of children, generated some pushback and disagreement from many people.

I received emails and calls from Chapter members, other health care providers, parents, teachers, municipal leaders, and some random people who seemed to have no connection to children in any way, expressing a range of opinions. I had felt the proposed approach appropriately balanced safety with the importance of in-person learning. However, there were some who were horrified by the thought of any mitigation efforts and voiced their strong opposition to masking, distancing, or other basic safety protocols while others felt that any effort to have any child or teacher in a school building was reckless and equivalent to genocide.

Both our executive director, Cathleen Haggerty, and I felt an obligation to respond to each and every email or call that came to us. It was time-consuming and emotionally exhausting, but we felt it was important. I naively thought that if I could

just explain things to those who were reaching out, I would be able to get them to understand why I was advocating for this approach. Unfortunately, I was not always successful. The emotions around this were so strong that no amount of data or explanation could change many people's opinions.

*“At the end of the path was Granny once again! So we wait in the dark until someone sets us free.”*

The frustration I felt was like nothing I had previously experienced. I generally think of myself as a rational thinker with moderate opinions on many controversial topics. Yet when it came to anything related to the pandemic, I have been accused of having extremist views by each side. As the pandemic has moved through various phases the topics that cause heated debate have changed. Starting in the spring of 2021, with the availability of COVID-19



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## A Half-Century of Holyoke Pediatrics

What a difference 50 years makes! I am referring to how Holyoke Pediatrics Associates (HPA) has evolved over the past 50 years. It grew from four pediatricians practicing in the greater Holyoke area (including South Hadley and Chicopee) who combined their solo practices into one office. The pediatricians alternated on-call schedules and cared for each other's patients and newborns in the Holyoke and Providence hospitals. The on-call doctor saw patients in both emergency rooms, and house calls were part of the daily routine. Children with complex medical problems like congenital heart disease and cancer were referred to three hospitals in Boston: Boston Children's, Tufts Floating, and Massachusetts General Hospital.

Each pediatrician saw about 40 or more patients every day. The medical notes were minimal. Abbreviations like NL (normal) or VAM (very anxious mother) often constituted the entire note. As more practitioners joined the practice, there was a need for more detailed notes and consistency. HPA developed a "Data Base for Pediatric Practice" that was published in *Clinical Pediatrics* in 1982.

The five staff members answered phone calls and prepared patients to be examined by the pediatrician. Patients' fees

were \$4 for an office visit and \$7 for a house call. A single bookkeeper handled all the billing.

The office remained open seven days a week. On Saturday and Sunday, the office closed at 5 p.m. During the week, evening hours ended after the last patient was seen. The pediatrician on call would then make hospital rounds again and see patients in the emergency room. The on-call pediatrician was also responsible for calls at night and overnight emergencies such as ear infections and croup. These patients were seen at home, as there were no ER doctors. When the office moved to sites farther away from the center of Holyoke, we set up a "taxi fund" with a local company to help families get to the new offices.

Each pediatrician was adept at performing procedures like spinal taps, exchange transfusions, IV placements, and casting non-displaced fractures. There were no neonatal intensive care units at that time, and HPA pediatricians cared for premature babies. There were few malpractice suits and insurance fees were low. Testing was kept to a minimum; there was little need to do extra lab and radiographic studies to provide a defense against malpractice suits.

In retrospect, it was a busy life. Fifty years ago, pediatricians worked longer hours and did more procedures. As I reflect with an element of nostalgia, it was satisfying and challenging with minimal burnout.

Fifty years later, there are now 14 practitioners and three psychiatric therapists who staff two offices. In 2022, there is an office manager, two office case managers to assist with complex social and financial problems, and 60 more staff members (medical assistants — many are bilingual — and billing personnel).

The challenges to pediatricians today are significantly different than those of 50 years ago. Many advances have led to significant improvements in the lives of children. Multiple vaccines have eliminated common childhood infectious diseases such as diphtheria, measles, mumps, and varicella. Life-threatening serious illnesses, such as cellulitis and meningitis due to *haemophilus influenzae* and meningococcal meningitis, are fortunately rare.

Premature infants have a significantly improved survival rate and quality of life, as do childhood leukemia survivors. Community fluoridation of water supplies has reduced dental decay. COVID-19 viral

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## Turning 18 Checklist

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with a new psychological evaluation that demonstrates the patient's limits in decision-making. The CTR is valid for six months after the psychological evaluation, which must be done by a psychologist licensed to sign the CTR. Then a social worker and a physician will need to sign the CTR, too. Parents will need to petition the court with the CTR for a court date and will likely need a lawyer. Consider helping your low-income families find a lawyer through the Volunteer Lawyer Project at [www.vlpnet.org](http://www.vlpnet.org). If your young adult patient is on anti-psychotic medication or needs other extraordinary treatment like ECT, his or her psychiatrist may need to help with a Rogers guardianship ([www.mass.gov/courts/selfhelp/guardians](http://www.mass.gov/courts/selfhelp/guardians)).

### 2. Supplemental security income (SSI):

Before age 18, supplemental security income is based on parent/guardian income. When patients turn 18, they are considered independent adults, and SSI will be based on their income. If an 18-year-old patient is determined to be disabled during this evaluation, he or she will also qualify for Massachusetts Medicaid. Often SSI will be directly deposited to a bank account or debit card. A parent/guardian may need to apply to be the representative payee for a special bank account for SSI ([www.ssa.gov/benefits/disability](http://www.ssa.gov/benefits/disability)).

### 3. Department of Developmental

**Services (DDS):** The DDS will provide your young adult with a care manager who is knowledgeable about day programs, housing, and other supports for this population. Patients all need to reapply upon turning 18 years old, even if they had DDS as a child ([www.mass.gov/doc/ddseligibility-application-for-ages-of-5-22-and-ages-22-and-above-1/download](http://www.mass.gov/doc/ddseligibility-application-for-ages-of-5-22-and-ages-22-and-above-1/download)).



### 4. Department of Rehabilitation

**Commission (MRC):** The MRC can help young adults with a disability find and train for a job that is right for them. Their school may refer the patient to the MRC ([www.mass.gov/orgs/massachusetts-rehabilitation-commission](http://www.mass.gov/orgs/massachusetts-rehabilitation-commission)).

**5. Draft:** Men who turn 18 need to apply for the draft. It is easy to apply and unlikely they would meet criteria for military involvement. It is a requirement for some of these federal benefits ([www.sss.gov/register](http://www.sss.gov/register)).

**6. Government-issued ID:** Once young adults turn 18, they may need an ID to identify themselves, especially if they are nonverbal. A government ID, such as those issued by the Massachusetts Department of Motor Vehicles for non-drivers, will help them identify themselves. Sometimes the school can help students obtain one (<https://atlas-myrmv.massdot.state.ma.us/myrmv>).

**7. Will:** Encourage families to have a will that clearly documents their wishes for their young adult. It should include financial and property information. However, bequeathing money or property may impact eligibility for public benefits. Leaving money in an ABLE (Achieving a Better Life Experience) account or special needs trust is the best way to ensure that money doesn't impact federal or state benefits.

**8. Section 8 housing voucher:** For a person with a disability, it may make sense to apply for a Section 8 housing voucher. This voucher will reduce the cost of your rent to one-third of your monthly income. There is a long wait for this voucher; however, some people with disabilities who can live independently may have a shorter wait. The common housing application for Massachusetts public housing (CHAMP) is accessible here: [www.mass.gov/doc/new-and-returning-applicants-how-to-create-a-champ-account/download](http://www.mass.gov/doc/new-and-returning-applicants-how-to-create-a-champ-account/download).

**9. ABLE account:** Since 2014, ABLE, a tax advantaged savings account like a 529 plan, allows individuals to use saved money for disability expenses. Yearly contributions increased in 2022 to \$16,000 per year. However, if the account holds more than \$100,000, SSI benefits may stop ([www.ablenrc.org/state-review/massachusetts](http://www.ablenrc.org/state-review/massachusetts)).

**10. Special needs trust:** A special needs trust allows a family to leave a larger amount of money than an ABLE account allows to a disabled person without threatening his or her public benefits. This may require a lawyer's help, too. — *Jodi Wenger, MD, Comprehensive Care Program, Boston Medical Center*



## I Know Things Now

*continued from page 3*

vaccines for adolescents and then in the fall for younger children, the debate around how, when, and why to vaccinate began. Most recently as we come down from the Omicron surge, the discussion surrounding relaxing of various mitigation efforts has taken center stage. Regardless of the topic, the passion around the discussions remains. The vitriol and commentary continue to be harsh, demeaning, and often unhelpful.

I worry that the legacy of this pandemic and the long-term impacts, especially to children, are not going to be the direct effects of the virus itself, but rather the damage to relationships and our ability to communicate with each other. Respectful discourse seems to no longer be a priority or even a goal. I wrote some about this in the fall 2021 President's message, and I remain very concerned about this topic.

*"And we're brought into the light, And we're back at the start. And I know things now, Many valuable things, That I hadn't known before."*

As I look back on these past two years during my time as president of the MCAAP and think about my own future, it is important to reflect upon the lessons that I have learned. From a professional standpoint, it is even more obvious to me that speaking the truth is important. Many of the issues throughout this pandemic that led to the most divisive opinions may have been preventable if those in positions to share information had simply told the truth rather than exaggerating information in order to achieve some goal. This was especially true when speaking with the media throughout the past two years — speak the truth, do not exaggerate for effect, and make sure that everything you say can stand alone when it is inevitably taken out of context. When you do this, you can be confident in your message at the end of the day.

Having a team of people around you who support you and lift you up even on the roughest of days is critically important. Just as a musical cannot come to fruition without the entire cast, stage crew, orchestra, and everyone else involved in the production, these past two years wouldn't have been endurable without the professional

support of an amazing clinical team in my office consisting of other physicians, advanced practitioners, nurses, medical assistants, and secretaries that all came together during a time when the needs of our patients often seemed to exceed our capacity. The team at the MCAAP is more than simply the president who is the public face of the organization, but much of the work is done by our executive director, and policies are set by a collaborative effort of our committees, officers, and executive board. This board had more unplanned, last-minute meetings than any other Chapter board in my memory, and I very much appreciate their time and effort. My ability to get through this time and successfully lead the Chapter is due to the efforts of Cathleen and your soon-to-be president, Dr. Mary Beth Miotto. We spent countless hours together on the phone, on Zoom, and over email determining the best course of action for the Chapter. Often decisions had to be made with no advance notice. They served as my checks and balances to ensure what I was saying and doing was always in the best interest of our Chapter and the children of the Commonwealth.

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## A Half-Century of Holyoke Pediatrics

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infections have presented many new challenges to children, including MIS-C (multisystem inflammatory syndrome in children). Climate change is a public health threat and an ever-present existential threat to civilization.

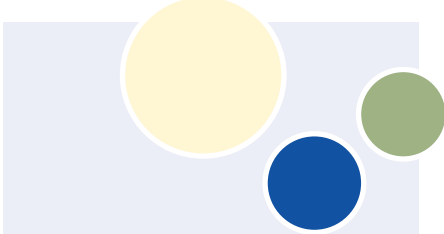
Today's challenges for pediatricians are different. The high cost of malpractice and worry about litigation can lead to excessive lab and radiographic studies. Electronic medical record systems are expensive and time-consuming. Medical school tuition and subsequent debt burdens many young pediatricians. Hospitalists ensure efficient, excellent care, but both families and pediatricians miss the continuity of care. Mental health disorders such as anxiety, depression, ADHD, and others occupy a far greater proportion of pediatricians' time in the office. Obesity and obesity-related

complications such as type 2 diabetes are seen often.

Training for pediatricians who plan to practice in the community, in a practice like HPA, needs to adapt to this new reality. In addition to time in the pediatric and newborn intensive care units and emergency departments, residents need more time with our child psychiatry and developmental pediatrics colleagues as well as with our pediatric medical subspecialty colleagues. Training in identification and treatment of developmental delays, autism, child abuse, gender identity issues, and more are needed as well.

In the end, children and families need the support that only their pediatrician can provide, even in this new reality of COVID. — **Robert M. Abrams, MD**

Ed. note: Dr. Abrams lives in South Hadley and is retired from the practice of pediatrics at HPA. His interests in retirement consist of writing and playing the cello. He can be reached at [rabrams19@me.com](mailto:rabrams19@me.com).



**SAVE THE DATE**  
**MCAAP 2022**  
**Annual Meeting**  
**Every Pediatrician Is**  
**a School Physician —**  
**Lessons Learned**  
**from the Pandemic**

**Tuesday, May 10, 2022**  
**3:30 p.m. to 7:30 p.m.**  
**Massachusetts Medical Society**  
**Waltham, MA**

*For more information,*  
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*at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).*



## New Massachusetts Vision Screening Protocols

The Massachusetts Department of Public Health (MDPH), in partnership with expert consultants from Children’s Vision Massachusetts (CVMA) and Prevent Blindness, recently updated the Massachusetts Preschool through Grade 12 Vision Screening Protocols (<https://cme.bu.edu/sites/default/files/MA%20Vision%20Screening%20Protocols%2010.2021.pdf>). The new guidance reflects both current evidence-based practices and streamlines the most appropriate screening methods across age groups. These protocols also align with recommendations from the American Academy of Pediatrics (AAP) and the American Association for Pediatric Ophthalmology and Strabismus.

A state-wide implementation date is set for September 1, 2022. The MDPH will provide a Vision Screening Manual with more detailed information during the coming months. A recent continuing education Clinical Update on children’s vision (<https://cme.bu.edu/shield.bu.edu/content/vision-clinical-update-2021>) and a free audit version ([\[inequities-and-implementing-new#group-tabs-node-course-default6\]\(#\)\) are available for viewing at Boston University School Health Institute for Education and Leadership Development \(BU SHIELD\) \(<https://cme.bu.edu/shield.bu.edu>\).](https://cme.bu.edu/shield.bu.edu/content/audit-vision-clinical-update-2021-addressing-health-</a></p>
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Massachusetts General Law c.71, § 57 (<https://malegislature.gov/laws/general-laws/parti/titlexii/chapter71/section57>) requires parents or guardians of children upon entering kindergarten to show proof the child passed a vision screening within the past 12 months. Children who do not pass their vision screening at either the primary care or school health office, and children diagnosed with neurodevelopmental delay require a comprehensive eye examination from an eye care provider. Primary care providers play an important role in completing vision screenings at well-child and school physical exam appointments as per the AAP/Bright Future health guidelines.

In accordance with AAP guidelines, the MDPH continues to approve instrument-based screeners such as PlusOptix or Spot™ for preschool children up to 6 years of age. Other devices may

be approved as the evidence basis becomes established. In addition, MDPH protocols recommend near visual acuity screening. **Note:** Inspection of ocular structures should still occur as part of a well-child visit, even if instrument-based screening is used for vision screening.

### Summary of Changes Beginning September 1, 2022

1. Children 3–5 years old enrolled in public preschool are vision screened annually.
2. The Critical Line standard for Visual Acuity screening is as follows:
  - 20/50: Preschool children 3 years old
  - 20/40: Preschool children 4–5 years old
  - 20/32: Kindergarten children 5 years and older
3. Vision testing machines are discontinued. Vision screening machines such as Optec, Titmus, and Keystone View will no longer be approved for any age group.

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## New Massachusetts Vision Screening Protocols

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- Near visual acuity (NVA) screening will begin at 3 years old. MDPH protocols recommend annual NVA screening with approved tools, for preschool through grade 3 children. If instrument-based screening is utilized in children 3–5 years old, NVA is recommended in addition.
- Visual acuity charts (such as in figures 1 and 2) must have logMAR notation and scoring (the Logarithm of the Minimum Angle of Resolution chart is a scientifically designed visual acuity chart meeting validation standards of professional organizations such as the National Institutes of Health and the AAP). All other visual acuity charts will be discontinued. Acceptable near and distance visual acuity logMAR charts are as follows:
  - LEA SYMBOLS® (for children unsure of their letters, or English-language learners)
  - Sloan Letters (for children able to reliably identify letters)

Use of a LEA SYMBOLS® matching lap card (shown in figure 1), where the child can point to the symbol, is helpful for children who are unsure

of their letters or hesitant to communicate verbally.

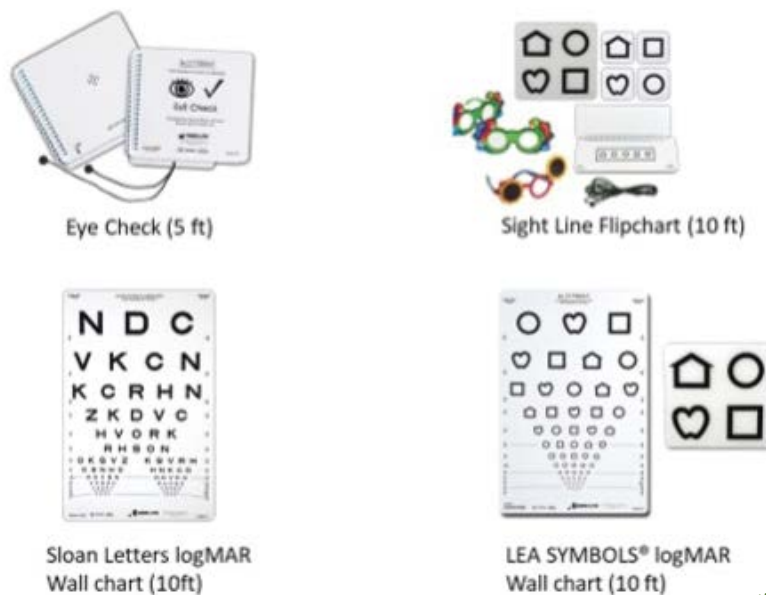
- Stereoacuity screening will use the “Pass 1” stereopsis test. The Random Dot E test is discontinued.

### Distance Visual Acuity (DVA)

This monocular screening is conducted annually from 3 years old or year of school entry through grade 5, once in middle school, and once in high school.

**Figure 1: Examples of approved DVA charts**

## Distance Visual Acuity Charts



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## 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](mailto:chaggerty@mcaap.org).

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1/3 page = \$300.00	1/2 page = \$400.00
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Please remember to double check that your ad is the correct size and contains the most up-to-date information.





## New Massachusetts Vision Screening Protocols

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### Near Visual Acuity

This binocular screening at 16 inches is conducted annually from 3 years old or year of school entry through grade 3.

### Approved Charts

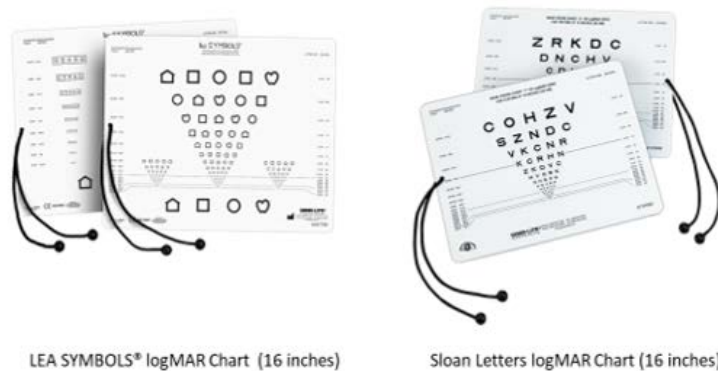
- LEA SYMBOLS®
- Sloan Letters

Critical line screening is acceptable.

**Note:** If using instrument-based screening for children 3–5 years old, NVA screening should be conducted in addition. Adding NVA screening to instrument-based screening increases the sensitivity for the detection of far-sightedness (hyperopia).

**Figure 2: Examples of approved NVA charts**

## Near Visual Acuity Charts



LEA SYMBOLS® logMAR Chart (16 inches)

Sloan Letters logMAR Chart (16 inches)

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## And the Ship Set Sail, for the Very Last Time

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members were on board. In 1931, the Floating Hospital was established to provide year-round care for children, as part of a newly formed New England Medical Center. A substantial expansion in 1982 brought state-of-the-art intensive care units and generously sized patient rooms with space for parents along with updates in equipment and facilities.

The front door of the hospital is guarded by a giant teddy bear, the mascot of the former FAO Schwarz toy store. The landlord of the bankrupt store bought the bear, and children all over the city voted on its new location. The bear was installed in front of the Floating in 2004 by Mayor Menino.

Safe and nutritious infant formula, eventually marketed as Similac (“similar to lactation”), was invented by a pediatrician from the Floating, Dr. Henry Bowditch, collaborating with a biochemist from Harvard Medical School, Dr. Alfred Bosworth. It was initially sold in 1924 by the Moores and Ross Milk Company of Columbus, Ohio, in cans with blank labels, so that doctors could put their own label on it for the

benefit of their patients. Apparently, the good doctors tinkered with 200 or more recipes before settling on the final one.

The pediatric residency program of Tufts University School of Medicine has a proud history as well. While a bit smaller than its counterparts across town at Children’s and Massachusetts General Hospital, the residency program has had great success in preparing its graduates for primary care and subspecialty fellowship training with a program grounded in clinical excellence, compassion, and breadth of knowledge. In the mid-to-late 20th century, the majority of practicing pediatricians in primary care throughout New England were Floating alumnae.

This decision to close the door to children at New England Medical Center has far reaching consequences for pediatric care, for health care costs and economics, for families, and most of all, for children. Children have been beautifully cared for in a location that provided clinical excellence, value in health care costs, and family-centered care before the term was even coined. The decision to close is reminiscent of the decision made across town at Boston Children’s Hospital to

build a tower on the site of the former Prouty Garden, a place of stillness, nature, repose, and healing so beloved that some families even deposited their children’s remains there. As with the loss of the Prouty Garden, the closing of the Floating Hospital, a.k.a. Tufts Children’s Hospital, shows again that in the boardrooms of some Boston hospitals, children matter less than they should.

One final thought: I happened to be working on *The Forum* when I was on call recently. I was paged, and the caller was a young hospitalist fellow from Tufts Children’s Hospital with an update on a patient. We finished our discussion, and I said, “How are you all doing?” After a long pause, the fellow said, “We’re OK. We don’t know what’s going to happen to us, but what we really care about is what is going to happen to the patients.” The spirit of the Floating will live on, long after the ship has sailed, for the last time.

— *Lisa Dobberteen, MD, FAAP*

# ShotClock

## CDC Publishes 2022 Immunization Schedules

The Centers for Disease Control and Prevention (CDC) has published the “Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2022” ([www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf](http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf)) and the “Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2022” ([www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf](http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf)).

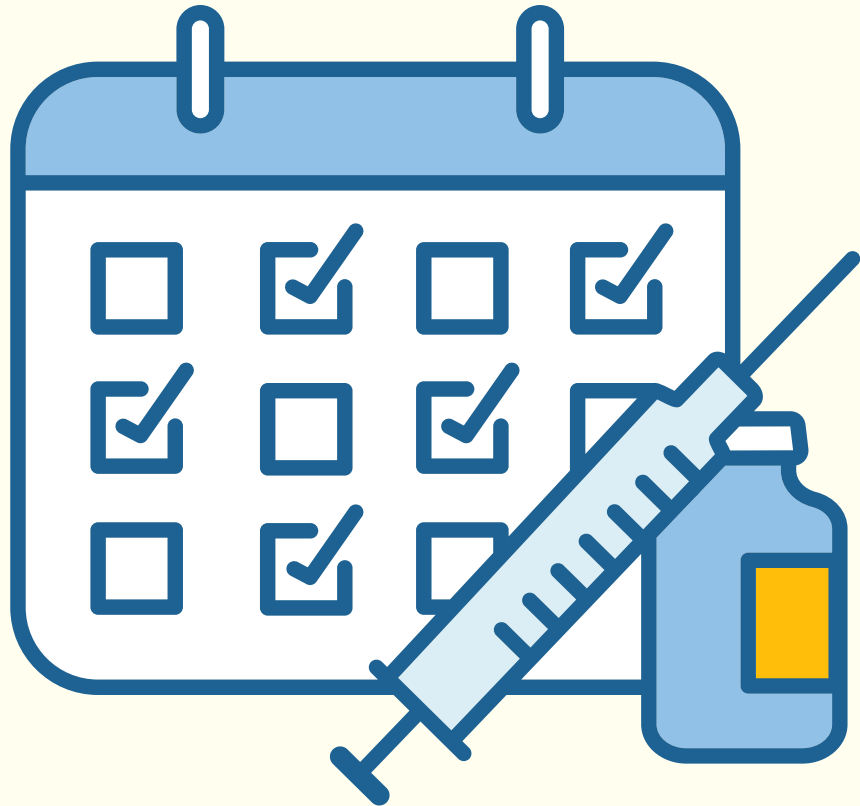
Updates to this year’s schedules are reviewed in the following articles, published in *Morbidity and Mortality Weekly Report (MMWR)*, on February 18, 2022:

- **Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger — United States, 2022:** [www.cdc.gov/mmwr/volumes/71/wr/mm7107a2.htm](http://www.cdc.gov/mmwr/volumes/71/wr/mm7107a2.htm)
- **Recommended Adult Immunization Schedule for Ages 19 Years or Older — United States, 2022:** [www.cdc.gov/mmwr/volumes/71/wr/mm7107a1.htm](http://www.cdc.gov/mmwr/volumes/71/wr/mm7107a1.htm).

A summary of schedule changes, along with guidance about COVID-19 vaccination, vaccination recommendations during the COVID-19 pandemic, and vaccine catch-up, can be found on the CDC website at the following link: [www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html).

Printable versions of the 2022 immunization schedules are available on the CDC website ([www.cdc.gov/vaccines/schedules](http://www.cdc.gov/vaccines/schedules)) in several formats, including portrait, landscape, and pocket-sized versions. Parent-friendly schedules also are available in English and Spanish ([www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html](http://www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html)).

The 2022 CDC Vaccine Schedules App for health care providers for iOS and Android devices can be downloaded for free at [www.cdc.gov/vaccines/schedules/hcp/schedule-app.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html).



Once again, the Immunization Action Coalition will be selling laminated versions of the 2022 immunization schedules. The schedules are now available for order. For more information, visit [www.immunize.org/shop/laminated-schedules.asp](http://www.immunize.org/shop/laminated-schedules.asp).

On March 10, the MCAAP Immunization Initiative Webinar Series presented “Updates in ACIP Recommendations for the 2022 Childhood/Adolescent and Adult Immunization Schedules.” The webinar recording can be found at [www.mcaap.org/immunization-cme](http://www.mcaap.org/immunization-cme).

### Additional Resources

- **“Recommended Childhood and Adolescent Immunization Schedule: United States, 2022” from *Pediatrics*, February 2022:** <https://doi.org/10.1542/peds.2021-056056>

- **“Recommended Adult Immunization Schedule, United States, 2022” from *Annals of Internal Medicine*, February 18, 2022:** <https://doi.org/10.7326/M22-0036> — *MCAAP Immunization Initiative*

## Vaccine Catch-Up Guidance Job Aids

The CDC has developed guidance job aids to assist providers in interpreting Table 2 of the 2022 childhood and adolescent immunization schedule, “Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind,” which can be found at [www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html#table-catchup](http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html#table-catchup).

The job aids can be found at [www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html](http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html). — *MCAAP Immunization Initiative*

## General Best Practice Guidelines for Immunization Course

The CDC's *General Best Practice Guidelines for Immunization: Best Practices Guidance of the Advisory Committee on Immunization Practices (ACIP)* was developed for clinicians and other health care providers who vaccinate patients in varied settings, including hospitals, provider offices, pharmacies, schools, community health centers, and public health clinics.

The guidelines include comprehensive information about the Advisory Committee on Immunization Practices best practice guidance on immunization. Content is organized as follows: (1) Timing and Spacing of Immunobiologics, (2) Contraindications and Precautions, (3) Preventing and Managing Adverse Reactions, (4) Vaccine Administration, (5) Storage and Handling of Immunobiologics, (6) Altered Immunocompetence, (7) Special Situations, (8) Vaccination Records, (9) Vaccination Programs, and (10) Vaccine Information Sources. A glossary also is included (Appendix 1: Glossary).

The guidelines will assist vaccination providers to assess vaccine benefits and risks, use recommended administration practices, understand the most effective strategies for ensuring that vaccination coverage in the population remains high, and communicate the importance of vaccination to reduce the effects of vaccine-preventable disease.

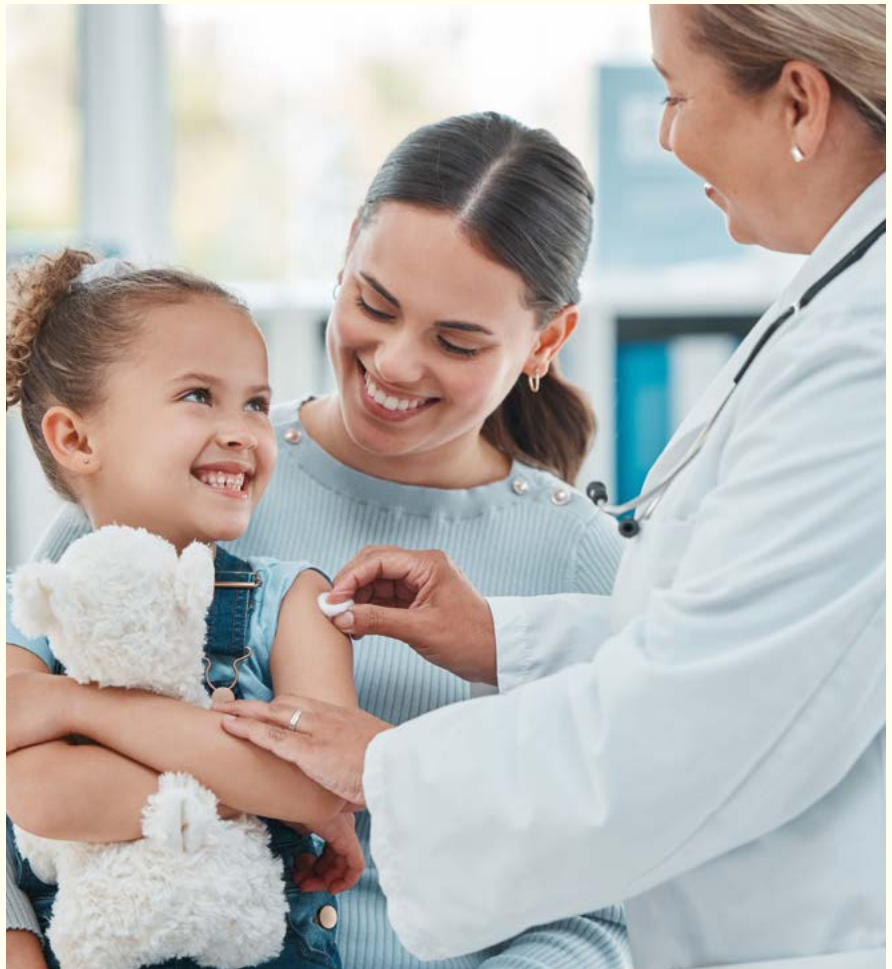
Continuing education credit is available for free for completion of the course. Continuing education information can be found at [www.cdc.gov/vaccines/ed/general-recs/ce-flyer.pdf](http://www.cdc.gov/vaccines/ed/general-recs/ce-flyer.pdf).

A printer-friendly version of the guidelines can be found at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf).

— **MCAAP Immunization Initiative**

### Reference

"Introduction" from *General Best Practice Guidelines for Immunization: Best Practices Guidance of the Advisory Committee on Immunization Practices (ACIP)*: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/intro.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/intro.html)



## 2022 MDPH Immunization Updates

The Massachusetts Department of Public Health's Immunization Division presents annual updates on immunization-related topics for health care professionals every spring. The 2022 Immunization Updates will take place as a series of one-hour webinars in May and June. Vaccine coordinators and backups can earn their Vaccine for Children (VFC) Certificate by taking the VFC Compliance/Vaccine Storage and Handling webinar.

The 2022 Immunization Updates schedule is as follows:

**Tuesday, May 24:** Massachusetts Immunization Information System (MIIS)

**Thursday, May 26:** Immunization Schedule Updates

**Thursday, June 2:** Vaccine Confidence with Dr. Noel Brewer

**Wednesday, June 8:** Vaccines for Children Compliance Training/Vaccine Storage and Handling

**Tuesday, June 14:** Epidemiology of Vaccine-Preventable Diseases in Massachusetts

All presentations will be held virtually and will start at noon (there will be no in-person sessions).

Updates, including information about registration and continuing education credits, will be posted as they become available at [www.mass.gov/service-details/immunization-division-events](http://www.mass.gov/service-details/immunization-division-events).

**Have questions about immunizations? Contact us!**

Massachusetts Department of Public Health  
Immunization Division: (617) 983-6800  
Vaccine Unit: (617) 983-6828  
MIIS Help Desk: (617) 983-4335

— **MCAAP Immunization Initiative**





## Upcoming Conferences and Meetings

### **National Infant Immunization Week (NIIW)**

April 25–May 1, 2022

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

### **MCAAP Annual Meeting: Every Pediatrician Is a School Physician – Lessons Learned from the Pandemic**

Tuesday, May 10, 2022, 3:30–7:30 p.m.

Massachusetts Medical Center, Waltham, MA

For more information, contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).

### **2022 MDPH Immunization Updates**

May and June 2022

The updates will be held as webinars. For more information, including the schedule, visit [www.mass.gov/service-details/immunization-division-events](http://www.mass.gov/service-details/immunization-division-events).

### **Massachusetts Vaccine Purchasing Advisory Council Meeting**

June 9, 2022, 4:30 p.m.

For more information, visit [www.mass.gov/service-details/massachusetts-vaccine-purchasing-advisory-council-mvpac](http://www.mass.gov/service-details/massachusetts-vaccine-purchasing-advisory-council-mvpac).

### **Advisory Committee on Immunization Practices (ACIP) Meeting**

June 21–22, 2022

Atlanta, Georgia

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

### **MCAAP Immunization Initiative Advisory Committee Meeting**

June 28, 2022, 6:30 p.m.

This meeting will be held virtually.

For more information, contact Cynthia McReynolds at [cmcreynolds@mcaap.org](mailto:cmcreynolds@mcaap.org).

## I Know Things Now

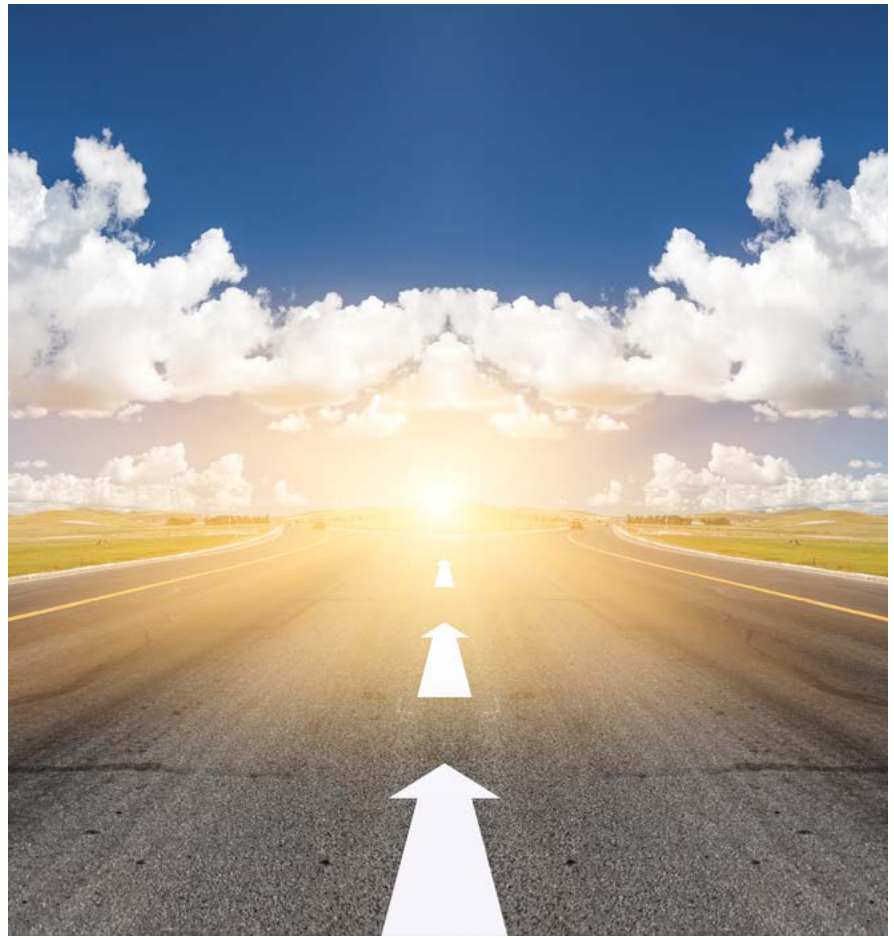
*continued from page 6*

It is also critically important to have support at home. My wife, a family physician, has always been essential to my success in all my professional endeavors. During the past two years, she has been invaluable to my survival, including proofreading my important emails, speeches, bullet points that I send to governmental leaders, and this very President's Message, as well as picking up the pieces at home when I was simply not around or was too stressed out to be helpful. My children have kept me grounded and reminded me why we do this — they are our future, and they deserve the best and brightest future we can provide them.

*“Now I know: don't be scared. Granny is right, just be prepared.”*

Although I found it hard to receive those emails and calls from various people who are upset with something that I had said or were sometimes even upset about something they felt the Chapter or I should have been saying, leaders must come to terms with the fact that their decisions will frequently not be supported by 100 percent of those impacted by the decision. One of my colleagues always says, “If I always wanted applause, I would've joined the circus.” Being on stage and receiving all the applause for a show well performed is an incredibly affirming experience, but being in a leadership position brings both bad reviews and accolades. While I've come to terms that with any leadership role comes the reality that people will disagree with you, I have also learned about my own limitations. Much to my wife's satisfaction, any thoughts that I had for a future in public office have been squashed. The ongoing personal attacks to which any elected official is subjected is just not something for me.

I have also accepted that when it comes to topics that elicit an ardent emotional response, data and logic often do not prevail. While I have always known this to be true, it was never so obvious as during the last couple of years. All of us have been swayed by anecdotes, personal stories, and emotions and ignored evidence at times. My spring 2021 President's Message



addressed how we are all influenced by our own personal N of 1.

Any time one faces a crisis or sees the world around them changing it forces us to take inventory of what is truly important in our lives. As pediatricians, we have an obligation to act in the best interest of children, whether they be our own patients or through broader advocacy on behalf of all children. Sometimes, especially during times such as those we have recently faced, these activities can make it difficult to be there for our own children. My children have grown significantly during these past two years, and I do worry about what I have missed. One thing we will never be able to get back is that time with our children during their youth. I have learned that I need to reconsider some of my priorities and how I allocate my time.

Looking ahead, I will continue to be a strong advocate for children and for pediatricians. I will continue to stand up for what I feel is the right path forward. I will work to meet people where they are when

discussions are on topics that I know elicit strong emotions and recognize that data and facts are less influential than we would like in certain situations. I am also going to enjoy a time, at least for now, with fewer meetings and fewer extracurricular activities so I do not miss out on this next phase of growth and development for my own children. I am confident that during this transition, the MCAAP will be in good hands with Dr. Miotto. As your immediate past president, I will continue to be involved but in a different role. It has been a pleasure to serve as your president these past two years as we navigated through these challenging times together.

*“Isn't it nice to know a lot? And a little bit not.”*

Thank you.

— **Lloyd D. Fisher, MD, FAAP**

### **I Know Things Now**

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## New Massachusetts Vision Screening Protocols

*continued from page 9*

### Stereoacuity Screening

This binocular screening at 16 inches is conducted annually for children in kindergarten through grade 3.

#### Approved Test

- Pass 1 Smile

**Note:** Stereoacuity screening is not required when using instrument-based screening in children age 5 in kindergarten. Instrument-based screening has high sensitivity for the detection of strabismus.

As with any developmental screening, a vision screening may not identify all potential vision disorders. The MDPH recommends a comprehensive eye exam by an eye care provider experienced in treating children be sought in the following cases:

- Children with a diagnosis of neurodevelopmental delay
- Children unable to complete, or who refuse to complete, a vision screening
- Children not reaching educational milestones such as those who receive additional educational support (e.g., Individualized Education Plan [IEP])
- Any parent-, teacher-, or screener-reported concerns, behaviors, or signs



that may indicate the existence of a vision problem even if the child passed his or her vision screening

There are many reasons why a child may not receive timely vision care after not passing a vision screening in the medical home or at school. Care coordination and follow-up is critical to overcome any vision-related barriers to developing early literacy skills and learning. Having a systematic process in place to check with the parent or caregiver that the child receives consistent comprehensive eye care will emphasize its importance. Providing linguistically and culturally appropriate informational materials (<https://childrensvision.preventblindness.org/when-to-take-your-child-eye-doctor>) can be helpful additions when speaking with

the parent or caregiver. Materials are available for free download at Children's Vision Massachusetts (CVMA) (<https://childrensvision.preventblindness.org/downloadable-cvma-resources-2-2>).

— *Karen Robitaille, MBA, MSN, RN, NCSN, director, School Health Services, Massachusetts Department of Public Health; CVMA Co-Chairs Jean Ramsey, MD (emeritus associate professor, Boston University School of Medicine, Department of Ophthalmology), Bruce Moore, OD (professor emeritus, New England College of Optometry), and Paulette Tattersall, DipPharm, MSc.; and Shanyn Toulouse MEd, BSN, RN, NCSN, nurse consultant, Northeast Regional School*

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### Our current opportunities include:

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- Chief, Pediatric Critical Care
- Chief, Pediatric Endocrinology
- Faculty, Pediatric Hospital Medicine (academic & community)
- Faculty, Pediatrician, Newborn Nursery
- Faculty, Pediatric Infectious Diseases
- Faculty, Pediatric Endocrinology
- Neonatology (per diem)



**FOR MORE INFORMATION ABOUT THESE OPPORTUNITIES, PLEASE CONTACT:**

#### Melissa Hale

Recruiter at Baystate Health

Phone: 413-794-2624

Email: [Melissa.Hale@BaystateHealth.org](mailto:Melissa.Hale@BaystateHealth.org)

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## JOB CORNER

### Pediatrician

Northampton Area Pediatrics (NAP) seeks a BC/BE Pediatric Primary Care Provider. NAP is a physician-owned practice with an excellent community reputation that prides itself on providing accessible, evidence-based medical care to a diverse patient population. Available now. Contact Kristen Deschene, MD, at [kdeschene@napeds.com](mailto:kdeschene@napeds.com) or (413) 584-8700.

### BC/BE Pediatrician

Amherst Pediatrics seeks a full-time BC/BE Pediatrician to join our well-established practice in Western Massachusetts. This is a private group practice with a solo office setting in a college town located in the beautiful Connecticut River Valley.

Please visit [www.amherstpeds.com](http://www.amherstpeds.com) for more information about the practice. Interested candidates should send their cover letter and CV to [mail@amherstpeditriacs.net](mailto:mail@amherstpeditriacs.net).

### Looking to Hire or Be Hired?

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

To submit a listing, email [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org). Please include the following information:

- Contact information
- Practice name/residency program
- Position title
- Description (25-word limit)
- Availability (e.g., available now)

\*Contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org) for rate and payment information.

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