

PRESIDENT'S MESSAGE

Advocating for Change

Today is the first day that feels like fall is coming and that is a welcome relief. The wet and cool spring I wrote about in my last President's Message morphed into the hot and humid summer of 2018 — one of the hottest summers on record in the past 150 years. I'm hoping that fall brings with it a mellowing of the wide swings in temperature we have been seeing. Unfortunately, there does not seem to be any abatement in sight to the challenging and difficult environmental threats facing children and families right now.

The MCAAP is diligently working to abate such environmental threats to child health and wellbeing and to the practice of pediatrics through legislative action. Our work focuses on local legislation, although the Chapter has been active in national campaigns as well. Over the past few years, requests for the Chapter to sign onto legislative campaigns have been increasing at a rapid and steady pace. In order to assure that our voice stays strong and powerful and that our input brings attention to children's health, the MCAAP is careful not to dilute our brand by signing on to too many bills. Ed Brennan, Esq., the Chapter's long-standing and terrific lobbyist and legal counsel, guides our advocacy work. While the Executive Board decides whether the Chapter will support, oppose, or remain neutral on a particular bill, our Legislative Committee, so ably lead by Drs. Karen McAlmon and Brenda Anders Pring, is where our legislative process starts.

Any member can submit a bill to the Legislative Committee for review and discussion. The committee then follows its policy and procedures in making a recommendation to the Executive Board. The board then reviews the recommendation

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Federal Court Orders FDA to Quickly Require Graphic Cigarette Warnings as Mandated by Law



In a major victory for the nation's health and the fight against tobacco, a federal court ordered the US Food and Drug Administration (FDA) in August to expeditiously issue a final rule requiring graphic health warnings on cigarette packs and advertising, as mandated by a 2009 federal law.

The ruling by US District Judge Indira Talwani of the US District Court for the District of Massachusetts was in response to a lawsuit filed in October 2016 by eight

public health and medical groups and several individual pediatricians. Judge Talwani agreed with the health groups that the FDA has both "unlawfully withheld" and "unreasonably delayed" agency action to require the graphic warnings.

Judge Talwani set a deadline of September 26, 2018, for the FDA to "provide to this court an expedited schedule for the completion of outstanding studies, the publication of the proposed graphic

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**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
ldobberteen@mcaap.org

PRESIDENT
Elizabeth Goodman, MD, MBA, FAAP
egoodman@mcaap.org

IMMEDIATE PAST PRESIDENT
DeWayne Pursley, MD, MPH, FAAP
dpursley@mcaap.org

VICE PRESIDENT
Lloyd Fisher, MD, FAAP
lfisher@mcaap.org

SECRETARY
Brenda Anders Pring, MD, FAAP
bpring@mcaap.org

TREASURER
Mary Beth Miotto, MD, FAAP
mmiotto@mcaap.org

LEGAL COUNSEL
Edward Brennan, Esq.
ebrennan@ebjlawoffice.com

DISTRICT 1
Stewart Mackie, MD, FAAP
smackie@mcaap.org

DISTRICT 2
Gina O'Brien, MD, FAAP
gobrien@mcaap.org

DISTRICT 3
Laura Lee, MD, FAAP
llee@mcaap.org

DISTRICT 4
David Lyczkowski, MD, FAAP
dlyczkowski@mcaap.org

DISTRICT 5
Daniel Slater, MD, FAAP
dslater@mcaap.org

DISTRICT 6
Nicholas Kasdon, MD, FAAP
nkasdon@mcaap.org

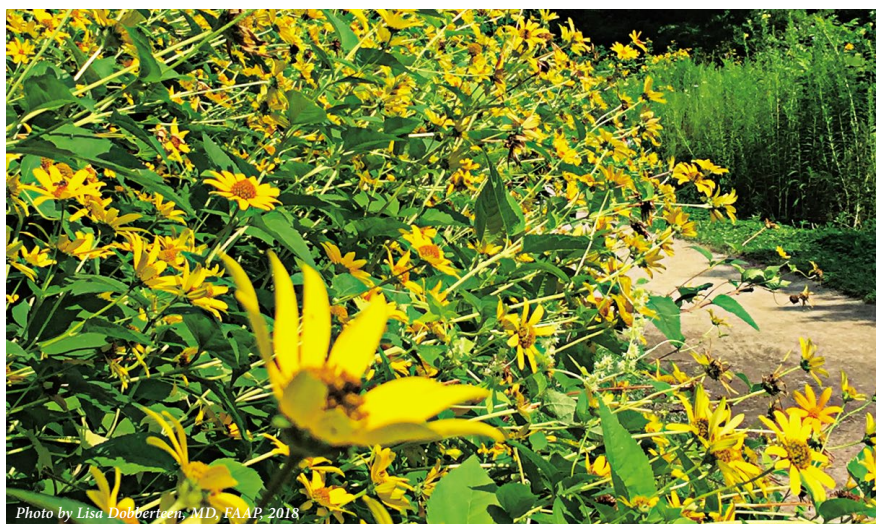
DISTRICT 7
Genevieve Daftary, MD, MPH, FAAP
gdaftary@mcaap.org

DISTRICT 8
Daniel Rauch, MD, FAAP
drauch@mcaap.org

DISTRICT 9
OPEN

EDITOR'S NOTE

Transitions



As I write, the weather along with the calendar has turned to fall, always my favorite season. I imagine, like me, you have been busy in your offices with end-of-summer tasks: back to school physicals, school medication consents, asthma action plans, and more.

Along with the transition of seasons, there are the many transitions our patients and families are experiencing. Babies are going to daycare for the first time. Toddlers are big enough to enter preschool. Preschoolers are taking that huge leap to kindergarten, a milestone equally important for parents as well as children. Older elementary school children are juggling lockers and changing classes as they begin middle school, and then there is high school for teens and all it represents.

A very rewarding moment for me, as a pediatrician, is watching my patients go off to post-secondary experiences, whether military service, vocational and technical programs, community college, or a four-year college. If we've done our job right, these young people will be off to the next phase of their lives wearing their seat belts and bicycle helmets, reading, being mindful of how much screen time they engage in, using no substances, and taking good care of themselves by eating healthy food and exercising.

I had a particular moment of joy when discussing plans with one young adult

patient and heard about her application for a Fulbright Scholarship! Watching her grow from a young child with her excited engagement in and involvement with the world to an exceptionally competent and intelligent young woman makes me feel very proud and confident of her future in whatever direction she chooses.

A transition of another sort appears every November, when it is time to participate in elections. We have the privilege of voting, which is denied to so many around the world. As pediatricians, we have a special responsibility to encourage all adults around us to vote and to vote on behalf of *all* children. This election is incredibly important. We can all provide a great example to our families in welcoming their participation in voting, particularly those who are voting for the first time!

It is a privilege to be present in these moments of transition in our patients' lives, as well as these transitions in our nation's history. Whether experiencing energizing, positive transitions or more somber, sad transitions in life, our families look to us for guidance and support to help survive, endure, and even soar with these transitions.

We can look to the AAP, the MCAAP, and of course, within our hearts to know best how to support all through whatever transitions life presents.

— **Lisa Dobberteen, MD, FAAP**

Advocating for Change

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and decides the Chapter's stand on all bills. The Legislative Committee can act upon a continuation of previously supported bills without the requirement for Executive Board approval, although the board is usually consulted and informed of such action. When a bill highly relevant to child health and/or the needs of our members requires urgent action, the Legislative Committee and the Executive Board are asked to comment via email and the president can make a decision on the Chapter's stand.

In the legislative session that just ended July 31, 2018, the Chapter was monitoring and had submitted testimony on 16 bills. Two of these — “An Act Modernizing Tobacco Control and

Protecting the Health of Minors” and “An Act Temporarily Preventing Firearm Access for Dangerous and Suicidal Individuals” — were signed into law. The other 14 bills (including bills lowering the lead action level, making sure adolescents have access to medically appropriate sex education, banning conversion therapy, developing a computerized immunization registry, creating emergency stock epinephrine supplies in schools, and promoting public health) did not make it into law this session.

Although the legislature will continue to meet in informal sessions and can take up bills by unanimous consent, it is highly unlikely that this will happen. So we will be back at it when the new legislative session starts! We look forward to another active session with



input from our members on legislation that will improve the lives of children and families. The Legislative Committee is open to all MCAAP members and is an excellent way to become involved in advocacy and learn about the legislative process. There are also opportunities for Chapter members to submit oral and written testimony under the auspices of the Chapter. For more information about the committee or process, please contact Cathleen Haggerty at chaggerty@mcaap.org. — **Elizabeth Goodman, MD, MBA**

Improve Children's Oral Health: Get Started with Fluoride Varnish in Your Clinic

Want to join many of your fellow pediatric providers in Massachusetts in improving child health? To date, more than 1,000 of the Commonwealth's pediatric providers have been trained to offer children fluoride varnish application in the pediatric and family medicine setting. Varnish application has been proven to reduce caries by 30–60 percent. The US Preventive Services Task Force gives fluoride varnish a level B recommendation — in fact, it is one of only three level A and B recommendations for one- to five-year-olds.

In Massachusetts, medical assistants and nurses can apply fluoride varnish. Some practices apply it just before giving vaccines; others apply it at the start of the clinical visit. Please consider performing this evidence-based, recommended, reimbursable service in your office. Call or email now to set up a free training for your entire office. If you have already been trained, we are happy to assist in addressing any barriers in fluoride varnish implementation in your office. Call or email Flor Piedrasanta, of DentaQuest, Outreach Coordinator/MassHealth Dental Program, at Flor.Piedrasanta@dentaquest.com or (617) 886-1797.

Any additional questions about children's oral health and integration into your practice? Contact

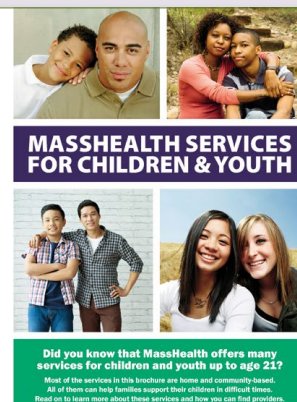
Michelle Dalal, MD, FAAP, Chapter Oral Health Advocate, at mdalal@mcaap.org. — **Michelle Dalal, MD, FAAP**



Download the New CBHI MassHealth Services for Children and Youth Brochure

MASSHEALTH PLAN CONTACT INFORMATION			
Health Plan Name	Customer Service Phone	Behavioral Health Phone	Website
Be Healthy Partnership	(800) 786-9999	(800) 495-0086	www.behealthypartnership.org
Berkshire Fallon Health Collaborative	(800) 786-9999	(888) 877-7184	www.fallonhealth.org/Berkshires
BMC HealthNet Plan	(888) 566-0010	(888) 217-3501	www.bmchp.org
BMC HealthNet Plan Community Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/community
BMC HealthNet Plan Mercy Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/mercy
BMC HealthNet Plan Signature Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/signature
BMC HealthNet Plan Southeast Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/southeast
Community Care Cooperative (C3)	(866) 678-9226	(800) 495-0086	www.c3aco.org
Fallon 365 Care	(855) 508-3390	(888) 877-7182	www.fallonhealth.org/365care
Partners HealthCare Choice	(800) 231-2722	(800) 495-0086	http://www.partners.org/for-patients/ACO/Partners-HealthCare-Choice-Medicaid.aspx
Primary Care Clinician (PCC) Plan	(800) 841-2900	(800) 495-0086	https://www.mass.gov/service-details/primary-care-clinician-pcc-plan-for-masshealth-members
My Care Family	(800) 462-5449	(800) 414-2820	www.mycarefamily.org
Steward Health Choice	(855) 860-4949	(800) 495-0086	www.stewardhealthchoice.org
Tufts Health Together	(888) 257-1985	(888) 257-1985	http://www.tuftshealthtogether.com
Tufts Health Together with Atrius Health	(888) 257-1985	(888) 257-1985	www.tuftshealthtogether.com/AtriusHealth
Tufts Health Together with BIDCO	(888) 257-1985	(888) 257-1985	www.tuftshealthtogether.com/BIDCO
Tufts Health Together with Boston Children's ACO	(888) 257-1985	(888) 257-1985	www.tuftshealthtogether.com/BCACO
Tufts Health Together with CHA	(888) 257-1985	(888) 257-1985	www.tuftshealthtogether.com/CHA
Wellforce Care Plan	(855) 508-4715	(888) 877-7183	www.fallonhealth.org/wellforce

CBHI-MH (Rev. 6/18)



MassHealth and the Children's Behavior Health Initiative recently announced the publication of the MassHealth Services for Children and Youth brochure that describes home- and community-based behavioral health services available to MassHealth-enrolled children and youth under the age of 21.

You may download or order the brochure on the CBHI Brochures and Companion Guide web page (www.mass.gov/masshealth-childrens-behavioral-health-initiative).

You may also call MassHealth Customer Service at (800) 841-2900 and request a brochure.

AAP/MCAAP Appointments, Chairs, and Expert Representatives

AAP/MCAAP Appointments

AAP BREASTFEEDING COORDINATOR

Susan Browne, MD
sbrowne@mcaap.org

CATCH CO-COORDINATOR

Anne Nugent, MD
anugent@mcaap.org

MMS DELEGATE/HOUSE OF DELEGATES

Lloyd Fisher, MD
lfisher@mcaap.org

PROS NETWORK COORDINATORS

David Norton, MD
dnorton@mcaap.org

Ben Scheindlin, MD
bscheindlin@mcaap.org

MCAAP Committees, Initiatives, and Task Forces

CHILDREN WITH SPECIAL HEALTH CARE NEEDS COMMITTEE

Judy Palfrey, MD, chair
jpalfrey@mcaap.org

CHILDREN'S MENTAL HEALTH TASK FORCE

Michael Yogman, MD
myogman@mcaap.org

Barry Sarvet, MD
bsarvet@mcaap.org

IMMIGRANT HEALTH COMMITTEE

Julia Koehler, MD
Julia.Koehler@childrens.harvard.edu

IMMUNIZATION INITIATIVE

Sean Palfrey, MD
spalfrey@mcaap.org

Richard Moriarty, MD
rmoriarty@mcaap.org

LEGISLATIVE COMMITTEE

Karen McAlmon, MD
kmcAlmon@mcaap.org

Brenda Anders Pring, MD
bpring@mcaap.org

MEDICAID ACO TASK FORCE

James Perrin, MD, chair
jperrin@mcaap.org

Greg Hagan, MD, co-chair
ghagan@mcaap.org

MEDICAL STUDENT COMMITTEE

Mallory Mandel
mmandel@mcaap.org

Liesel Matzka
lmatzka@mcaap.org

PEDIATRIC COUNCIL

Peter Rappo, MD
prappo@mcaap.org

SCHOOL HEALTH COMMITTEE

Lisa Dobberteen, MD
ldobberteen@mcaap.org

Karen Sadler, MD
ksadler@mcaap.org

SUSPECTED CHILD ABUSE AND NEGLECT

Stephen Boos, MD
sboos@mcaap.org

MCAAP Appointments and Expert Representatives

FETUS AND NEWBORN

Munish Gupta, MD
mgupta@mcaap.org

FORUM EDITOR

Lisa Dobberteen, MD
ldobberteen@mcaap.org

FOSTER CARE

Linda Sagor, MD
lsagor@mcaap.org

INJURY PREVENTION

Lois Lee, MD, MPH
llee@mcaap.org

Greg Parkinson, MD
gparkinson@mcaap.org

INTERNATIONAL CHILD HEALTH

Sheila Morehouse, MD
smorehouse@mcaap.org

David Norton, MD
dnorton@mcaap.org

ORAL HEALTH

Michelle Dalal, MD
mdalal@mcaap.org

Federal Court Orders FDA to Quickly Require Graphic Cigarette Warnings as Mandated by Law

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warnings rule for public comment, review of public comments, and issuance of final graphic warnings rule in accordance with the Tobacco Control Act.”

The rule is a major victory in the fight against tobacco use, the nation’s number one cause of preventable death. In accordance with the court’s order, we urge the FDA to quickly issue, finalize, and implement a rule requiring graphic cigarette warnings. The current US cigarette warnings, which are printed on the side of cigarette packs and haven’t been updated since 1984, are stale and unnoticed and are a major impediment to greater progress in reducing cigarette smoking. Studies around the world have shown that graphic warnings are most effective at informing consumers about the health risks of smoking, preventing children and other non-smokers from starting to smoke, and motivating smokers to quit. Requiring graphic cigarette warnings in the United States will protect kids, save lives, and reduce tobacco-related health care costs, which total \$170 billion a year.

The 2016 lawsuit was filed by the American Academy of Pediatrics, the Massachusetts Chapter of the American Academy of Pediatrics, the American Cancer Society, the American Cancer Society Cancer Action Network, the American Heart Association, the American Lung Association, the Campaign for Tobacco-Free Kids, Truth Initiative, and several individual pediatricians.

The plaintiffs have been represented by the legal staff of the Campaign for Tobacco-Free Kids and the Boston law firm of Anderson & Kreiger LLP.

Background

The 2009 Family Smoking Prevention and Tobacco Control Act required graphic warnings covering the top half of the front and back of cigarette packs and 20 percent of cigarette advertising and gave the FDA until June 22, 2011, to issue a final rule requiring such warnings. While the FDA met that deadline, the specific graphic warnings required by the FDA were struck down in August 2012 by a three-judge panel of the US Court of Appeals for the DC Circuit, which ruled 2-1 that the proposed warnings violated the First Amendment. That ruling only applied to the specific images proposed by the FDA and did not address the law’s underlying requirement.

Ruling in a separate case in March 2012, the US Court of Appeals for the Sixth Circuit upheld the law’s requirement for graphic warnings, finding that this provision did not violate the First Amendment. That court found the warnings “are reasonably related to the government’s interest in preventing consumer deception and are therefore constitutional.” The US Supreme Court declined to hear a tobacco industry appeal of this ruling.

Taken together, these two federal court decisions mean the FDA is still legally obligated to require graphic health warnings, and the agency is free to use different images than those struck down by the DC Circuit in 2012. The FDA stated in March 2013 that it planned to issue a new

rule requiring graphic warnings, but has yet to act.

The graphic warnings were mandated by a large, bipartisan majority of Congress, which relied on an extensive scientific record demonstrating the need for the warnings and their effectiveness. Because of this evidence, at least 122 countries now require large, graphic cigarette warnings.

The 2012 DC Circuit ruling striking down the FDA’s proposed warnings was based, in part, on the court’s judgment that the FDA had not provided sufficient evidence that graphic warnings would reduce the number of Americans who smoke. But the evidence of the public health benefits of graphic warnings has grown even stronger since that ruling. A 2013 study based on Canada’s experience with graphic warnings found that if the United States had implemented such warnings in 2012 as planned, the number of adult smokers would have decreased by 5.3–8.6 million in 2013.

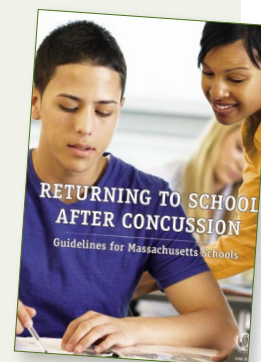
Tobacco use is the number one preventable cause of death in the United States, killing more than 480,000 Americans and costing about \$170 billion in health care expenses each year. — *The American Academy of Pediatrics, the Massachusetts Chapter of the American Academy of Pediatrics, the American Cancer Society, the American Cancer Society Cancer Action Network, the American Heart Association, the American Lung Association, the Campaign for Tobacco-Free Kids, and Truth Initiative*

Concussion Guidelines

The Massachusetts Department of Public Health has released a booklet entitled, “Returning to School after Concussion—Guidelines for Massachusetts Schools.” It provides guidance and tools for school staff — particularly teachers, guidance counselors, school nurses, and athletic trainers — and parents, as they support students in the “return to learn” process of returning to the classroom after a concussion. This booklet can also be a useful resource for pediatricians working with families dealing with concussion. It contains information about concussion identification, graduated reentry plans, and recommended activities and accommodations in the classroom as the student is recovering from concussion.

Booklets can be ordered free of charge at the Massachusetts Health Promotion Clearinghouse at <http://massclearinghouse.ehs.state.ma.us/INJ/IP2940.html>.

Or it can be downloaded at www.mass.gov/lists/returning-to-school-after-concussion-guidelines-for-massachusetts-schools.



ShotClock

2018–2019 Influenza Season Update

The Centers for Disease Control (CDC) published recommendations for the 2018–2019 influenza season in the August 24 issue of *Morbidity and Mortality Weekly Report* (MMWR): “Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2018–19 Influenza Season.” (www.cdc.gov/mmwr/volumes/67/rr/rr6703a1.htm)

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months who do not have contraindications. A licensed, recommended, and age-appropriate vaccine should be used. Vaccines that are expected to be available for the 2018–2019 season include the following:

- Inactivated influenza vaccines (IIVs)
- Trivalent and quadrivalent vaccines
- Egg-based, cell culture-based, and recombinant vaccines
- Adjuvant and unadjuvanted vaccines
- High-dose and standard-dose vaccines
- Recombinant influenza vaccine (RIV)
- Live attenuated influenza vaccine (LAIV)
- Intradermal vaccine will not be available

Standard-dose, unadjuvanted, inactivated influenza vaccines will be available in

quadrivalent (IIV4) and trivalent (IIV3) formulations. Recombinant influenza vaccine (RIV4) and live attenuated influenza vaccine (LAIV4) will be available in quadrivalent formulations. High-dose inactivated influenza vaccine (HD-IIV3) and adjuvanted inactivated influenza vaccine (aIIV3) will be available in trivalent formulations. The Advisory Committee on Immunization Practices (ACIP) does not express preference for any influenza vaccine product.

New and updated information in this report includes the following:

1. Vaccine viruses included in the 2018–19 US trivalent influenza vaccines will be an A/Michigan/45/2015 (H1N1)pdm09-like virus, an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus, and a B/Colorado/06/2017-like virus (Victoria lineage). Quadrivalent influenza vaccines will contain these three viruses and an additional influenza B vaccine virus, a B/Phuket/3073/2013-like virus (Yamagata lineage).
2. Recommendations for the use of LAIV4 (FluMist Quadrivalent) have been updated. Following two seasons (2016–17 and 2017–18) during which ACIP recommended that LAIV4 not be used for the 2018–19 season, vaccination providers may choose to administer any licensed, age-appropriate influenza vaccine (IIV, RIV4, or LAIV4). LAIV4 is an option for those for whom it is appropriate. *Editor's note: Continue reading for guidance from the AAP on use of LAIV4.*

3. Persons with a history of egg allergy of any severity may receive any licensed, recommended, and age-appropriate influenza vaccine (IIV, RIV4, or LAIV4). Additional recommendations concerning vaccination of egg-allergic persons are discussed in the report.
4. Information on recent licensures and labeling changes is discussed, including expansion of the age indication for Afluria Quadrivalent (IIV4) from ≥ 18 years to ≥ 5 years and expansion of the age indication for Fluarix Quadrivalent (IIV4), previously licensed for ≥ 3 years, to ≥ 6 months.

The recommendations also include dose volume for children aged 6 through 35 months, the influenza vaccine dosing algorithm for children aged 6 months through 8 years, guidance for specific populations and situations, and contraindications and precautions to the use of influenza vaccines.

AAP Guidance for the 2018–2019 Influenza Season: The American Academy of Pediatrics (AAP) recommends: “inactivated influenza vaccine (IIV3/4) as the primary choice for all children because the effectiveness of LAIV4 was (1) inferior against A/H1N1 during past seasons; and (2) is unknown against A/H1N1 for this upcoming season adding that LAIV4 may be offered for children who would not otherwise receive an influenza vaccine (and for whom it is appropriate by age and health status).”

Influenza Vaccine Information Statements (VISs) will be the same as for the 2017–2018 influenza season. The current influenza vaccine VISs can be found at www.cdc.gov/vaccines/hcp/vis/current-vis.html.

Influenza updates will be circulated as they become available throughout the 2018–2019 influenza season. — *MCAAP Immunization Initiative*

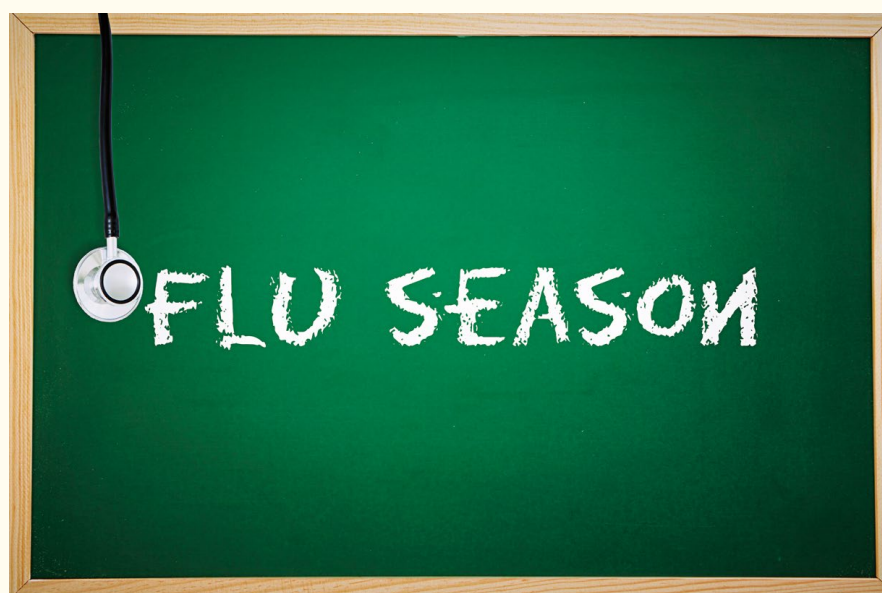
References

Prevention and control of seasonal influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices—United States, 2018–19 Influenza Season. *MMWR*. August 24, 2018; 67(3): 1–20. www.cdc.gov/mmwr/volumes/67/rr/rr6703a1.htm.

Recommendations for prevention and control of influenza in children, 2018–2019. *Pediatrics*. 2018; 142(4): e20182364

Update: ACIP Recommendations for the use of quadrivalent live attenuated influenza vaccine (LAIV4) — United States, 2018–19 Influenza Season. *MMWR*. June 8, 2018; 67(22): 643–645. www.cdc.gov/mmwr/volumes/67/wr/mm6722a5.htm.

AAP influenza recommendations revised for the 2018–2019 influenza season. *AAPNews*. June 7, 2018. www.aapublications.org/news/2018/06/07/influenza060718.



CDC Training Presentation: 10 Ways to Create a Culture of Immunization within Our Practice

Every pediatric practice staff member, including nonclinical staff, plays an important role in supporting parents in their vaccine decisions. The Centers for Disease Control and Prevention has developed a presentation, "10 Ways to Create a Culture of Immunization Within Our Pediatric Practice." The presentation is intended for use by physicians or vaccine coordinators during staff meetings or lunch-and-learn presentations. It includes concrete ways that your practice can create a culture of immunization during a well-child visit, from check-in to check-out. It also can be easily customized with practice-specific information.

The presentation was developed based on formative research, informed by risk communication principles, and reviewed extensively by subject matter experts. It can be downloaded at www.cdc.gov/vaccines/partners/downloads/creating-culture-of-IZ-in-your-practice-508.pptx.

— MCAAP Immunization Initiative

10 Ways to Create a Culture of Immunization in Your Practice

1. Make parents aware of your immunization philosophy and policy.
2. Keep up-to-date on current CDC vaccine recommendations.
3. Make clinical resources readily available to staff.
4. Assess a child's immunization status at every visit.
5. Give strong recommendations for immunization.
6. Help parents feel supported by welcoming questions and knowing how to answer them.
7. Give Vaccine Information Statements (VISs) and handouts to answer specific questions.
8. Make immunization resources easy for parents to find.
9. Schedule follow-up immunization appointments before the child leaves the office.
10. Remind parents about upcoming immunization appointments and contact those who miss appointments.

www.cdc.gov/vaccines/partners/downloads/creating-culture-of-IZ-in-your-practice-508.pptx

Upcoming Immunization Initiative Webinars

The fall 2018 Immunization Initiative Webinar Series is well underway. You can still register for the following upcoming webinars:

Thursday, November 15, 2018,

12:00–1:00 p.m.

2018–2019 Influenza Season Update; MDPH Vaccine Update

Susan Lett, MD, MPH, medical director, MDPH Immunization Program

Learning Objectives

As a result of participating in this program, learners should be able to:

- Review the Advisory Committee on Immunization Practices (ACIP) recommendations for the 2018–2019 influenza season
- Describe the latest MDPH information about vaccine availability and shortages, as well as programmatic updates

Thursday, December 13, 2018,

12:00–1:00 p.m.

The 2016 Massachusetts Mumps Outbreak: Understanding Why Mumps Spread Among Vaccinated Individuals

Larry Madoff, MD, director, Division of Epidemiology and Immunization, Massachusetts Department of Public Health

Learning Objectives

As a result of participating in this program, learners should be able to:

- Review the 2016 Massachusetts mumps outbreak
- Describe research efforts to assist public health investigations of mumps outbreak
- Discuss the rationale for the recent CDC recommendation for use of a third dose of mumps vaccine in persons at increased risk for mumps during an outbreak



Continuing Education Accreditation

The Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Public Health is accredited by the Massachusetts Medical Society to provide continuing medical education for physicians.

The Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Public Health, designates these Live web-based activities for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should

JOIN THE IMMUNIZATION INITIATIVE

The Immunization Initiative Welcomes New Members!

By participating you can:

- Stay current on state and national infectious disease and immunization information
- Network with colleagues interested in promoting vaccination
- Advocate for legislative and regulatory policies that optimize the immunization of Massachusetts children and adolescents
- Learn strategies to improve vaccination rates in your practice and larger community

Please contact Cynthia McReynolds (cmcreynolds@mms.org) for more information.

claim only the credit commensurate with the extent of their participation in the activity.

Certain webinars offered meet the criteria of the MA Board of Registration in Medicine for Risk Management study. The webinars which qualify for 1.0 RM credits are noted.

This program has been offered by the Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Public Health. A maximum of 1.0 contact hours for each program will be provided in accordance with the regulations governing continuing education requirements for the following Boards of Registration:

Board of Registration in Nursing (CMR 244 5.00), Board of Registration of Social Workers (258CMR 31.00et seq), Board of Mental Health Professions (262CMR 7.00), Board of Certification of Health Officers (241CMR 4.03), Board of Registration of Sanitarians (255CMR 5.02).

Pharmacists may receive up to 1.0 AMA PRA Category 1 Credit™ in accordance with 247CMR 4.00.

Visit www.mcaap.org/immunization-cme/ #upcoming for more information about the webinar series and to register for these webinars. — **MCAAP Immunization Initiative**

Vaccine Confidence Project Update

The MCAAP Immunization Initiative and the MDPH Immunization Program have been collaborating on a vaccine confidence project focused on increasing vaccine confidence across Massachusetts. We are currently targeting Western Massachusetts as one area susceptible to vaccine-preventable diseases as a result of higher than state average school exemption rates. You can find more information about school immunization and exemption rates on MDPH's School Immunizations web page: www.mass.gov/service-details/school-immunizations.

The overall project goal is to develop a vaccine confidence module that we will bring back to the region training for health care

professionals as well as future outreach to the general public. Our initial step was to meet with key constituencies about common concerns and issues specific to Western Massachusetts. In May, meetings were held in Holyoke and Pittsfield with providers, local public health, school nurses, parent advocates, nonprofit organizations, and other partners interested in increasing vaccine confidence.

Project updates will be communicated as they become available through the Immunization Initiative monthly e-newsletter and *The Forum*. If you are interested in participating in this project or would like additional information, please contact Cynthia McReynolds, program manager, MCAAP Immunization Initiative, at cmcreynolds@mms.org or (781) 895-9850; or Rebecca Vanucci, immunization outreach coordinator, MDPH Immunization Program, at rebecca.vanucci@state.ma.us at (617) 983-6534. — **Cynthia McReynolds, MBA, program manager, MCAAP Immunization Initiative; and Rebecca Vanucci, MA, immunization outreach coordinator, MDPH Immunization Program**

Upcoming Immunization Conferences and Meetings

Grand Rounds Seminar

October 11, 2018, 12:30–1:30 p.m.
Cambridge Health Alliance, Cambridge
Presenter: Ronald Samuels, MD, MPH, FAAP

For more information, please contact Cynthia McReynolds at cmcreynolds@mms.org.

23rd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

October 18, 2018, 9:00 a.m.–4:00 p.m.
Sheraton Framingham Hotel and Conference Center, Framingham
On-site registration is available. The on-site registration fee is \$100

For more information, visit www.mcaap.org/immunization-cme.

Massachusetts HPV Coalition Meeting

October 18, 2018, 4:15–5:45 p.m.
This meeting will immediately follow the 23rd Annual MIAP Pediatric Immunization Skills Building Conference.

For more information, contact Cynthia McReynolds at cmcreynolds@mms.org.

Advisory Committee on Immunization Practices (ACIP) Meeting

October 24–25, 2018
Atlanta, Georgia
ACIP meetings are open to the public (in-person, and by telephone/webinar). Pre-registration is required.

For more information, visit www.cdc.gov/vaccines/acip/index.html.

Grand Rounds Seminar

October 26, 2018, 8:00–9:00 a.m.
UMass/Memorial Healthcare, Worcester
Presenter: Richard Moriarty, MD, FAAP

For more information, please contact Cynthia McReynolds at cmcreynolds@mms.org.

MCAAP Immunization Initiative Webinar Series

November 15, 2018, noon–1:00 p.m.
2018–2019 Influenza Season Update; MDPH Vaccine Update
Presenter: Susan Lett, MD, MPH

For more information, visit www.mcaap.org/immunization-cme.

6th Annual HPV-Related Cancer Summit

November 30, 2018, 8:00 a.m.–3:00 p.m.
Courtyard Marriott, Marlboro

For more information, email Kelly@TeamMaureen.org.

National Influenza Vaccination Week (NIVW)

December 2–8, 2018

For more information, visit www.cdc.gov/flu/resource-center/nivw/index.htm.

Grand Rounds Seminar

December 3, 2018, noon–1:00 p.m.
Winchester Hospital, Winchester
Presenter: Richard Moriarty, MD, FAAP

For more information, please contact Cynthia McReynolds at cmcreynolds@mms.org.

MCAAP Immunization Initiative Webinar Series

December 13, 2018, noon–1:00 p.m.

*The 2016 Massachusetts Mumps Outbreak:
Understanding Why Mumps Spread Among
Vaccinated Individuals*

Presenter: Larry Madoff, MD

For more information, visit www.mcaap.org/immunization-cme.**Advisory Committee on Immunization Practices
(ACIP) Meeting**

February 27–28, 2019

Atlanta, Georgia

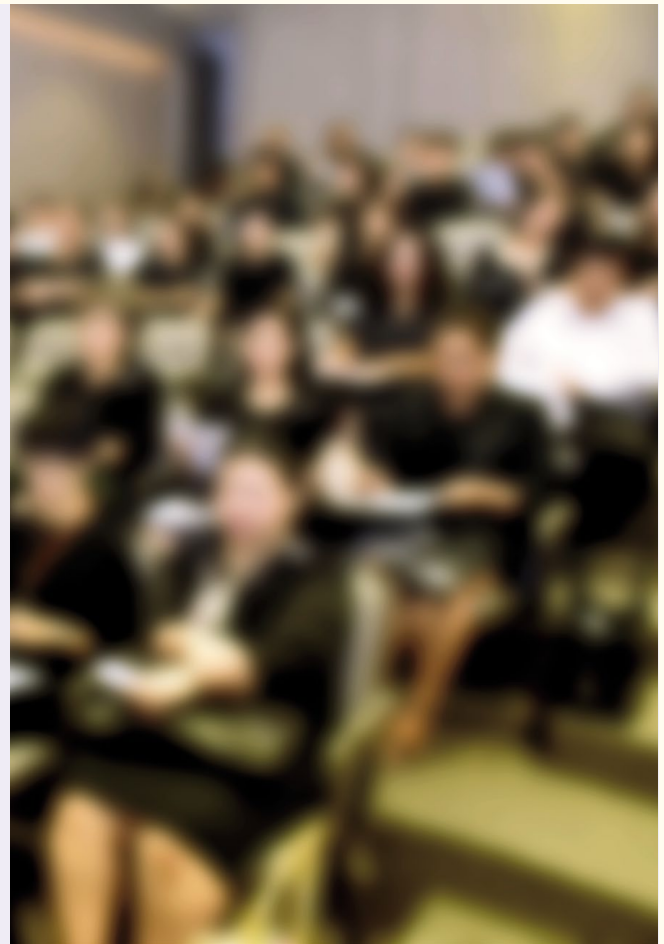
ACIP meetings are open to the public (in-person, and by
telephone/webinar). Pre-registration is required.For more information, visit www.cdc.gov/vaccines/acip/index.html.**Massachusetts Vaccine Purchasing Advisory Council
(MVPAC) Meeting**

March 14, 2019, 4:00–6:00 p.m.

Massachusetts Medical Society, Waltham

For more information, visit [www.mass.gov/eohhs/gov/departments/dph/programs/
id/immunization/mvpac.html](http://www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/mvpac.html).**Massachusetts Adult Immunization Conference**

April 2, 2019, 9:00 a.m.–4:00 p.m.

Sheraton Framingham Hotel and Conference Center,
FraminghamFor more information, visit <https://maic.jsi.com>.

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Childhood Vision Screening in the Medical Home

Clear vision influences a child's early neurologic, cognitive and physical development and overall ability to function optimally.¹ Although a vision disorder can start at any stage of childhood or adolescence, a young child's eyes must send clear images to the brain for normal vision to develop. Conditions such as congenital cataracts or amblyopia have a narrow window of opportunity in which to treat effectively or permanent vision loss can occur.

Early identification through vision screening in the medical home and immediate referral to an optometrist or ophthalmologist,² with confirmation of care, is critical. Vision impairment can occur without being obvious to a parent/caregiver, and is typically not articulated by the child. The pediatrician, with regular

and early access to the child and parent, is in a unique position to identify and intervene when a vision disorder exists.

Vision screenings are recommended throughout childhood as noted in joint guidelines^{2,3} issued by the American Academy of Pediatrics, the American Association of Certified Orthoptists, the American Association for Pediatric Ophthalmology, and the American Academy of Ophthalmology, and they are required by insurers such as Medicaid.⁴ Vision screening protocols and referral criteria are described in the joint guidelines,³ with intervals listed in the Bright Futures Periodicity Schedule, 2017.⁵ The Massachusetts Department of Public Health (MDPH) updated their protocol for

vision screening in 2016.⁶ Refer to these documents for full clinical protocols.

Instrument-based screening: Photo-screeners and auto-refractors provide information about amblyopia risk factors, such as estimates of abnormal refractive errors and eye misalignment, but do not measure visual acuity. The MDPH accepts pediatrician screening results for 1- and 2-year-old children, and it allows these devices to replace Visual Acuity and Stereopsis tests for 3-, 4-, and 5-year-olds. Instrument-based devices may increase testability in 3-, 4-, and 5-year-olds⁷ but are not approved for use in children 6 years and older unless the child cannot participate in optotype-based screening.^{2,6}

Table 1: Recommended Vision Assessment and Screening Intervals in the Medical Home

Age of Child	Type of Test	Interval
Newborn through 12 months old	Visual risk assessment (ocular history, assessment of the eyes, lids, ocular motility and alignment, pupils, and red reflex) ³	Birth, 3–5 days, 1, 2, 4, 6, and 9 months ⁵
1 and 2 years old	Visual risk assessment (as above) ³ Instrument-based ³	12, 15, 18, 24, and 30 months ⁵ Annually from 12 months ³
3 through 5 years old	Instrument-based ^{3,6} <i>or</i> 1. Visual Acuity Optotype (LEA SYMBOLS™ or HOTV letters wall chart or flip cards [MassVAT]) ^{3,6} <i>and</i> 2. Stereopsis ⁶	Annually ^{5,6} Annually ^{5,6}
6 through 9 years old and any child of any age entering a MA school from outside the state (if no evidence of vision screening or eye exam)	1. Visual Acuity Optotype • Distance ⁶ (Wall Sloan letter Chart preferred) ³ <i>and</i> • Near ⁶ (Near Sloan letter card preferred) ³ <i>and</i> 2. Stereopsis ⁶	Annually ⁶ Annually ⁶
10 and 11 years old	Visual Acuity Optotype • Distance ⁶ (Wall Sloan letter Chart preferred) ³ <i>and</i> • Near ⁶ (Near Sloan letter card preferred) ³	Annually ⁶
12 through 14 years old	Visual Acuity Optotype • Distance and near ⁶ (as above)	Once ⁶
15 through 18 years old	Visual Acuity Optotype • Distance and near ⁶ (as above)	Once ⁶

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Childhood Vision Screening in the Medical Home

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Optotype screening: This directly measures visual acuity and is recommended when children can reliably name letter optotypes.³ Vision screening should be conducted in a quiet area with lighting levels equal to those in an examination room.

The joint guidelines³ no longer recommend these eye charts:

- Allen figures
- Lighthouse characters
- Sailboat chart
- Landolt C
- Tumbling E (approved for use by MDPH)

The use of an age-appropriate, validated screening test, and applying the technology and/or screening distance correctly will help to ensure accurate vision screening results. Screening personnel must be trained to avoid inaccurate procedures (e.g., pointing to a single optotype, inappropriate lighting, a child peeking). Vision screening training for all personnel can be obtained at BU-SHIELD⁸ or Prevent Blindness.⁹

Some children are at significantly higher risk for visual impairment and should be referred to an eye professional experienced in treating children regardless of screening outcome.^{2,10,11}

- Preterm infants, low birth weight, oxygen at birth, grade III or IV intraventricular hemorrhage
- Newborns with a family history of retinoblastoma, congenital cataracts, or metabolic disease, or in whom systemic disease associated with ocular abnormalities is suspected
- Mother smoking during pregnancy
- Infection of mother during pregnancy (e.g., rubella, toxoplasmosis, venereal disease, herpes, cytomegalovirus, or AIDS)
- Readily observable ocular abnormalities (e.g., photophobia, ptosis, unequal pupil size, excessive watering)
- A first-degree relative with amblyopia, high refractive error, strabismus, or anisometropia
- Known or suspected central nervous system dysfunction evidenced by developmental delay (hearing or

Table 2: Recommended Vision Assessment and Screening Intervals in the Medical Home

Age	Milestone
1 month	Focusing on and following slowly moving near objects or lights
2 to 3 months	Stable eye contact Awareness of hands Following moving lights, faces, and people Social smile
3 to 4 months	Watching hands Reaching and grasping objects Bringing objects to midline or mouth Moving eyes from person to person or object to object
5 months	Eyes appear straight constantly
6 to 7 months	Goal-directed reaching and following
8 to 10 months	Recognizing family member faces with a smile Looking at small objects such as cereal or raisin
11 to 12 months	Interest in books and/or pointing to things in books Looking for objects dropped into containers

cognitive impairment, speech delay, autism spectrum disorders, motor abnormalities, cerebral palsy, dysmorphic features, seizures, or hydrocephalus)

- Children using medications with side effects of a vision disorder
- Children who are untestable or who do not pass a vision screening

Lack of attainment of developmental milestones during a baby's first year may be an early indicator of a vision disorder.¹²

In addition to the family history and past health history of the child, the pediatrician can observe the child while performing other routine assessments. **Behavioral symptoms that may indicate a vision disorder** in a preschooler¹³ include:

- Body rigid, or thrusting head forward or backward when looking at distant objects
- Tilting head/head-turning
- Squinting/frowning or excessive blinking
- Easily distractible/unable to focus or maintain attention
- Avoidance of eye contact
- Wants to be carried by parent continuously

A visit to the pediatrician is a chance for the parent to discuss the child's progress. If the child has difficulty learning or reading,¹⁴ is enrolled in Early Intervention or Special Education, or has an Individualized Educational Program plan at school, a vision disorder could be a contributing factor and a comprehensive eye examination should be part of the evaluation

process. Additionally, **a parent may describe a concern regarding his or her child** that could be vision-related:

- Frequent headaches or nausea/dizziness
- Closing one eye when doing near work, or holding books close
- Difficulty coordinating hand/eye movements
- Clumsiness
- Sitting close to TV
- Avoidance or dislike of school work or of sports/games
- Poor social or behavioral interaction

The well-child visit is another opportunity to check if a comprehensive eye examination was completed following referral from a vision screening. Parents and caregivers may not understand their next step, the consequences of delayed evaluation, or the necessity for continued treatment. Treatment plans can be reinforced and supported.

Untreated vision disorders affect up to 6% of preschoolers and about 20% of school age children in the United States.¹⁵ Vision screening in the medical home is not only effective in early detection of severe vision disorders like amblyopia and its risk factors,¹⁶ it enables pediatricians to work closely with families to ensure referred children have consistent comprehensive eye care. — **Paulette Tattersall**

Paulette Tattersall is the director of Prevent Blindness in the northeast region and co-chair of Children's Vision Massachusetts (CVMA). CVMA is an 80-member

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Childhood Vision Screening in the Medical Home

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coalition representing ophthalmology, optometry, nursing, pediatrics, public health, family practice, education, and parents. The coalition's mission is to create a systematic approach to children's vision services in Massachusetts to support early detection, diagnosis and treatment of vision problems in children.

Editor's note: As a parent, I experienced first-hand the value of early detection and treatment for vision problems. One of my children had significant amblyopia, and now fortunately has near perfect vision.

The author acknowledges the contributions of the following colleagues: Kira Baldonado, vice president, Public Health and Policy, Prevent Blindness; Kay Nottingham Chaplin, EdD, education and outreach coordinator, National Center for Children's Vision and Eye Health at Prevent Blindness, and director of Vision and Eye Health Initiatives for Good-Lite and School Health Corporation; and Bruce Moore, OD, professor emeritus, New England College of Optometry, and co-chair, CVMA.

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⁹Prevent Blindness. Vision Screening Certification. www.preventblindness.org/prevent-blindness-childrens-vision-screening-certification-course.

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