



### PRESIDENT'S MESSAGE

## Vaccine Practice and Policy — A Chapter Priority

Occasionally either a member or a non-member pediatrician will ask me, “What does the Massachusetts Chapter of the American Academy of Pediatrics do?” Rather than rattle off a list of the chapter’s achievements, I take the opportunity to paint a picture of relatable child health priorities and the goals that spring from them. As a rule, chapter activities draw together child health practice and policy.

Walking into my health center on a recent Tuesday morning, I looked forward to a mix of familiar young faces and new narratives. What I didn’t expect that sunny morning was a winding detour away from a heartfelt discussion about a young child’s new autism diagnosis towards a more challenging conversation about vaccines. The young immigrant mother whom I had known for a little less than a year reported that she had no questions for me about her child’s delayed four-year-old vaccines. She continued with thoughtful reflection on our society’s troubling history of health disparities based on race, expressed concern over the government’s role in providing and recommending routine childhood vaccines, and ended by expressing her concerns about whispers linking vaccinations with autism. Here was a mother who had taken extreme risks to transport herself and a toddler to safety across South and Central America, had willingly completed catchup vaccinations over many months, and now was confiding in her pediatrician that she didn’t know if she could trust the process. What did I do? My immediate objective was to

*continued on page 3*

### Table of Contents • Summer 2023 • Volume 24 No. 3

<a href="#">President’s Message . . . . .</a>	<a href="#">1</a>	<a href="#">National Health Center Week Is August 6–12, 2023 . . . . .</a>	<a href="#">7</a>
<a href="#">Update On Newborn Hearing Screening and Follow-Up . . . . .</a>	<a href="#">1</a>	<a href="#">2023–2024 Influenza Season Update. . .</a>	<a href="#">7</a>
<a href="#">Editor’s Note . . . . .</a>	<a href="#">2</a>	<a href="#">Upcoming Events and Meetings . . . . .</a>	<a href="#">7</a>
<a href="#">FREE Online CME Course and Pilot Study . . . . .</a>	<a href="#">4</a>	<a href="#">Massachusetts DPH Changes Vision Screening Protocols . . . . .</a>	<a href="#">8</a>
<a href="#">ShotClock . . . . .</a>	<a href="#">6</a>	<a href="#">Opportunity to Reduce Effects of Child Sexual Abuse Through Anticipatory Guidance . . . . .</a>	<a href="#">9</a>
<a href="#">MDPH Welcomes Angela Fowler, MD, MPH, as Associate Medical Director for Vaccine Preventable Diseases. . . . .</a>	<a href="#">6</a>	<a href="#">Reach Out and Read’s Mission to Promote Early Relational Health . . . . .</a>	<a href="#">11</a>
<a href="#">Why the AAP Recommends Initiating HPV Vaccine at Age 9 . . . . .</a>	<a href="#">6</a>	<a href="#">Book Corner . . . . .</a>	<a href="#">12</a>
<a href="#">August Is National Immunization Awareness Month. . . . .</a>	<a href="#">6</a>		

## Update On Newborn Hearing Screening and Follow-Up

In response to the new guidelines published by the Joint Committee on Infant Hearing, the Massachusetts Department of Public Health Universal Newborn Hearing Screening Program recently announced a new algorithm for referral to diagnostic audiological evaluations for infants who pass their newborn hearing screen and are identified with a risk factor for late-onset changes in hearing (please see figure on page 5). This article has been approved by the Advisory Committee for the Universal Newborn Hearing Screening Program, of which the authors are members.

To read the guidelines in their entirety, please go to “[Universal Newborn Hearing Screening materials for health care providers.](#)”

Highlights include a change to the recommendations for newborns diagnosed with hyperbilirubinemia and those admitted to the NICU. To provide primary care providers with this new information, we would like to share the most



*Image courtesy of OPENPediatrics*

common questions we have received about the new algorithm.

### Is NICU admission a risk factor?

NICU admission alone is no longer a risk factor warranting further diagnostic evaluation, unless other risk factors are present. In the past, admission to the NICU for five days was an automatic risk factor, indicating the need for referral to diagnostic testing, but based on presented evidence, this is no longer considered a risk factor in isolation. On the other hand, babies who are admitted to the NICU and have a history of prolonged mechanical ventilation, very preterm status (≤32 weeks gestational age or ≤1500 grams

*continued on page 5*

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

**EXECUTIVE DIRECTOR**  
**Cathleen Haggerty**  
chaggerty@mcaap.org

**FORUM EDITOR**  
**Lisa Dobberteen, MD, FAAP**

**PRESIDENT**  
**Mary Beth Miotto, MD, MPH, FAAP**  
mmiotto@mcaap.org

**IMMEDIATE PAST PRESIDENT**  
**Lloyd Fisher, MD, FAAP**

**VICE PRESIDENT**  
**Brenda Anders Pring, MD, FAAP**

**SECRETARY**  
**Michelle Trivedi, MD, MPH**

**TREASURER**  
**David Lyczkowski, MD, FAAP**

**LEGAL COUNSEL**  
**Edward Brennan, Esq.**

**DISTRICT 1**  
**Monica Liao, MD, FAAP**

**DISTRICT 2**  
**Jay Fong, MD, FAAP**

**DISTRICT 3**  
**Lauren Hittner, MD, FAAP**

**MEMBER-AT-LARGE**  
**Lorraine Schratz, MD, FAAP**

**DISTRICT 5**  
**Katherine Wu, MD, FAAP**

**DISTRICT 6**  
**Clovene Campbell, MD, FAAP**

**MEMBER-AT-LARGE**  
**Marc Grella, MD, FAAP**

**DISTRICT 8**  
**Kristen Shanahan, MD**

**DISTRICT 9**  
**Lindsey Burghardt, MD, MPH, FAAP**

## EDITOR'S NOTE

### I'm Sorry...

I came into the room to see a young adult patient of mine, someone I'd cared for, along with other family members, since birth. This was my first visit with the patient since the early days of the COVID-19 pandemic. During that visit, my patient and other family members disclosed to me that they had adopted a shared religious belief opposing all vaccinations, including the one for COVID-19.

"What's on your mind today? How can I help you?" I cheerfully began.

"I'm here because I want a new doctor," the patient said.

This wasn't too surprising, as the patient was in the age range the AAP tells us patients should be transitioning to adult medicine providers ([AAP clinical report](#)). What came next was certainly a surprise.

"You didn't listen to me. You ignored what I said and didn't help me. Now it's three years later, and it's still a problem." The young adult went on to describe, in great detail, their perception of my lack of caring, my lack of skills, and what was perceived as my utter failure in dealing with this problem.

I was momentarily speechless, and then I said, "I'm sorry. It's terrible that you didn't feel heard by me. That is certainly not at all what I want for any of my patients, especially you." I had the patient tell me more about the problem, I reviewed the chart, and quickly tried to get a handle on the difference in our perceptions of the problem and the steps taken to remedy the issue. Because it had been three years since I'd last seen this patient, there was a lot to process.

The details of the problem are not important. It was not life-threatening, and there was no follow-up or further communication to let me know the condition was still a concern. What was vitally important in this interaction was the enormous abyss between the patient's perception and mine.

Over the years, I've often felt that our visits represent the tip of the iceberg in a family's life. We hope that we know enough to understand what goes on outside our exam rooms in the lives of our patients, but that is not always the case. In some cases, like this one, the tip of the iceberg was tiny, and what was below the surface is enormous.

Apologizing to patients is important and indicated in a variety of circumstances. See "[Apology in medical practice](#)." As noted, it is a required skill in medicine. Medical errors are beyond the scope of this discussion, but apologies are essential in helping to resolve many difficult situations with patients.

As we all do, I hope I do my best every day in the office, in every exam room, and with every family. Even when I believe I have, but my efforts are perceived to have fallen short, I hope my apology is heard as heartfelt. I finished up the young adult wellness exam, began the transfer of care to an adult medicine colleague, wished the patient well, and moved on to the next patient. I tucked away the sadness I felt to process later.

To end on a happier note, wishing you, your staff, and your families a lovely summer with time outdoors and appreciation of all the best parts of New England and beyond. — *Lisa Dobberteen, MD*



## President's Message

*continued from page 1*

be present, to express understanding and admiration for her desire to protect her child, especially after getting that difficult diagnosis, and then to take baby steps in vaccine science so as not to imperil the therapeutic alliance I knew would be so important for our travels together through the early stages of autism.

I completed medical school and residency training in Washington, DC, in the 1990s and opened a small pediatric practice in suburban Virginia right down the road from the headquarters of a vaccine opposition advocacy group then called Dissatisfied Parents Together and now called the National Vaccine Information Center. A local barrage of misinformation provoked me to keep abreast of vaccine science early on and throughout my career. How could I offer interventions to healthy children without understanding the basic science, the research and development process, and any adverse effects?

I was in the cohort of trainees who witnessed the integration of Hepatitis B, Hepatitis A, varicella, rotavirus, and conjugate pneumococcal and Hib vaccines into the childhood vaccination schedule. I'm in the age group that remembers the frequency of infant and toddler lumbar punctures and the higher prevalence of patients with otitis media, pneumonia, sepsis, meningitis, and even varicella-associated necrotizing fasciitis. I've held the hand of a newborn who was dying of pertussis. I spent a call night in a level three NICU worried about the dew drops on a rose petal that had appeared on my chest.<sup>1</sup> You don't have to sell me on vaccine science. However, the quest for better vaccine messaging has only gotten more urgent.

As a pediatrician, my responsibility to parents encompasses both medical mastery and the ability to respectfully answer parental questions to inform strong shared plans of care. What earlier seemed like more straightforward questions on vaccine safety and effectiveness have now become more nuanced as vaccine misinformation overruns social

media and opponents strategically target specific communities. Even after pursuing additional vaccine science coursework a few years ago to complete my master's in public health degree, I readily admit that my task as a pediatrician often feels more daunting than ever.

The Chapter and national AAP are here to support us in both practice and policy. The American Academy of Pediatrics has partnered with the Frameworks Institute to study vaccine confidence and hesitancy and frame vaccine information to better meet parental needs. Additional messaging tools may be found at the AAP website: [rb.gy/dw3pr](http://rb.gy/dw3pr), and through [rb.gy/8t5ax](http://rb.gy/8t5ax). The Massachusetts Immunization Initiative ([mcaap.org](http://mcaap.org)), a joint project of the chapter and the Massachusetts Department of Public Health, offers frequent educational webinars on specific vaccine topics and vaccine messaging skills, and [www.immunize.org](http://www.immunize.org) provides a myriad of resources on vaccine science, office work aids for nurses and support staff, general FAQs, and newer tools for tough parental questions.

Your chapter leaders are themselves being trained on the newer "framing" knowledge base so we can share resources with our members. We are putting into practice digestible vaccine analogies such as "updating computer software" and literacy metaphors to explain to parents how vaccines team up with the immune system so our bodies can learn how to respond to viruses. MCAAP Immediate Past President, Dr. Lloyd Fisher, stepped into the role of Immunization Initiative Medical Director in July 2022 and is a readily accessible resource to pediatricians, other health-care professionals, policymakers, and the community.

The MCAAP is also one of the founding members of a coalition of child health advocacy groups supporting Massachusetts legislation eliminating non-medical vaccine exemptions for students in prekindergarten through high school and creating a mandate for school immunization level reporting to the public. H.604 and S.1391 would preserve the medical exemption for any child who is deemed medically unable to receive a

vaccination by their medical home. The use of nonmedical exemptions for school vaccination requirements has been steadily rising statewide and puts us all at risk of a full-scale outbreak of one or more of these preventable diseases. Partnering with parents, other medical specialty and hospital associations, rare disease support groups, and the March of Dimes, the Chapter lends both scientific expertise and a commitment to safe families to help lawmakers understand the critical need for widespread childhood immunity to prevent outbreaks of life-threatening infections. For more information, visit [mafamiliesforvaccines.org/exemptions](http://mafamiliesforvaccines.org/exemptions). Please let us know if you would like to be included in "calls to action" to reach out to your own legislators by phone or email or even to testify on these important vaccine topics.

I have a number of follow-up visits scheduled with that rising kindergartner to provide additional resources needed to grow their communication and behavior skills in the next year. In that last visit, I explained to the mother how anyone can apply for a nonmedical exemption from the school and encouraged her to bring specific questions to our next chat. I will continue to offer support and to make confident recommendations for full immunization. Our therapeutic alliance will hopefully grow as I explain why I vaccinated my own children, the complex process of vaccine approval, and utilize better strategies to participate in a fruitful, respectful conversation. I'll continue to allow her some space to be the authority on her child and see me as a trusted expert on the health of children. My Chapter and AAP memberships bring practice and policy resources right to me to ensure health improvements in my patients.

— **Mary Beth Miotto, MD, MPH, FAAP**

Do you have a question or concern about Chapter initiatives on vaccination or other policy and practice activities? Would you like to get more involved? Do you have an important story to tell? Please contact Dr. Miotto or Cathleen Haggerty, our Chapter Executive Director.

### Reference

<sup>1</sup>Ed. note: for our younger readers, this is a poetic way of describing the rash of varicella.

## 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

##### FORUM EDITOR

Lisa Dobbertein, MD

##### INJURY PREVENTION

Michael Flaherty, DO

Greg Parkinson, MD

##### ORAL HEALTH

OPEN

##### SCHOOL HEALTH

Genevieve Daftary, MD

## FREE ONLINE CME COURSE AND PILOT STUDY

### Caring for Deaf and Hard of Hearing Children: An Overview for the Medical Home

We hope you will participate in this 1-hour online innovative CME opportunity to learn about the most up-to-date recommendations for providing care to children who are deaf and hard of hearing and their families. The curriculum is hosted on OPENPediatrics, an open-access peer-reviewed online repository of health care education sharing best practices from all resource settings around the world through innovative collaboration and digital learning technologies.

#### Instructions for participation:

- **Register for a Free Account on OPENPediatrics.**
  - Website: <https://learn.openpediatrics.org/learn/register>
  - Click “Create an Account” at bottom of page (or sign in if you are already a registered user).
  - Fill out all required fields (indicated by asterisks) then click “Create an Account” at the bottom of the page, “Registration Request Sent” should pop up.
  - You will receive a confirmation email (“Please confirm your registration request”) once your account is activated.
  - If confirmation email is not received within an hour, check the spam folder first, then contact the OPENPediatrics helpdesk using the blue “Help” button at the bottom left of the homepage (<https://learn.openpediatrics.org>).
  - Confirm your registration by clicking on the link in the email. You will then see “Registration Completed” and can sign in to the [OPENPediatrics website](https://learn.openpediatrics.org).
- **Enroll in Pilot Course.**
  - Once you have created and verified your account, you can log on and access the course using the enrollment code **DHHcode**.

- To access the course:
  - Click on “Menu” at the top left of the page.
  - Click “Courses.”
  - Enter DHHcode where it states, “Enrollment code,” then click the small green arrow to submit.
  - Click “View All My Courses and Learning Plans.”
  - Click “Caring for Deaf and Hard of Hearing Children: An Overview for the Medical Home.”
- Visual instructions can be found at this [link](#).

#### • Obtain FREE CME Credit.

- Once the course is completed, a window will pop up saying “Continuing Education (CE) Credits Are Available for This Course.”
- Follow the prompts in this window, clicking either “Physicians,” “Nurses,” or “Physician Assistants” depending on your profession.
- You must complete an end-of-course survey, required by the accrediting body to obtain the CME credit.
- Once completed, you will be able to download your certificate of completion.

Participation will require the completion of four online steps:

1. Brief **Premodule Survey**
2. One-hour **Educational Module**
3. Brief **Postmodule Survey**
4. Brief **Three-Month Postmodule Survey**, sent via a registered email address

#### Note

- You will have four weeks to complete the module.
- You will continue to have access to the curriculum after you complete the posttest.

Questions? Please feel free to contact the authors of this article (Jane Stewart, [jstewart@bidmc.harvard.edu](mailto:jstewart@bidmc.harvard.edu) or Arielle Spellun, [Arielle.Spellun@childrens.harvard.edu](mailto:Arielle.Spellun@childrens.harvard.edu)).

## Update On Newborn Hearing Screening and Follow-Up

*continued from page 1*

birthweight) or other high risk conditions, as listed within the algorithm, are still at higher risk and should be referred for audiologic diagnostic evaluation.

### What level of jaundice warrants a diagnostic hearing evaluation?

In the past, a level of 20 mg/dL or greater was considered high enough to warrant further testing. Based on presented evidence, the new recommendation is for diagnostic testing referral only for those infants who have reached a bilirubin level high enough to meet criteria for exchange transfusion. This is true for both infants who do ultimately end up undergoing exchange transfusion and for those who do not, but their bilirubin levels reached the threshold for exchange transfusion.

### Which risk factors warrant hearing testing as soon as possible after birth (within 1-2 weeks)?

Congenital cytomegalovirus (CMV), bacterial meningitis, and parental or

medical provider concern all warrant diagnostic audiological evaluation as soon as possible after birth.

### Are all babies screened for CMV?

No. Screening for CMV is currently only recommended for babies who do not pass their newborn hearing screen or demonstrate other possible signs of CMV infection (e.g., thrombocytopenia, microcephaly, low birthweight for age). This is so that potential treatments can be presented to the infant’s caregivers in a timely manner for shared decision-making.

### Which babies who are evaluated for hypoxic-ischemic encephalopathy (HIE) should have additional hearing testing?

Any infant who receives therapeutic hypothermia or who has been given a diagnosis of hypoxic-ischemic encephalopathy due to their neuroimaging or clinical course is at risk for later onset hearing loss, even if they pass their initial screen, and should be referred for diagnostic evaluation.

### What other neurologic diagnoses are associated with reduced hearing?

Hydrocephalus (congenital or acquired) and microcephaly are associated with reduced hearing.

### What about ear pits and preauricular tags?

The updated recommendation is for routine initial hearing screening at birth and then a follow-up behavioral audiological evaluation at nine months of age if either pits OR preauricular tags are present.

Remember, when in doubt or if a parent expresses a concern about their child’s hearing, schedule that hearing evaluation as soon as possible! — *Jane Stewart, MD, SM, FAAP; Arielle Spellun, MD, FAAP; Jennifer Bentley, AuD; and members of the Universal Newborn Hearing Screening Program Advisory Committee*

Questions? Please feel free to contact the authors of this article (Jane Stewart, [jstewart@bidmc.harvard.edu](mailto:jstewart@bidmc.harvard.edu); Arielle Spellun, [Arielle.Spellun@childrens.harvard.edu](mailto:Arielle.Spellun@childrens.harvard.edu); Jennifer Bentley, AuD, [bentley1@bu.edu](mailto:bentley1@bu.edu); or the Universal Newborn Hearing Screening Program, [Newborn.Hearing@mass.gov](http://Newborn.Hearing@mass.gov)).

## Audiologic diagnostic appointments: Risk factor algorithm for birth hospitals

For infants who pass the newborn hearing screen, but have any of the following risk factors for reduced hearing:

### TIER 1\*

Schedule diagnostic evaluation immediately in the event of:

- Bacterial meningitis
- Congenital cytomegalovirus (cCMV) infection
- Parental or medical provider concern

Schedule evaluation by 1 month of age in the event of:

- History of maternal in utero Zika infection and screening via otoacoustic emissions methodology only

Schedule evaluation by 3 months of age in the event of:

- Aminoglycoside administration for more than 5 days
- Chemotherapy
- Cleft lip/palate
- Craniofacial anomalies (e.g. microtia/atresia)
- Down Syndrome
- ECMO
- Hyperbilirubinemia with exchange transfusion
- Perinatal asphyxia or hypoxic ischemic encephalopathy
- Permanent childhood hearing loss in immediate family (infant’s parents or siblings)
- Positive diagnosis of infection associated with reduced hearing (e.g. herpes, rubella, syphilis, toxoplasmosis, viral meningitis, encephalitis)
- Significant head trauma especially basal skull/temporal bone fractures
- Syndromes associated with reduced hearing (e.g. CHARGE, Treacher Collins, Pierre Robin)

### TIER 2\*

Recommend behavioral audiological diagnostic evaluation to occur at 9 months of age (corrected age) in the event of:

- ≥10 days mechanical ventilation
- ≤ 32 weeks gestational age
- ≤1500 grams birthweight
- Ear pits and/or preauricular tags
- History of maternal in utero infection (e.g. herpes, rubella, syphilis, toxoplasmosis)
- History of maternal in utero Zika infection and screening via ABR methodology
- Permanent childhood hearing loss in extended family

**\*NOTIFY FAMILY AND PEDIATRICIAN IN ALL CASES**



February 2023

# ShotClock

## MDPH Welcomes Angela Fowler, MD, MPH, as Associate Medical Director for Vaccine Preventable Diseases

In March, the Massachusetts Department of Public Health's (MDPH) Bureau of Infectious Disease and Laboratory Sciences (BIDLS) welcomed Angela Fowler, MD, MPH, as the Associate Director for Vaccine Preventable Diseases. Dr. Fowler joined the Office of the Medical Director and will provide clinical oversight in activities related to vaccination and vaccine preventable diseases throughout the BIDLS. Her roles will include consultation for vaccine preventable diseases and outbreak management, medical direction of the perinatal Hepatitis B program, consultation for the Massachusetts Immunization Information System (MIIS), and teaching and outreach with providers, provider groups, and the general public. She will support the increasingly critical task of promoting vaccine confidence and combatting vaccine misinformation.

Dr. Fowler is an honors graduate of Brown University and Harvard Medical School. She performed her Internal Medicine Residency at Massachusetts General Hospital and a Preventive Medicine Residency at the University of North Carolina at Chapel Hill, where she also received a master's degree in public health. Her career has been multifaceted including clinical work in multiple settings, research, and community service. She has been a grant-funded researcher in the area of obesity medicine and the study of leptin. She has been a primary care provider in the United States Air Force, Beth Israel Deaconess Medical Center, and most recently provided university medical services at Massachusetts Institute of Technology (MIT) Health. Throughout her career as clinician, teacher, and researcher, she has been a strong advocate for immunization and health equity. Dr. Fowler succeeds Dr. Susan Lett in providing medical leadership for immunization for BIDLS and MDPH.

Welcome, Dr. Fowler!

## Why the AAP Recommends Initiating HPV Vaccine at Age 9

The American Academy of Pediatrics (AAP) recommends starting the human papillomavirus (HPV) vaccine series between 9 and 12 years, at an age that the provider deems optimal for acceptance and completion of the vaccination series. Introduced in the AAP's 2018–2021 *Red Book*, the recommendation follows: "The American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention recommend routine HPV vaccination for females and males. The AAP recommends starting the series between 9 and 12 years, at an age that the provider deems optimal for acceptance and completion of the vaccination series."<sup>1</sup>

The AAP recommendation differs from the Advisory Committee on Immunization Practices (ACIP), which recommends that "routine HPV vaccination be initiated at age 11 or 12 years. The vaccination series can be started beginning at age 9 years."<sup>2</sup>

A 2022 commentary by Sean O'Leary, MD, FAAP, discusses the reasoning behind AAP's decision to differ from ACIP, even though the AAP and ACIP immunization schedules are essentially harmonized for all other vaccines. These reasons include recognition that (1) HPV vaccination uptake is suboptimal; (2) offering HPV vaccination earlier offers provider's flexibility in introducing the vaccine; (3) initiating the HPV vaccine at age 9 or 10 may be preferable for parents or adolescents who do not want to receive  $\geq 3$  concomitant vaccines at age 11 or 12; (4) earlier initiation may disentangle HPV recommendations from discussions of sexuality; (5) earlier recommendation might alleviate HPV vaccine hesitancy "fatigue;" (6) the immune response is robust at younger ages with no evidence of waning protection; and (7) there is a dearth of evidence supporting starting the recommendation at age 11 or 12 within the "adolescent immunization platform."<sup>3</sup>

The commentary notes that "Additionally, there is no known downside to earlier initiation. The immune response is robust at younger ages, and there is no evidence of significant waning protection after antibody

levels plateau approximately 18 to 24 months after series completion.... While no randomized trials have compared introduction at 9 or 10 years to introduction at 11 or 12 years, there is some evidence supporting earlier initiation. A retrospective study showed that adolescents who started the HPV vaccine series at age 9 or 10 were 22 times more likely to complete the two-dose series by age 15 than those who initiated the series at age 11 or 12. In addition, there are anecdotal reports of increased uptake when providers introduce HPV vaccine at age 9–10."<sup>4</sup>

To access the complete article, [click here](#).

### References

<sup>1</sup>Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*, 32nd edition. American Academy of Pediatrics; 2021.

<sup>2</sup>Petrosky E, Bocchini JA, Hariri S, et al. Use of 9-valent human papillomavirus (HPV) vaccine: updated HPV vaccination recommendations of the advisory committee on immunization practices. *MMWR Morb Mortal Wkly Rep*. 2015;64(11):300–304.

<sup>3</sup>St. Sauver JL, Finney Rutten LJ, Ebbert JO, et al. Younger age at initiation of the human papillomavirus (HPV) vaccination series is associated with higher rates of on-time completion. *Prev Med*. 2016;89:327–333.

<sup>4</sup>O'Leary ST. Why the American Academy of Pediatrics recommends initiating HPV vaccine at age 9. *Hum Vaccin Immunother*. 2022;18(6):2146434. DOI: 10.1080/21645515.2022.2146434.

### Resource

[Start at Age 9 Toolkit](#). National HPV Vaccination Roundtable.

— **MCAAP Immunization Initiative**

## August Is National Immunization Awareness Month

### #vax2protect

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



The disruption in well-child visits and routine immunization during the COVID-19 pandemic has resulted in a drop in routine immunizations for children and adolescents. While routine vaccination coverage is rebounding, it has been uneven and has not yet recovered among all groups. Our community plays an essential role by ensuring that children are up to date on all recommended vaccines. You can help by identifying families whose children have missed recommended vaccines and contacting them to schedule vaccine appointments.

The NIAM [toolkit](#) contains helpful resources that can be utilized by providers throughout August, including key messages, vaccine information, sample news releases

and articles, social media messages, web links from CDC and other organizations, web banners, logos, and social media graphics.

Be on the lookout for #vax2protect updates throughout August! If you have questions or are looking for specific resources for your practice, please contact Cynthia McReynolds ([cmcreynolds@mcaap.org](mailto:cmcreynolds@mcaap.org)).

Thank you for all that you are doing to keep Massachusetts' children safe from vaccine preventable diseases!

— MCAAP Immunization Initiative

## National Health Center Week Is August 6–12, 2023

Each August, the National Association of Community Health Centers (NACHC) sponsors National Health Center Week (NHCW). NHCW celebrates and increases awareness of America's 1,400 Community Health Centers. NHCW will be held this year from August 6 to 12.

NHCW provides a wonderful opportunity to highlight the commitment and passion of community health center staff, board members, and supporters who make it possible to provide quality, comprehensive health care services to more than 30 million patients across 14,500 communities annually. [Click here](#) to learn more about NHCW.

The MCAAP would like to recognize and thank community health center staff for their

dedication to the health and well-being of their communities!

— MCAAP Immunization Initiative

## 2023–2024 Influenza Season Update

### Advisory Committee on Immunization Practices' Recommendations

The Advisory Committee on Immunization Practices' recommendations for the 2023–2024 influenza season will be published in *Morbidity and Mortality Weekly Report* once they are approved by the Centers for Disease Control and Prevention (CDC). It is anticipated that the 2023–2024 influenza season recommendations will be published in August 2023.

— MCAAP Immunization Initiative

### 2023–2024 State-Supplied Flu Vaccine

There will be **no preordering or prebooking** for the 2023–2024 state-supplied flu vaccine.

Your practice's flu allocation/ceiling limit will be based on administered doses reported to the MIIS throughout the 2022–2023 flu season.

An email regarding flu vaccine allocation/ceiling limit will be sent out in early August 2023. The email will come from [dph-vaccine-management@mass.gov](mailto:dph-vaccine-management@mass.gov).

— MCAAP Immunization Initiative

## Upcoming Events and Meetings

### National Immunization Awareness Month (#vax2protect)

August 2023

For more information, visit [cdc.gov/vaccines/events/niam/index.html](https://cdc.gov/vaccines/events/niam/index.html).

### National Health Center Week

August 6–12, 2023

For more information, visit [healthcenterweek.org](https://healthcenterweek.org).

### Massachusetts Vaccine Purchase Advisory Council Meeting

October 12, 2023

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

### 28th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

Wednesday, October 25, 2023

The conference will be hybrid. The in-person conference will be held at the DCU Center, Worcester, Massachusetts. Registration will open in early August. Updates will be posted as they become available at [mcaap.org/immunization-initiative](https://mcaap.org/immunization-initiative).

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

October 25–26, 2023

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



## Massachusetts DPH Changes Vision Screening Protocols

As pediatric providers, we all know that the work we do caring for children hopefully provides a lifetime of healthy living and productivity. Our children are dependent on good vision for normal development and learning. It is up to all of us to ensure that vision problems in children are detected and treated early in life.

There is now scientific data to support the connection between vision and learning:

- The NIH-funded Vision in Preschoolers-Hyperopia in Preschoolers Study (VIP-HIP) revealed deficits in early literacy in children with moderate to high farsightedness (>4Diopters).<sup>1</sup>
- The Test of Preschool Early Literacy (TOPEL) used in the VIP-HIP showed deficits in print knowledge in children with >4D of hyperopia.
- Many state vision screening protocols fail to identify children with moderate to high hyperopia, and these children are the most likely to develop amblyopia and strabismus and to struggle with learning.

### A significant portion (10%) of preschool children have detectable vision problems.

- 3% of preschoolers have strabismus.
- 1–2% have amblyopia.
- 5% have refractive errors that need correction.

Multiple national trials over the past two decades (Vision in Preschoolers, Multi-Ethnic Pediatric Eye Disease Study, and Baltimore Pediatric Eye Disease Study) have focused on vision screening in our preschool population.<sup>1-3</sup> Data from these studies revealed that vision problems in young children are quite prevalent.

### What is the impact on our preschoolers if the problem isn't found?

- Worse performance in early literacy studies, which can continue throughout childhood and life.
- Worse general health-related quality of life.

The Vision in Preschoolers Study (VIP-HIP) shows that uncorrected moderate to high hyperopia in children enrolled in

preschool or kindergarten is associated with worse performance on early literacy testing (TOPEL) compared to those with no significant refractive error.<sup>1</sup> The Multi-Ethnic Pediatric Eye Disease Study found that strabismus, whether diagnosed or not before the study, was independently associated with significantly worse general health-related quality of life in preschool children.<sup>2</sup>

Why vision problems in children are so important:

- Relationship to permanent vision loss
- Relationship to overall child health
- Relationship to education
- Relationship to physical and motor development
- Relationship to social and emotional development
- Ultimately, to future economic and social status

### Vision Screening in the Pediatric Primary Care Office

We know your primary care well child visit is spent on many aspects of a child's health. Vision screening is just one of them. Vision screening for young children can be thought of as difficult and time-consuming. Often, it is not well reimbursed. But it is important that we detect children with vision issues who will most benefit from early treatment, and this is especially true for children less than 5 years old. The reward for designing a successful vision screening program is to find these young children whose vision problems will hold back their learning and development. We know that the medical home is a key part of this initiative.

Our goal is to make recommendations for your practice that are evidence-based. We hope the addition of a few changes to the protocols will ultimately save you time. Please refer to *The Forum* article from Spring 2022, Volume 23 No. 2, for the new DPH-approved vision screening protocol. [https://mcaap.org/2018/wp-content/uploads/115422MS\\_Forum\\_Spring2022\\_0222\\_FINAL2.pdf](https://mcaap.org/2018/wp-content/uploads/115422MS_Forum_Spring2022_0222_FINAL2.pdf)

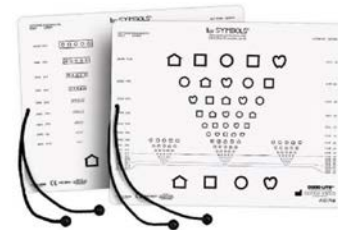
Since the publication, two notable updates have emerged. First, there is now a Near Visual Acuity single line card available for preschoolers at 20/50 and 20/40. Second, it has been clarified that the approved stereoacuity test is the Pass 1-OH (with 120 seconds of arc).



PASS 1-OH Stereo Smile @ 16 inches



Near Card in logMAR or single critical line format with 16-inch cord (@ 20/50, 20/40, and 20/32)



LEA SYMBOLS@ or Sloan Letters

### How can we help?

It is amazing that the simple introduction of eyeglasses in an amblyopic child without other treatment (e.g., patching or atropine) will result in a three-line improvement in their vision. In practical terms, these simple treatments translate to improved living, self-esteem, and learning. But finding these children is the hardest part. Primary care offices are in the unique position to not only identify vision disorders but also check in with families at future well-child visits to ensure the family took the child to an eye care provider and their treatment plan is being followed.

Children's Vision Massachusetts (CVMA) wants to work with primary care providers' offices to incorporate

*continued on page 9*



## Opportunity to Reduce Effects of Child Sexual Abuse Through Anticipatory Guidance

### Improving Physical and Mental Outcomes for Children Through Anticipatory Guidance On Sexual Abuse Prevention and Early Detection with Parents and Caregivers

While it is not possible to know the exact extent to which child sexual abuse (CSA) occurs, consistent research has reinforced that CSA is a serious threat to the safety and well-being of children, affecting an [estimated 10% of children](#). Historically, the first [Adverse Childhood Experiences Study](#) (ACE Study) estimated 25% of women and 16% of men are survivors of CSA. The ACE Study did not reflect an accurate depiction of juvenile-perpetrated abuse, as participants were required to only indicate abuse perpetrated by someone five or more years older than them, nor did it represent the exponentially high rates of abuse that affect [children with disabilities](#). Irrespective of estimates, CSA is a serious issue that greatly affects the health and wellness of children. Children who experience sexual abuse are at increased risk of PTSD, depression, and anxiety. Traumatic stress can present itself through unexpected consequences such as [digestive issues](#), [migraines](#), [eczema](#), and other maladies requiring medical evaluation and treatment, which may be overlooked as a possible result of CSA.

Child sexual abuse cannot simply be classified as a crime, but a public health issue that requires a united effort to prevent and support the healing of those affected. Statistically, during childhood, there is an exponentially [greater risk of sexual assault](#) than all ages of adulthood combined. With over [90% of CSA](#) being perpetrated by someone known to the child, and [40% of perpetrators](#) being juveniles, there is a significant opportunity to address prevention within the home, as victims often live with or are intimately connected to their perpetrator. The younger the child, the more likely the perpetrator is a family member, thus parental and caregiver education is essential to reduce risk and improve effective intervention. Another consideration, in regard to child-perpetrated sexual abuse, is the opportunity and necessity to address sexual behavior problems in children. Massachusetts-based organization, [MASOC](#), works to identify and support best practices in providing therapeutic resources to such children and their families, as parental involvement is often essential to treatment.

CSA prevention, historically, focused on child education primarily in schools, however, annual messaging is not considered sufficient by experts, and with a significant percentage of children

experiencing abuse prior to entering school, there is an identified need for improved protection for children ages 2–5 years, requiring comprehensive awareness and education of parents and caregivers. Research has shown that most victims [do not disclose during childhood](#) and CSA is rarely reported to the authorities.

Furthermore, survivors of CSA have widely reported that those they disclosed to (often parents) did not believe them, or responded in a way that made them feel ashamed or discouraged from divulging more information. Parental support is a crucial component to building resilience in children, thus further supporting the need for improved adult awareness to support healing.

In response to this complex issue, our organization conducted a survey of parents and caregivers, to understand how to better support their role as protectors and educators of children regarding sexual abuse, also known as “body safety” education. Our research, summarized in our [Parental & Caregiver Perspective on Child Sexual Abuse Prevention report](#), found that most parents gain information on the issues of CSA via the internet/social media, followed by training presentations, and books. When asked

*continued on page 10*

### Massachusetts DPH Changes Vision Screening Protocols

*continued from page 8*

these changes into their screening practices in a practical way. We recognize this is cumbersome for practices and value the effort primary care providers put into all aspects of a child’s health and well-being.

While most school nurses receive mandated vision screening education and support through Massachusetts’s Department of Public Health: School Health Unit approved training and programs, gaps continue to exist. Reaching out to

school nurses, ophthalmologists, and optometrists in your community may be beneficial in the development of comprehensive systems of vision care within your practice. Partnerships and collaborations can help lessen the burden on any one system while ensuring children’s vision conditions are identified early and treated in a timely manner, avoiding unnecessary suffering and learning loss.

The vision screening program changes are being made at the school level via the school nurses. CVMA leadership can help with tips and tricks discovered by the school nurses as they implement these changes. A future round table

discussion or other forum for the exchange of information can be planned if this would be helpful for practices going forward. Please don’t hesitate to reach out to any of us.

— **Danielle Ledoux, MD;**  
**Katherine Majzoub, RN, MBA;**  
**Bruce Moore, OD;**  
**Jean Ramsey, MD, MPH;**  
**Paulette Tattersall, DipPharm, MSc;**  
**Shanyn A. Toulouse, DNP, MEd, RN,**  
**NCSN; Co-Chairs Children’s Vision MA;**  
[childrensvision.preventblindness.org](http://childrensvision.preventblindness.org)

#### References

- <sup>1</sup>Kulp, et al. *Ophthalmology*. 2016; 123(4):681–689.  
<sup>2</sup>Wen, et al. *Ophthalmology*. 2011; 118(3):574–580.  
<sup>3</sup>Giordano, et al. *Ophthalmology*. 2009;116(4):739–746.

## Child Sexual Abuse

*continued from page 9*

where parents felt children should receive education on body safety the top three answers were:

- Within the home
- School
- Doctor's offices

Specific to the role of pediatricians, 91.5% of parents felt pediatricians should be providing guidance on sexual abuse prevention.

Effective pediatric involvement in abuse prevention does not require doctors to become expert educators on the subject, but rather, function as advocates that support and guide parents to learn and take steps to protect and empower children with knowledge of their rights.

Given that body safety messaging is dependent upon age and development, parents and caregivers will benefit from continued guidance from pediatricians through all stages of childhood, to understand the nuances and risks as children engage in more activities with increased independence.

The Mama Bear Effect has worked with the support of Dr. Martin Finkel of the CARES (Child Abuse Resource Educational Services) Institute to produce a *Pediatric Best Practices Guide* available at no cost through the [Pediatric section](#) of our educational [website](#) and developed a Pediatric Kit to support messaging and access to take-home resources for parents. — **Adrienne Simeone, Founder and President, The Mama Bear Effect**



## JOB CORNER

### Pediatrician

Bowdoin Street Health Center is seeking a board-certified pediatrician to join our expanding primary care team and provide patients with high-quality treatment and diagnostic services. Seeking candidates interested in 0.5-1.0 FTE. Contact Talya Salant, MD, at [tsalant@bidmc.harvard.edu](mailto:tsalant@bidmc.harvard.edu).

### Developmental Behavioral Pediatrician

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

### Newborn Hospitalist

Mount Auburn Hospital, a Harvard Medical School teaching hospital and member of the Beth Israel Lahey Health network serving the greater Cambridge, Massachusetts area, is seeking a part-time newborn hospitalist to join the Department of Pediatrics. Mount Auburn Hospital cares for a diverse mix of suburban and urban patients and is characterized by an exceptional and collegial working environment. Job responsibilities include providing inpatient care at Mount Auburn Hospital's well-baby nursery. Join a team of four pediatricians who round daily on term infants, with no night-call requirements. For more information, click [here](#).

*continued on page 13*



## Reach Out and Read's Mission to Promote Early Relational Health

You may know Reach Out and Read (ROR) as a nonprofit organization that collaborates with health care providers to enhance early literacy and school readiness. During pediatric visits, ROR distributes books and provides parents with advice on the benefits of reading aloud to their children. However, our work extends beyond literacy; we also aim to promote early relational health in pediatric visits, recognizing that positive parent-child relationships are essential for healthy child development.

The opportunity for health begins in our families, neighborhoods, schools, and jobs. As such, early relational health (ERH) refers to the quality of the parent-child relationship during the first years of life. It encompasses factors such as communication, emotional responsiveness, and attachment, and it will come as little surprise that research shows ERH has a significant impact on child development, including cognitive, social, and emotional outcomes. Positive parent-child relationships have been associated with higher IQs, better academic achievement, and fewer behavioral problems. They also act as a buffer against toxic stress, which has been shown to have profound physiological impacts throughout adolescence and into adulthood. By promoting early relational health, we can contribute to building healthy families and communities.

In 2019, ROR recognized that promoting ERH through pediatric care nationally could play a critical role in a population-level movement towards healthier communities. We realized part of our responsibility in partnering with providers was to collectively transform our communities, systems, and policies in ways that better promote these critical connections between parents and children.

Our efforts to advance this goal emerge in several ways. First, through a shift in how we think about our work. Our core model — giving books to children and guidance to parents on how to read aloud — inherently promotes these positive parent-child interactions. ROR naturally encourages parents to bond with their children and communicate with them in a positive way. In discussing the importance of reading aloud and other aspects of early childhood development, practitioners are supporting parents in their role as their child's first teacher, helping them feel more confident in their parenting skills, creating meaningful moments in their relationship with their child, and building stronger relationships with their provider. While it seems simple, the reality is that engagement with families through the ROR program does more than promote literacy; it is a baseline for building protective factors within families.

Scaled across tens of thousands of pediatricians, family physicians, and

nurse practitioners in our network of pediatric primary care, we have a profound opportunity to create these bonds among the families we work with.

Second, ROR has updated its training and guidance to build momentum for this shift in perspective. Our core training, an online, accredited module that is a prerequisite for all clinicians joining the ROR community, now reflects our organizational emphasis on the promotion of ERH through ROR, including:

- The wealth of evidence for the importance of promoting ERH
- The critical role that pediatric care clinicians can play in promoting ERH because of their near-universal access to families with young children
- Updated guidance about how to promote ERH through ROR by encouraging parents/caregivers

We believe investing in early relational health, along with literacy promotion, can contribute to building a brighter future for our children and our communities. If you would like to learn more or find information about how to join the Reach Out and Read network of providers, please visit our website at [reachoutandread.org](http://reachoutandread.org).

— *Alex Chu, Executive Director, Reach Out and Read Northeast*



### BOOK CORNER

## Ebooks and ASD: Can Screens Actually Help?

When I was young, the pages of a book were always in competition with a television screen or video game. It was always understood that time with a book was time well spent, while watching television or staring at a computer were to be done only in moderation. To this day, I carry some of that philosophy with me, as I imagine many others of my generation do.

However, this is a very different world than the one I grew up in. At least in this country, screens dominate many, if not most, parts of our lives. This much is obvious. One of the challenges we have had to contend with recently is how to both limit screen time for children and to foster reading and active play. The AAP has recommended limiting screen time and emphasizing meaningful interactions with caregivers, as well as discussing the content children consume. Resources such as the [Family Media Plan](#) have been developed to assist in navigating this issue.

So what, then, do we make of ebooks? A marriage of page and screen, these have the potential to enhance reading with features such as animation or voice or detract from the experience by tempting children to pursue other, less productive forms of entertainment. This makes recommendations challenging.

In addition, ebooks are increasingly utilized in the home and the classroom, particularly in the wake of the COVID-19 pandemic.

One interesting question that has been asked is how children with autism spectrum disorder (ASD) do with ebooks compared with traditional print books. Sung Hee Lee and Aja McKee at California State University Fullerton recently published a case series of four children with ASD who were assigned to read both books in print and ebooks with their parents. They compared vocabulary gain, comprehension, engagement, and decoding (using letter sounds to interpret unfamiliar words) in these children. Interestingly, the ebook actually produced greater gains in vocabulary, comprehension, and engagement relative to the paper book in these children. Neither book made a difference in decoding ability. It is important to note, however, that one child showed less engagement with the ebook and attempted to access the home screen and other applications on the iPad. Another child showed more improvement with the ebook but was noticeably bothered by some of the noises that accompanied the animations. The biggest gains from ebooks appeared to occur in children who had higher reading readiness scores on testing.

As per usual, complicated questions yield complicated answers. This case study is helpful in that it shows a potentially positive value in ebooks, particularly if there is guidance on proper use for primary caregivers as well as mindfulness regarding sensory sensitivity.

So should we be recommending ebooks for children with ASD? Frankly, we may not have a choice either way. However, we do know that technology can be of tremendous value to these children, particularly in assisting with communication. If similar technology can help improve literacy as well, so much the better. Time will tell. — **Rajapillai Pillai, MD, PhD, Fellow, Neurodevelopmental Disabilities, Boston Children's Hospital.** Dr Pillai can be reached at [Rajapillai.Pillai@childrens.harvard.edu](mailto:Rajapillai.Pillai@childrens.harvard.edu).

Editor's note: while a small case study, this offers food for thought in considering the positive effects of one form of electronic media in a select population. There is much more to be studied carefully in this area.

#### Reference

Lee SH, McKee A. Reading ebooks and printed books with parents: A case study of children with autism spectrum disorders. *Autism Dev Lang Impair.* 2023 Apr 16;8:23969415231168571:1–17. doi: 10.1177/23969415231168571. PMID: 37091216; PMCID: PMC10114290.

## Job Corner

continued from page 10

### Pediatrician

BC/BE Pediatric Primary Care Provider, Northampton Area Pediatrics (NAP). 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.

### 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.



@Jack Maypole, MD