

# THE FLORIDA PEDIATRICIAN

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The Florida Pediatric Society is the Florida Chapter  
of the American Academy of Pediatrics

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™



*Staring Early—Jake at age 2 years old by Allen Liberato*

# CONTENTS & CME

- 2 Continuing Medical Education (CME)
- 4 President's Message
- 5 Editor's Page
- 8 Chairperson
- 10 Committee Reports
- 12 Medical Student Section
- 14 Advocacy
- 14 Photo Op!
- 16 Scientific Update
- 22 Physician Heal Thyself
- 32 Spotlight!
- 34 CME continued
- 35 Who's Who?

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## **Practical Pediatrics CME Course**

Lake Tahoe, CA  
Resort @ Squaw Creek  
Jan 29—Feb 1, 2009  
Maximum 17.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Protecting Our Next Generation, 0—3**

Ft. Lauderdale, FL  
Renaissance Ft. Lauderdale—Plantation Hotel  
Nova Southeastern University  
Jan 30—31, 2009  
Maximum 12 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

For more, please visit [http://www.medicine.nova.edu/ce/protecting\\_generation.html](http://www.medicine.nova.edu/ce/protecting_generation.html)

***Please read further details regarding this wonderful CME -  
located on page 35 of this issue!***

## **Future of Pediatrics Conference: Quality Care for All Children**

Anaheim, CA  
Anaheim Marriott  
Feb 27—Mar1, 2009  
Maximum 18 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **3rd International Meeting on Indigenous Child Health: Many Voices into One Song**

Albuquerque, NM  
The Hotel Albuquerque at Oldtown  
Mar 6—8, 2009  
Maximum 13 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Uniformed Services Pediatric Seminar**

Indianapolis, IN  
Hyatt Regency Indianapolis  
Mar 8—11, 2009  
Maximum 24.75 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Practical Pediatrics CME Course**

Orlando, FL  
Hilton in the Walt Disney World Resort  
Mar 9—11, 2009  
Maximum 17.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

# CONTINUING MEDICAL EDUCATION

## **PREP The Course**

Savannah, GA  
Hyatt Regency Savannah  
Mar 21 - 25, 2009  
Maximum 37.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Practical Pediatrics CME Course**

Providence, RI  
Westin Providence  
Apr 2–4, 2009  
Maximum 17.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Workshop on Perinatal Practice Strategies 2009:**

### **The Lightbulb Moment:**

### **Embedding Innovation in Practice**

Pointe Hilton Squaw Peak Resort  
Apr 3–5, 2009  
Maximum 15.5 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Practical Pediatrics CME Course**

Seattle, WA  
Sheraton Seattle Hotel & Towers  
May 14–16, 2009  
Maximum 17.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **Practical Pediatrics CME Course**

Hilton Head Island, SC  
Hilton Head Marriott  
May 21–23, 2009  
Maximum 17.25 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>

## **PREP The Course**

Cincinnati, OH  
Millennium Hotel Cincinnati  
Jun 13–17, 2009  
Maximum 37.25 *AMA PRA Category*

For more, please visit <http://www.pedialink.org/cme>

## **Editor's Request:**

Please contribute to the Newsletter. You, the member, are a vital part of the process for helping the Newsletter become an excellent resource tool and vehicle of unification for the entire Florida Pediatric Society. Subject matter need not only be scientific. I strongly encourage you to submit articles and artwork of a personal nature. Contribute well and contribute as often as you like.

## **Deadlines for Artwork & Articles!**

Scanned artwork, photography, or other digital artwork are accepted in jpeg, bmp, & pdf format. Please submit all articles and artwork for the next issue of The Florida Pediatrician by February 28., 2009.

# PRESIDENT'S MESSAGE



## Healthcare for Children – Changes Coming Jerry Isaac, MD, FAAP

Candidate Barak Obama promised change if he was elected. One of those changes we are sure to see will be in children's healthcare. We need to prepare for those changes now so his plans are instituted in a way that will get the best results for children. I remember the last time we had a major expansion in children's healthcare; it was the SCHIP program in 1997. It offered government subsidized health insurance to children whose families earned a little too much for Medicaid eligibility. We were told that the program needed to be implemented immediately. There was no time to create a new

structure so the legislature basically put all these children into Medicaid style HMOs. Let's have a better outcome this time.

One of the first items of business for the new Congress in January will undoubtedly be an expansion of the SCHIP program to families with higher incomes. It passed both Houses of Congress this year, but was vetoed by President Bush. He thought more children would be dropped from private insurance and go into the government plan. President Obama will certainly sign the bill. Therefore, we need to let our legislators know how we feel this expanded insurance coverage should be organized in order to best serve children.

The "Obama Plan" promises universal healthcare for children. Considering our current economic problems, it is hard to predict exactly when this will come about. If and when it does, we want this plan to follow the medical home model as outlined by the American Academy of Pediatrics. We feel that this provides the best and most cost effective way to provide medical care for children. New insurance money should not go for more unnecessary and fragmented ER, walk-in clinic and retail based clinic visits. We want more comprehensive and preventative care in a pediatrician's office.

The way the plan is currently structured, health coverage for children will be mandatory. Employers with over 50 employees will either have to "play or pay". If they do not have their own plan, there will be a payroll tax to subsidize government coverage for those children. All children will be guaranteed that they can be covered by the plan regardless of any pre-existing medical conditions. It will be portable so there will be no loss of coverage if the parents change jobs. There will be a national plan that parents can buy into, if they are working for small employers. The premium will be subsidized by the government according to a parent's income.

I am setting up a committee of our legislative and healthcare policy experts to plan our response to this initiative. They will work with our legislature, the AAP, insurance carriers and other interested parties to help insure that if and when the new President's plan gets enacted, it will be implemented in the way we all would like to see.

Significant alterations in the mental health system for children are also coming. A report was presented to the legislature this year outlining the current state of affairs in the criminal justice system in Florida. It indicated that providing more

appropriate pediatric psychiatric care has the potential for large monetary savings in the criminal justice system. Incarceration has become the default treatment for a great number of young people with mental health problems who get into trouble. Unfortunately, this is the most expensive way to not treat the problem. These young people need to have their mental health problems dealt with at an earlier stage in a medical setting.

Up to now cost has been a great deterrent to receiving appropriate psychiatric services because that type of treatment was not covered by insurance plans the same way physical illness was. However, this too is about to change. Mental health parity has recently been enacted into law. This applies to large employer insurance plans. We need to start to work now on how this will be implemented. Do we have enough Pediatric Psychiatrists in Florida to handle the increase in mental health services that will be needed? How can pediatricians and psychiatrists work together to make sure that the workload is distributed appropriately? I have consulted with Chairman Bucciarelli of the Department of Pediatrics in Gainesville and he is working with his psychiatric staff to give us input into how this can best be approached.

We are entering an era with the potential for major improvements in children's healthcare and we must prepare for the initiatives that we know are coming. As experts in pediatric healthcare, we can help to formulate a plan that will lead to real advances in the health of the children of Florida.

I want to extend my best wishes for a happy and a healthy New Year to all of our members and a tremendous thank you for supporting the efforts of our Chapter.



Friends and Colleagues,

**Yes, We Can!**

This is an exciting time in the history of the United States of America. Positive energy is in the air. We have the first African-

American President. Many have said they never believed this day would come. Others knew it would; they just didn't it would happen in their lifetime.

I'm filled with hope for our country. We have a leader that has inspired many to be more than what we have been. United efforts for change are crucial for this great country's future. Healthcare for all children is still one of our main goals. I believe this will happen sooner than we think.

Much hard work will be required. We will need to make concerted efforts involving letter writing, phone calls, and possibly meeting with our leaders to help facilitate an promise of hope and a new era of change for our children. Are you up for the challenge? Do you believe? The more we say it, the more we feel it, the more it will happen. Yes, we can!

We all have a voice, waiting to be heard. So speak up. Share. Someone is listening.

Sincerely,



**Nancy M. Silva, MD, FAAP**  
**Editor**

# CHAIRPERSON: SEBASTIAN FERRERO FDTN



## University of Florida Gainesville

**Richard L. Bucciarelli, MD,  
FAAP**

Department of Pediatrics  
Professor and Interim Chair

On October 8, 2007 the unspeakable occurred in the Department of Pediatrics at the University of Florida. Due to several serious systems errors, we administered a lethal dose of IV Arginine, during a routine outpatient test, to Sebastian Ferrero, a bright and healthy three year old that was deeply loved by his family and friends. Following his death, his parents, Horst and Luisa, recognizing that nothing could possibly replace their loss, pledged to honor their son by partnering with the University of Florida College Of Medicine to develop a nationally recognized, comprehensive safety program. In addition they created the Sebastian Ferrero Foundation to promote

safety in the health care arena and to raise funds to build a children's hospital in Gainesville.

What has happened in the last 12 months? An Office of Clinical Quality and Safety has been established at the University of Florida Health Science Center, named after Sebastian Ferrero. A task force was created to develop a four year patient safety curriculum for medical students and residents.



*Sebastian Ferrero*

The College of Medicine initiated a program of funding intramural Clinical Quality Education Grants promoting faculty and resident research to develop approaches to improve the quality and safety of care. A special session on quality and safety will be added to this year's College of Medicine's annual Research Day program. On October 29<sup>th</sup>, a little over a year after Sebastian's death, Horst and

Luisa addressed the freshman class as they began the newly established safety curriculum for medical students. Most of the faculty and residents of the Department of Pediatrics attended as well. After describing the horrible chain of events which led to Sebastian's death, Horst asked the audience to remember five points, good lessons for all of us:

- Treat every patient with compassion, courtesy and dignity
- Give every patient the time an attention they deserve
- Listen to parents. They know their children better than anyone
- Work as a team with you colleagues and staff. Patient safety is everybody's responsibility
- Don't assume others have checked (for errors), double-checking can save lives

So what about the free standing children's hospital, a dream of ours for over 40 years? The Foundation has led a high visibility public awareness campaign in Gainesville. These efforts resulted in several articles regarding a children's hospital in the media with 6 appearing in the last three weeks. This campaign has been galvanized the community in

# CHAIRPERSON: SEBASTIAN FERRERO FDTN

support of a children's hospital in Gainesville. Every pediatrician in the area signed on to full page letter in the Sun pledging support of the effort. Before October 8, 2007, many of our influential community leaders probably didn't even know that there was a children's hospital within Shands at UF. Now they are pledging their financial and emotional support as advocates for profound changes in safety and deliver of pediatric care

contributions/pledges received, in less than one year, exceed \$650,000. To make things even better, the Ferrero's pledged to match the first \$1M raised with a \$1M of their personal funds. The rapid success of the Foundation is testimony to the support and respect the Gainesville community has for Ferrero family and testimony to the community's desire to build a children's hospital. .

but community support has moved this idea from a faculty dream to a community dialogue. The greatest hurdle is to obtain approval for a free standing children's hospital from Shands HealthCare Board of Directors and from the University's Board of Trustees, a task far more difficult that it would seem to be based on the degree of community support, but this too will come in time.

On November 20, 2008 a Gala fund raiser held by the Foundation resulted in cash donations in excess of \$330,000! In addition, the foundation has raised \$120,000 from personal appeals and has \$200,000 in pledges. Thus total

There are still several mountains to climb. We will need to raise at least \$100 Million in an ugly economy, but the economy will recover soon. There are many competing agendas within the University and Shands HealthCare,

So, out of tragedy comes hopes and dreams. Out of a great loss comes the potential for great gains. I have served on many boards during my career, but there is none which moves me more than working with the Sebastian Ferrero Foundation on our mutual dreams.



# CHAIRPERSON



## **Orlando Regional Healthcare/Arnold Palmer Hospital for Children**

**Joan Y. Meek, MD, MS, RD,  
IBCLC, FAAP, FABM**

Academic Chairman and  
Residency Director

The Pediatric Emergency Medicine Fellowship Program has been approved by the ACGME. Dr. Jose Ramirez has been named the fellowship director. One of the first fellows in the program will be Dr. Efren Salinero, PL-3, Arnold Palmer Hospital.

Drs. Vinny Chulani and Eva Desrosiers have led a team of faculty, residents, and community partners in developing a new resident rotation in Pediatric Community Advocacy. This resident rotation will be in collaboration with the Parramore Kidz Zone (PKZ), which is

modeled after the well-known Harlem Children's Zone in New York City. PKZ aims to lower teenage pregnancy, juvenile crime and child abuse rates and improve school performance among children in the Parramore neighborhood through the provision of quality early childhood education, after school programs, programs that build family economic success, youth development programs for teenagers, access to health care, and mentoring. Residents will be engaged with community agencies to provide education and guidance on medical issues. Dr. Chulani serves as a resource for the PKZ project on medical matters and was recently engaged in negotiations to provide direct clinical and preventive services in the community through Teen Xpress, the adolescent mobile health unit in Orange County. Dr. Desrosiers applied for the Leonard P. Rome CATCH Visiting Professorships Program in conjunction with our Community Pediatrics Advocacy project. Our visiting professorship was awarded and will be used as a kick off for the community rotation, which will be a collaborative partnership with the Parramore Kidz Zone (PKZ) and the city of Orlando. Dr. Tom Tonniges will be our Visiting Professor in March 2009.

Dr. Chulani has partnered with the Orange County Office for a Drug

Free Community in developing an educational campaign targeting prescription drug use and misuse by teenagers. In addition, Dr. Chulani continues to partner with the University of Central Florida, Office of Alcohol and other Programming in developing educational programs for pediatric residents on substance abuse identification, treatment and prevention.

Dr. Nicole Cameron, PL-3, submitted a grant application and was awarded a Julius B. Richmond American Academic of Pediatrics/FAMRI Visiting Lectureship Program Award. There were only 4 applications accepted nationwide, and Orlando Health, Arnold Palmer Hospital was selected. The goal of this award is to provide training for attending physicians, community physicians, residents, and medical students on the topic of tobacco prevention and control. These goals are consistent with the Orlando Health Tobacco Free Campus and other statewide initiative on making Florida tobacco free. Dr. Cameron received a letter of congratulation from the AAP and from the leadership of the Florida Chapter of the AAP. This visiting lectureship will be completed in 2009.

Dr. Janice Howell serves on the multidisciplinary committee for asthma care at APH. She also

# CHAIRPERSON

chairs the Asthma Education Curriculum Development Committee and has been instrumental in developing a comprehensive asthma education course which has been presented at APH to physicians, residents, and support staff. This course is designed to improve patient care and help assure compliance with the asthma core measures. Dr. Howell serves as a moderator and faculty for each course, which provides 12-14 contact hours for respiratory therapists and nurses, as well as CME for physicians. In addition, Dr. Howell and the Medical Education General Academic Pediatrics faculty continue the collaboration with the APH Pharmacy Team, in which the Pharm.D.s (William Maish and Heidi Smith-Hoopingarner) provide a comprehensive Asthma Education Program for both resident training and patient education.

Drs. Anita Moorjani and Odett Stanley-Brown have incorporated the M-CHAT screening for childhood autism and the Ages and Stages Developmental Screening questionnaires to improve the identification of children with autism and other developmental delays for patients followed in the Arnold Palmer Hospital Pediatric Faculty Practice and resident continuity clinics. Drs. Moorjani

and Stanley-Brown conducted training seminars for both faculty and pediatric residents.

Dr. Colleen Moran-Bano serves as the general pediatric representative to the multidisciplinary craniofacial team, directed by Dr. Ramon Ruiz, the craniomaxillofacial surgeon. This experience has been incorporated into the Developmental and Behavioral Pediatrics rotation for the pediatric residents.

We have developed a research curriculum, directed by Drs. Robert Sutphin, Maricor Grio, and Jessica Roberson, all former Arnold Palmer Hospital Residents, who have completed their fellowship training at other institutions and returned in faculty positions in their subspecialty disciplines of Pediatric Hematology/Oncology (Sutphin, Roberson) and Nephrology (Grio). Dr. Sutphin has served as the faculty mentor for several pediatric residents in their research projects.

Dr. John Tilelli, Pediatric Intensive Care, serves as the faculty leader for the Pediatric Departmental Professor Rounds, a clinicopathological conference, in which a case is summarized by a pediatric resident and then discussed by pediatric faculty, subspecialists, and consultants, with pediatric radiology and

pathology participation. This conference has been very popular among our faculty and residents.

We have added new sites for pediatric residents to rotate for their community rotations. These include the Pine Hills Family Health Center, under the direction of Drs. Debra Andree and Anabella Torres, both former Arnold Palmer Hospital residents. In addition, Dr. Joseph Savona also serves as a faculty preceptor for a community rotation in his private practice office.

We had 141 attendees at our recent Care of the Sick Child Conference held November 12-15 at the Gaylord Palms Resort in Kissimmee, FL. Drs. Nicole Bramwell, Robert Cooper, Janice Howell, Joan Meek, Michael Muszynski, Doug Short, Penelope Tokarski, and Bonnie Lanternier, ARNP, serve on the planning committee. Drs. Daniel Garcia, David Nykanen, Ramon Ruiz, Carlos Sabogal, and Doug Short are local faculty who presented at the conference.

# COMMITTEE REPORT: P & T COMMITTEE



**Lisa A Cosgrove, MD, FAAP**

Pharmacy & Therapeutics  
Committee

Lisa A. Cosgrove, MD, FAAP

On Wednesday, January 16, 2009, we had one of my last three (3) P & T committee meetings. There has to be a budget cut of \$13 Million from the pharmacy budget so they were trying to get rid of a lot of things. Pediatrics changes are noted below.

Lovenox injectable heparin was still kept on the Medicaid Provider Drug List (PDL).

Venlafexine ER was approved for depression.

Ovide was approved for head lice but please be cautionary in using it. It is very expensive to the state.

Xopenex inhalation solution can be used for children 6 years old and

younger. This was a big fight and will cost money. I felt it was important to the youngest of our children and cardiac patients. So, I fought and won. The Xopenex HFA will not be on there. All other albuterols will be on the formulary. Remember that it is cheaper to use an inhaler with a spacer device, assuming you can get cooperation with the families.

Growth hormones consisted of Tev-tropin, Saizen, Genotropin and Serostim.

All incretin hypoglycemics have been kept on the PDL. Insulin products remained the same which means all Lilly products plus Levemir. Under discussion of this, Lilly basically gives the state free Humulin and Humalog to get the contract.

You can still use Ofloxin, Cipro ophthalmic, Vigamox, and now Iquix and Quixin for ophthalmic antibiotics.

The biggest fight came with the Proton pump inhibitors. Prevacid Solutabs were recommended off of the PDL but after the discussion by Dr. Jimenez and me stating that there are no other products to use and untreated GERD in an infant may lead to asthma, the committee agreed to use it for up to 12 years of age at which time the Prevacid pill is available. It again is an expensive drug so should not be

used for excessive periods of time. It is expensive to the state.

The last item was vitamins. You can get vitamins with fluoride for your patients as well as regular vitamins. Just write a script.

Well until the next Pharmacy and Therapeutics committee meeting, Lisa Cosgrove, MD  
Chair of the Medicaid Pharmacy and Therapeutic Committee of the State of Florida with Jose D. Jimenez, MD on the board as well.

Please address questions to either one of us.

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# MEDICAL STUDENT SECTION: UF PIG



**University of Florida  
College of Medicine  
Pediatrics Interest Group  
Kristina Betters, MS-2**

The first two years of medical school are a whirlwind of basic science lectures, readings, labs, and exams, with little time to learn about potential specialties and volunteer within fields of interest. At the University Of Florida College Of Medicine, interest groups such as the Pediatrics Interest Group (PIG), give students the opportunity to learn more about specialties. Students are exposed to the field of pediatrics through guest speakers, faculty interaction, community service, and extracurricular activities. Support from the university, pediatric alumni, faculty, residents, staff, and groups such as the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics (FPS/FCAAP) allow the PIG to offer a wide array of

opportunities for students.

At the start of the school year the PIG held one of our most popular lunch meetings with a panel of pediatric fellows. In an informal setting, students were given the opportunity to ask the panel about their decision to enter the field, life as a resident/fellow, residency/fellowship programs, and any other questions regarding subspecialty training. Additional lunch presentations held in the fall include "The Developmental Exam" by our faculty sponsor Dr. Maureen Novak; the pediatric faculty brought in their children for live demonstrations. A talk concerning metabolic syndrome in children was also given by Chief of UF Pediatric Endocrinology, Dr. Janet Silverstein.

Outside of lunch meetings, medical students were given the opportunity to participate in various pediatric orientated events. Two years ago, the PIG started the annual "Health and Fun Fair." The fair was held in October this year at a local Gainesville elementary school serving children from a lower socioeconomic status. Parents and children were invited to come learn about various health topics. This year, UF medical students counseled parents on asthma, diabetes, nutrition, and sleep habits while entertaining the children with healthy snacks, face painting, basketball, and a bounce house. The UF Chapter of the American Medical Association also partnered with the PIG to aid parents with health insurance



# MEDICAL STUDENT SECTION: UF PIG

questions. Other volunteer opportunities included three visits to the Shands Children's Hospital to make arts and crafts and interact with the pediatric inpatients.

Our final event of the semester was a holiday party at Dr. Maureen Novak's home. Students from all four years attended to meet and greet current pediatric residents, chief residents, and pediatric faculty. The residents held a brief presentation on the AAP and entertained numerous questions about pediatrics, residency, and subspecialty training.

As the spring semester begins, the PIG is preparing for a busy few months. We will be participating in another elementary school fair at the end of January, with a goal to council parents and children on tobacco prevention and cessation. Future lunch meetings include a child abuse talk from Children's Services and a panel of current pediatric residents. More volunteer opportunities will also be held at Shands Children's Hospital in the spring. Our annual NICU tour is being organized, as well as pediatrician shadowing opportunities for interested medical students.

*These pictures were taken at the UF PIG "Health 'n Fun Fair" at Rawlings Elementary.*



Lastly, another meet and greet evening with UF pediatrics faculty and residents is in the works. Before we know it a new group of

rising first year students will be elected to PIG office and begin planning activities for the 2009-2010 school year!



# ADVOCACY: MARCH OF DIMES

## Local Signature Chefs Serve Up Their "Best" for the March of Dimes Annual Event Raises over \$136,000

Fort Lauderdale – The aroma was tantalizing at the March of Dimes Signature Chefs & Wine Extravaganza presented by

Rothstein Rosenfeldt Adler, Attorneys at Law, on September 25 at the Bahia Mar Beach Resort & Yachting Center. In one delightful evening over 500 guests interacted with the finest chefs from the area's top restaurants,



*Jorge Garrido, Event Co-Chair Dr Wilhelmena Mack, Alejandra Celestin, MOD Board Member Dr Deborah Mulligan, and Christopher Del Campo*

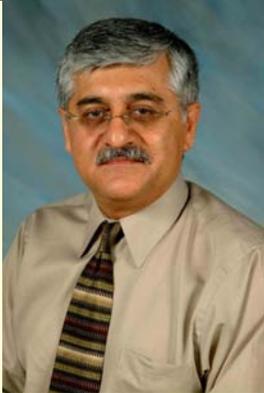


*Mr. Christopher Del Campo & Dr. Deborah Mulligan*

sampled distinctive wines and cocktails, and bid on outstanding live and silent auction items while listening to the smooth jazz sounds of Davis and Dowd. **Nova Southeastern University** was a sponsor for this year's *sold out*

event raised over **\$136,000** toward funding the March of Dimes vital programs of community service, research, advocacy, and education to give every baby a healthy start.

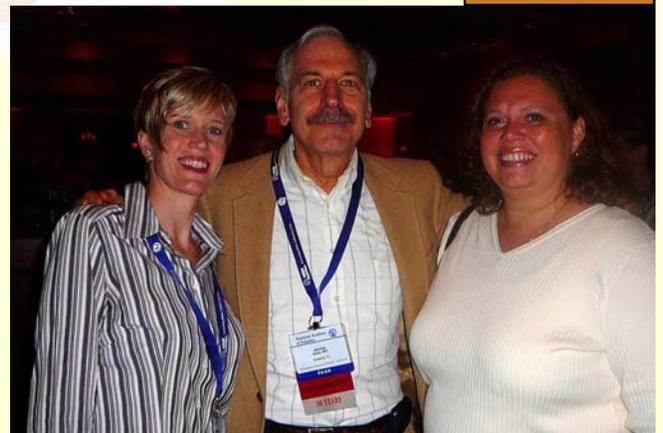
## PHOTO OP! NCE & NEW OFFICERS



**Mobeen Rathore, MD,  
FAAP**  
Florida Pediatric Society  
**First Vice President**  
New Officer



**Xavier Sevilla, MD,  
FAAP**  
Florida Pediatric Society  
**Second Vice President**  
New Officer



*Michelle Floyd, MD, Jerry Isaac, MD, and Thresia Gambon, MD in Washington, DC at the AAP National Conference & Exhibition*

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# SCIENTIFIC UPDATE: PSR TAMPA BAY



Lynn Ringenberg, MD, FAAP

## Healthy Environment - Healthy Child Toolkit to Keep Kids Safe Marybeth Palmigiono, MPH Lynn Ringenberg, MD, FAAP

Pediatric Environmental Health has been gaining momentum since the early days of working to ban lead in gasoline and paint products. Recently the discipline has been embracing a more holistic view to include such threats as pesticide residues on foods, mercury in fish, and arsenic in drinking water and on play structures. Yet, few clinicians feel confident in discussing environmental health risks. Lack of training on the links between environment and health and lack of available clinical tools for patient education contribute to the inattention to this topic in the clinical setting. Studies have shown few environmental histories are taken, and that less than one-in-five pediatricians report having

received training in environmental history-taking even though they strongly believe in the importance of environmental exposures in children's health. The issue is a high priority with parents. In a recent paper written by Dr. Sophie Balk, former chair of the American Academy of Pediatrics (AAP) environment committee and editor of the AAP "Green Book" for pediatricians, "...environmental exposures are among parents' top concerns for their children."

In order to fill this unmet need for Pediatric Environmental Health clinical tools, Greater Boston and San Francisco Bay Area chapters of Physicians for Social Responsibility, in partnership with the Pediatric Environmental Health Specialty Unit at the University of California, San Francisco, and a team of pediatricians from around the country, developed the *Pediatric Environmental Health Toolkit*. The AAP endorsed *Pediatric Environmental Health Toolkit* identifies critical developmental stages, and opportunities for age-appropriate interventions to promote health and wellness. By recognizing these "teachable moments," the routine well child exam becomes a powerful vehicle by which families can begin to understand the links between environment and health, and embrace the changes necessary to minimize exposure. Included in the Toolkit are:

### ***Provider Materials:***

A laminated *Reference Card* with brief summaries of major toxicants. Adapted from the AAP Green Book, the reference card allows providers to quickly reference environmental toxicants, health effects, routes of exposure, and exposure prevention strategies.

An *Anticipatory Guidance Pocket Card* that fits in a large pocket for handy use during a well child visit. The topics on the pocket card are both developmentally appropriate and take advantage of "teachable moments."

***Key Concepts in Pediatric Environmental Health*** which provides additional background on a number of topics including the unique vulnerabilities of children, higher risk communities, "Built Environment" and "Food Environment," Right-to-Know issues and much more.

Two colorful **Posters**, *Have a Healthy Home*, and *Play Safe*, with prevention tips from the Toolkit to display in office and patient waiting rooms.

### ***Patient Materials:***

***Rx for Prevention "prescription" slips*** are keyed to 4 developmental stages: Birth-1 year, 1-4 years, school age, and teens. Each "Rx" (there are multiple slips for

## SCIENTIFIC UPDATE: PSR TAMPA BAY

each age group) contains two to four high priority “tips on prevention” for parents, such as how to avoid mercury in fish, protection from solvents, reducing use of pesticides, eliminating toxic cleaners, etc. The provider hands the slip to a family as if prescribing a medication.

*Magnets with “Tips for Prevention”* include six different magnets with brief prevention tips. Patients can use the magnets to post the “Prescriptions” on the refrigerator.

The Rx slips and posters are English on one side and Spanish on the other. Magnets are available in English and Spanish.

These evidence based clinical materials are user friendly to assist the clinician in incorporating preventative public health education into the typical 15 minute patient exam.

A PowerPoint Training program is available as a companion piece to the Toolkit. The training uses various case examples to highlight the relationship between environmental exposures and children’s health, and clinical use of the *Toolkit*. Upon completion the learner will be able to: identify routes of exposure to common toxic chemicals and substances including mercury, lead, arsenic, solvents, pesticides, and persistent

organic compounds such as PCBs; recognize links between these toxic chemicals and health effects; provide anticipatory guidance keyed to well-child visits; enhance patient communications on environmental health issues; discuss the unique vulnerabilities of children, the “built” and “food” environments, and other important issues; and use the *Pediatric Toolkit* in the busy practice setting.

Beginning in late Fall of 2008 this training will be available on line as a free continuing education course offering 1.5 credits. All materials are available on the PSR website – [www.psr.org](http://www.psr.org)

PSR Tampa Bay is the newest and only chapter of Physicians for Social Responsibility (PSR) in the State of Florida. National PSR was organized in 1961 as the medical and public health voice calling for the elimination of the gravest threats to humanity: nuclear weapons, global warming, and toxic chemicals. In 1985, PSR shared the Nobel Peace Prize awarded to International Physicians for the Prevention of Nuclear War (IPPNW) for building public awareness and pressure to end the nuclear arms race. In 1992, PSR expanded its mission to apply its medical expertise to environmental health issues. Since then, PSR has used expert reports, advocacy, and education campaigns to promote safe drinking water, the elimination of

persistent organic pollutants, and reducing mercury exposure. PSR brings unique resources to the challenge of confronting toxic chemicals, including strong public confidence in the medical profession, specialized expertise in the health consequences of exposure to toxic chemicals, 32 chapters and 32,000 members across the United States, and a national staff with extensive experience in grassroots organizing.

PSR Tampa Bay is partnering with PSR national to bring the *Pediatric Environmental Health Toolkit* to the pediatric and medicine-pediatric residency programs throughout Florida, through collaboration with the Resident Section of the Florida Pediatric Society.

If you’d like to learn more about PSR Tampa Bay or to schedule a Grand Rounds or other educational conference on the *Pediatric Environmental Health Toolkit*, please contact Lynn Ringenberg, M.D. at [lringenb@health.usf.edu](mailto:lringenb@health.usf.edu) or call 813-259-8752.

# SCIENTIFIC UPDATE: "COPING WITH CRYING"

## Healthy Tomorrows Grant

Janet H. Evans

Florida Department of Health  
MSPA, Director

I just wanted to make sure that you were aware of the activities that CMS through my Unit has been involved with over the past years with Shaken Baby Syndrome Prevention - "Coping with Crying".

I also wanted to let you know the response that we got from the Department of Children and Families when we solicited their interest in providing a letter of support and/or other support. The Prevention Unit has responsibility for providing hospitals and others information to reduce the occurrence of Shaken Baby Syndrome. To that end we undertake several activities which I have summarized below:

1. Annual distribution of brochures to birthing facilities -

<<shakenbaby.p0001.pdf>>

<<shakenbaby.p0002.pdf>>

We changed the message a couple of years ago from "One Shake Can Last a Lifetime" to "Coping with Crying." This was in response to some market research that showed that new parents did not related to shaking their baby; instead, all parents worried about what to do with a crying baby. In addition, the basic research that shows that the majority of SBS cases result

from a caregiver who is frustrated with a crying infant.

2. Produced a brochure for child care providers <<Coping with crying 2\_eng.pdf>>

3. Developed and produced a magnet for families with the "Coping with Crying" message - <<Ways to Handle Frustration with DPI logos.pub>>

The magnet has a center "punch out" for a picture of their baby. It also has coping strategies around the border. We distributed these, along with our brochures, to pediatricians and family practice physicians in FY 06-07 for use with their new parents' education. We have not had funds to re-print the magnets.

4. Provide train-the-trainer training for hospital-based nurse on presenting the "Coping with Crying" educational material to parents before they are discharged from the hospital. This includes use of a DVD "Elijah's Story" and a Pledge form.

This training has been provided for about 20 hospitals thus far. We are planning to contract for this training again this year for an additional 10-12 hospitals. This training has also been made available for County Health Departments and Children's Medical Services.

5. Provide awareness and educational information at various conferences, meetings, health fairs.

The Department of Children & Families has indicated that they will provide a Letter of Support for the grant. They also indicated that are willing to have a staff person participate in any advisory group that might result from the grant. They also indicated that if the grant activities require the purchase of existing materials - they may be able to use some of their funds for this purpose! They would have to do the actually purchasing, but it might be a great resource for in-kind....

If I can be of further assistance, please let me know.

Janet H. Evans, M.S.P.A., Director

Prevention Unit

Division of Prevention & Interventions

Children's Medical Services

850-245-4246

janet\_evans@doh.state.fl.us

*For more information on Prevention & Interventions programs access this website: <http://www.doh.state.fl.us/cms/index.html>*

As a child care worker, your frequent contact with children puts you in an important position to identify and report shaken baby syndrome or other forms of abuse/maltreatment.

## Symptoms that may indicate a baby has been shaken:

If these symptoms are present, immediately call 911

- Irritability
- Projectile vomiting
- Dilated pupils
- Rigidity or poor muscle tone
- No appetite
- Inability to suck or swallow
- Inability to vocalize
- Seizures
- Pale skin
- Breathing difficulty
- Unable to follow movements with eyes
- Bruising on torso or arms

Note: In many cases of Shaken Baby Syndrome, there is no sign of external injury (bruising etc.)

If any of the ● symptoms occur you should immediately contact 911 for emergency medical attention.

It is critical if a baby is exhibiting the symptoms of SBS or is sleeping when dropped off at the day care facility to:

- Wake the baby and make sure the baby is alright before accepting the child
- Be aware that symptoms resulting from SBS occur immediately following the shaking event.

Remember that as a child care provider you are required to report to the Abuse Hotline any known or suspected child abuse incidents.

**Florida Abuse Hotline number:**  
1-800-96ABUSE (1-800-962-2873)

Produced and distributed in accordance with the Kimberlin West Act.

For more information visit the Florida Department of Health website or <http://www.doh.state.fl.us/cms/HProviderPIAbusePrev.html>

For more information:

150-285, 8-05 Stock No. 5730-285-0150-9



## Coping with crying.



Soothe, don't shake, babies.



Facts about Shaken Baby Syndrome for Child Care Staff

## WHY BABIES CRY

- hunger ■ too hot or too cold ■ diaper needs changing
- discomfort/pain, fever/illness ■ teething ■ colic ■
- boredom/over-stimulation ■ fear—of loud noises or a stranger ■

### Did you know?

- Shaken Baby Syndrome (SBS) is one of the most common causes of death by physical abuse to infants
- Shaking a baby or a young child can cause problems that could last the rest of a child's life.
- Shaking a baby may result in severe injury or death.
- Crying is the most frequent event that causes the shaking of a baby.
- Young males who take care of a baby alone are most at risk to shake a baby.
- Much of the general public does not know the dangers of shaking a baby.
- Shaken Baby Syndrome is 100% preventable.

Everyday handling of a baby, playful acts and minor accidents do not have the force needed to create these injuries.

Shaking injuries are NOT caused by bouncing baby on your knee, gently tossing baby in the air, jogging or biking with a baby, or falls off furniture.

### Shaking a baby or young child can cause

- Permanent brain damage
- Paralysis
- Blindness
- Seizures
- Delay in normal development
- Broken Bones
- DEATH

### Understanding babies

Taking care of a baby can be fun and enjoyable. But when a baby won't stop crying, it can be very upsetting for any caregiver. Just remember:

- It is normal for a baby to cry. A baby may cry two to three hours a day—sometimes more.
- Crying happens more often in the evening.
- Crying may start or stop and you don't know why.
- Crying may not stop no matter what you do.
- Crying will not harm a baby.

### Coping with a Crying Baby

Babies cry for a variety of reasons. Crying is the only way a baby can tell you something is wrong. Try to find the reason why the baby is crying.

- Make sure the baby has a dry diaper.
- Make sure the baby is not too hot or too cold.
- Check of signs of illness or discomfort, such as diaper rash, teething, or tight clothing.
- Soothe the baby by lightly rubbing its back.
- Gently rock the baby.
- After immunizations, be sure the baby is comfortable.
- Call the parents if the baby appears sick.



### Ways to calm a baby and handle your frustration

It may seem that the baby you are caring for cries more than any other baby, but ALL babies cry, some are champion criers!

After you have tried everything else:

**Try swaddling the infant.**

**Take the baby for a walk in a stroller or just walk around. Motion often calms infants.**

**Place the baby in the crib and let him cry, ensuring the baby is within sight and hearing of a caregiver.**

**Try to relax.**

**Take 20 deep breaths.**

**Stay calm and Play with other babies or children.**

**Ask for help from others.**

Sometimes a baby just needs attention. BE PATIENT. Taking care of a baby is a big job. It's okay to be overwhelmed or frustrated. It is NOT okay to SHAKE a child to stop the crying.

**NEVER, NEVER, SHAKE A BABY!**

Dedicated to the memory of thousands of infants and young children whose lives are forever changed by shaking.

# SCIENTIFIC UPDATE: WIC

## WIC Food Packages Time for a Change

Within the next year, you will see new, healthier food choices for participants of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In response to a 2005 Institute of Medicine Report, "WIC Food Packages: Time for a Change," the United States Department of Agriculture, Food and Nutrition Service issued an interim rule governing the WIC food packages on December 6, 2007. The new food packages better meet the nutritional needs of WIC participants and align with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics. Additionally, the new food packages promote and support the establishment of successful, long-term breastfeeding, and provide WIC participants with a wider variety of foods, including fruits, vegetables and whole grains. Also, WIC State agencies have greater flexibility in prescribing food packages to accommodate the cultural preferences of WIC participants.

### Things to Know About the New WIC Food Packages

**The Florida Department of Health  
and all other state WIC agencies**

**must implement the new food  
packages by October 1, 2009.**

#### New WIC foods

- Fruits and vegetables
- Whole grain breads and cereals
- Baby foods for infants 6 months and older that include fruits and vegetables for all infants and meat for exclusively breastfed infants

#### New alternatives (at State agency option) to appeal to culturally diverse populations

- Soy beverage and tofu as a substitute for milk
- Brown rice, soft corn or whole wheat tortillas, oatmeal, barley, or bulgur as a substitute for whole wheat bread
- Canned beans as a substitute for dried beans
- Canned salmon, sardines, and mackerel as a substitute for canned light tuna

#### New quantities of the current WIC foods

- Reduced quantities of milk, eggs, juice, and cheese for women and children
- Additional amounts of beans or peanut butter for women
- No juice for infants
- Reduced quantities of infant formula for partially breastfed infants
- Variable quantities of formula for non-breastfed infants

based on the age of the infant

#### New requirements

- Reduced fat, low fat, or fat free milk for women and children 2 years of age and older
- Additional WIC foods for children over 1 year of age receiving a special formula with a medical request

#### How do the new WIC food packages address public health nutrition-related issues?

The revised food packages for women and children provide fruits and vegetables, less saturated fat and cholesterol, and more fiber. The food packages for breastfeeding infant-mother pairs provide stronger incentives for continued breastfeeding, including the provision of less formula to partially breastfed infants, and additional quantities and types of food for breastfeeding mothers and for the breastfed infants.

#### How do the new food packages reinforce the nutrition education messages provided to WIC participants?

The new food packages are more consistent with the nutrition education messages provided to participants, i.e., "eat more fruits and vegetables;" "lower saturated fat;" "increase whole grains and fiber;" "drink less sweetened beverages and juice;" and "babies

# SCIENTIFIC UPDATE: FDA: HEALTH SMILES

are meant to be breastfed.”

## How do the new WIC food packages appeal to WIC’s culturally diverse populations?

The new food packages provide more participant choice and a wider variety of foods than the previous food packages. Foods such as tortillas, brown rice, canned salmon, and a wide choice of fruits and vegetables will provide State agencies increased flexibility in prescribing culturally appropriate food packages.

## For more information:

**WIC Food Package Regulations at <http://fns.usda.gov/wic/regspublished/foodpackages-interimrule.htm> for the complete provisions and requirements for foods in the new WIC food packages.**

**Institute of Medicine Report at <http://www.iom.edu/CMS?3788/18047/26667.aspx> for the complete report.**

**USDA, National Agriculture Library-WIC Work Resource at [http://www.nal.usda.gov/wicworks/Learning\\_Center/Food\\_Package.html](http://www.nal.usda.gov/wicworks/Learning_Center/Food_Package.html) for information and resources about the new WIC food packages.**

**Department of Health, Florida WIC Program at <http://www.FloridaWIC.org> for**

## information about the Florida WIC Program and the current WIC food packages.

WIC is an equal opportunity provider.



## Healthy Smiles, Healthy Childhood

Childhood is full of learning, friendships, activities and smiles, but sometimes caring for these smiles isn’t high on the priority list. Oral and overall health are directly related – dental-related illnesses account for more than 51 million lost school hours each year in the United States.

“Good dental habits at a young age bring lifelong smiles,” Florida Dental Association President Dr. Ted Haeussner said. “It is important to encourage children to develop dental routines early – it can affect their overall health in the long run.”

Preventive maintenance is the first step toward having lifelong dental health. It is important to brush teeth twice a day with an American Dental Association-recommended toothbrush. In addition to

brushing, fluoride is an important natural mineral that safely strengthens tooth enamel, the hard outer “shell” of the tooth. However, fluoride toothpaste should not be used for children ages 2 and younger. Flossing is also very important to good oral care and should be done at least once a day. Parents should start flossing their child’s teeth when the sides of two teeth touch.

The prevention of dental injuries is also important. A mouthguard is a flexible appliance used to protect teeth and jaws from trauma, and is used most commonly in contact sports, such as boxing, football, hockey and lacrosse. However, findings show that even in noncontact sports like basketball, soccer, gymnastics or skateboarding. Athletes are more than 60 percent more likely to suffer harm to their teeth without a mouthguard.

The FDA strives to improve the oral health of Florida residents, promote ethical practice standards and direct the evolution of the practice environment through continuous education and advocacy for the profession and the public.

For more information about the FDA, visit [www.floridadental.org](http://www.floridadental.org).

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-12-25  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-10

**DATE:** October 24, 2008  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Standing Orders in Hospitals Revisions to S&C Memoranda

## Memorandum Summary

- A. Standing Order Clarification:** We are clarifying a portion of S&C-08-12 and S&C-08-18, issued on February 8 and April 11, 2008 respectively, regarding use of standing orders in hospitals. The use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.
- B. Future Directions:** We express our interest in working with the professional community to advance safe practices and develop a common understanding of both best practices and important operational definitions as they pertain to standing orders, preprinted order sets, and effective methods to promote evidence-based medicine.
- C. Signatures on Order Sets:** We are also clarifying the circumstances under which signatures are required on pre-printed order sets.
- D. Use of Rubber Stamps:** We add an information-only note to the Guidance as an alert to note that some payers, including Medicare, do not accept the use of rubber stamps for payment purposes. The Conditions of Participation (CoPs), however, do not prohibit such use.

## A. Standing Orders

On February 8, 2008 and April 11, 2008 we issued via memoranda S&C-08-12 and S&C-08-18 an advance copy of updates to the State Operations Manual (SOM) for the SOM Hospital Appendix A. The official version of these updates was issued on October 17, 2008 (Transmittal 37, CMS Manual System, Publication 100-07, State Operations Provider Certification). We are taking this opportunity to clarify expectations regarding standing orders as they pertain to the following regulation:

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

Page 2 State Survey Agency Directors

*§482.23(c)(2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).*

The February 8<sup>th</sup> and April 11<sup>th</sup> advance copies of surveyor guidance for the SOM Hospital Appendix A each contained the following additional note:

*Note: If a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocols or standing orders requires an order from a practitioner responsible for the patient's care*

We have removed this note from the on-line versions of the S&C memoranda as well as from the final edition of the SOM Hospital Appendix A. We concluded that the note may cause confusion about the ability of rapid response teams and other health care professionals in hospitals to initiate effective responses to emergency situations and/or to implement best practices for providing necessary patient care in a timely fashion under the aegis of standing orders.

The use of standing orders must be documented as an order in the patient's medical record and authenticated by the practitioner responsible for the care of the patient, as the regulations at 42 CFR §482.23(c)(2) and §482.24(c)(1) require, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances. We would expect to see that the standing order had been entered into the order entry section of the patient's medical record as soon as possible after implementation of the order (much like a verbal order would be entered), with authentication by the patient's physician.

We also note that there may be a misconception that CMS regulations require all orders to be written by a community physician who admitted the patient to the hospital. This is incorrect. All qualified practitioners responsible for the care of the patient and authorized by the hospital in accordance with State law and scope of practice are permitted to issue patient care orders. This includes not only the attending physician, but also hospitalists, intensivists, and residents. In addition, 42 CFR 482.12(c)(1)(i) recognizes the authority of a doctor of medicine or osteopathy to delegate tasks, including writing orders, to other qualified health care personnel, such as nurse practitioners and physician assistants, to the extent recognized under State law.

## **B. Future Directions on Standing Orders**

CMS strongly supports the use of evidence-based protocols to enhance the quality of care provided to hospital patients. Many hospitals employ such protocols developed by physicians and other clinical staff that are designed to standardize and optimize patient care in accordance with current clinical guidelines or standards of practice.

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

Page 3 State Survey Agency Directors

CMS, through its policies, payments and *Hospital Compare* Web site, promotes hospital-specific compliance with evidence-based standards of practice for treatment of certain conditions and/or prevention of infection. Many hospitals have developed protocols and preprinted (or computerized) order sets that are ready to be used with patients diagnosed with acute myocardial infarction, congestive heart failure, or community-acquired pneumonia, or for patients undergoing surgery. Many protocols help enhance hospital performance in important areas of care that are measured and reported as part of the CMS measurement and reporting of hospital quality data.

Hospitals also have created formal protocols for a number of other scenarios, e.g., for Rapid Response Teams. Such protocols are designed to bring hospital staff with critical care skills to the bedside of patients when clinical changes (that may portend the patient's deterioration) are recognized by staff (or by the patient or patient's family) in the patient's unit.

While there is significant merit to the use of standing orders, there is also the potential for harm to patients if hospitals use such orders so that nurses or other clinical staff are routinely expected to make clinical decisions outside their scope of practice. This is a complex issue which requires careful consideration by hospitals, physicians, nurses and other licensed health care professionals, experts in patient safety and quality improvement, and patients.

We therefore intend to engage with the professional community in consensus-building efforts to advance safe practices and develop a common understanding of both best practices and important operational definitions as they pertain to standing orders, pre-printed order sets, and effective methods to promote evidence-based medicine. We further intend to build on the results of such a process to inform CMS decision-making. In the next several months we hope to formulate the specific steps and partnerships necessary to accomplish these goals.

## **C. Preprinted Order Sets**

We refer to a preprinted order set as a tool generally designed to assist qualified practitioners as they write orders. Order sets may include computerized programs that are the functional equivalent of hard copy preprinted order sets. Such tools may include a menu of medications or actions from which the qualified practitioner makes selections to be applied to a particular patient. They sometimes include a standard combination of medications and actions to be followed without amendment whenever the physician selects that order.

Preprinted order sets are permitted under the CMS Conditions of Participation (CoPs). CMS recognizes the role that pre-printed order sets can play in reducing medication errors and promoting optimal treatments for patients with certain conditions.

Preprinted order sets should be reviewed and approved by the hospital's medical staff. Under the CoPs at §482.24(c)(1), all orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering physician or another practitioner who is responsible for the care of the patient as specified under 482.12(c). We consider this requirement to include orders employing preprinted order sets.

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

Page 4 State Survey Agency Directors

In the February 8<sup>th</sup> and April 11<sup>th</sup> advance copies of the updated SOM we stated the following in interpreting §482.24(c)(1): Where a practitioner has written a set of orders or is using a preprinted order set contained on one page, or on several pages, the physician must sign, date, and time each page of orders.

Upon closer review we find agreement with commenters that CMS has discretion under the regulation at §482.24(c)(1) to interpret the requirement in a manner that is less burdensome but is still consistent with the regulation and ensures that the ordering practitioner's intent is clear on those order sets that provide a menu of choices for a physician to make, or where portions of the preprinted order set may have been amended.

We are therefore revising the guidance (revised advance copy attached) to read as follows:

*When a practitioner is using a preprinted order set, the ordering practitioner may be in compliance with the requirement at §482.24(c)(1) to date, time and authenticate an order if the practitioner accomplishes the following:*

- **Last page:** Sign, date, and time the last page of the orders, with the last page also identifying the total number of pages in the order set.
- **Pages with Internal Selections:** Sign or initial any other (internal) pages of the order set where selections or changes have been made.
  - The practitioner should initial/sign the top or bottom of the pertinent page(s)*
  - The practitioner should also initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made*
  - *It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, so long as there are no changes made to the option(s) selected.*

*In the case of a pre-established electronic order set, the same principles would apply, so that the practitioner would date, time and authenticate the final order that resulted from the electronic selection/annotation process, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.*

## **D. Use of Rubber Stamps**

The CoPs do not prohibit the use of rubber stamps in a hospital setting, when properly controlled, for authentication of medical record entries. However, as a point of information for surveyors and providers, we are taking this opportunity to add an information-only statement to the interpretive guidance for §482.24(c)(1) to note that some payers, including Medicare, may not accept such stamps as sufficient documentation to support a claim for payment.

If you have additional questions or concerns, please contact David Eddinger at 410-786-3429 or via email at david.eddinger@cms.hhs.gov.

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

Page 5 State Survey Agency Directors

**Effective Date:** Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

**Training:** The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

*/s/*  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management  
Attachment: (1)

## *Revised Interpretive Guidelines Advance Copy*

### **§482.23(c) Standard: Preparation and Administration of Drugs**

\* \* \*

#### **A-0406**

**482.23(c)(2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).**

#### **Interpretive Guidelines §482.23(c)(2)**

All orders for drugs and biologicals, with the exception of influenza and pneumococcal polysaccharide vaccines, must be documented and signed by a practitioner who is authorized by hospital policy, and in accordance with State law, to write orders and who is responsible for the care of the patient as specified under §482.12(c). In accordance with §482.12(c)(1), practitioners who are authorized to provide care for Medicare patients include:

- A doctor of medicine or osteopathy;
- A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;
- A doctor of optometry who is legally authorized to practice optometry by the State;
- A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist;
- A clinical psychologist as defined in §410.71, but only with respect to clinical psychologist services as defined in §410.71 and only to the extent permitted by law.
- A doctor of dental surgery or dental medicine.

Consistent with delegation agreements, collaborative practice agreements, hospital policy, and the requirements of State law, Nurse Practitioners and Physician Assistants responsible for the care of specific patients are also permitted to order drugs and biologicals.

Influenza and pneumococcal polysaccharide vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.

In accordance with standard practice, elements that must be present in orders for all drugs and biologicals to ensure safe preparation and administration include:

- Name of patient (present on order sheet or prescription);
- Age and weight of patient, when applicable;
- Date and time of the order;
- Drug name;

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

- Dose, frequency, and route;
- Exact strength or concentration, when applicable;
- Quantity and/or duration, when applicable;
- Specific instructions for use, when applicable; and
- Name of prescriber.

Hospitals are encouraged to promote a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding orders. Any questions about orders for drugs or biologicals are expected to be resolved prior to the preparation, or dispensing, or administration of the medication.

\* \* \*

## §482.24(c) Standard: Content of Record

**The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.**

\* \* \*

### A-0450

**482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.**

#### **Interpretive Guidelines §482.24(c)(1)**

All entries in the medical record must be **legible**. Orders, progress notes, nursing notes, or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events.

All entries in the medical record must be **complete**. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. With these criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard.

All entries in the medical record must be **dated, timed, and authenticated**, in written or electronic form, by the person responsible for providing or evaluating the service provided.

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

- The time and date of each entry (orders, reports, notes, etc.) must be accurately documented. Timing establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating entries is necessary for patient safety and quality of care. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or timelines of various signs, symptoms, or events. (71 FR 68687)
- The hospital must have a method to establish the identity of the author of each entry. This would include verification of the author of faxed orders/entries or computer entries.
- The hospital must have a method to require that each author takes a specific action to verify that the entry being authenticated is his/her entry or that he/she is responsible for the entry, and that the entry is accurate.

The requirements for dating and timing do not apply to orders or prescriptions that are generated outside of the hospital until they are presented to the hospital at the time of service. Once the hospital begins processing such an order or prescription, it is responsible for ensuring that the implementation of the order or prescription by the hospital is promptly dated, and timed in the patient's medical record.

*When a practitioner is using a preprinted order set, the ordering practitioner may be in compliance with the requirement at §482.24(c)(1) to date, time and authenticate an order if the practitioner accomplishes the following:*

- ***Last page:*** Sign, date, and time the last page of the orders, with the last page also identifying the total number of pages in the order set.
- ***Pages with Internal Selections:*** Sign or initial any other (internal) pages of the order set where selections or changes have been made.

*The practitioner should initial/sign the top or bottom of the pertinent page(s)  
The practitioner should also initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made.*

- *It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, so long as there are no changes made to the option(s) selected.*

*In the case of a pre-established electronic order set, the same principles would apply, so that the practitioner would date, time and authenticate the final order that resulted from the electronic selection/annotation process, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.*

Authentication of medical record entries may include written signatures, initials, computer key, or other code. For authentication, in written or electronic form, a method must be established to identify the author. When rubber stamps or electronic authorizations are used for authentication, the hospital must have policies and procedures to ensure that such stamps or authorizations are used only by the individuals whose signature they represent. There shall be no delegation of stamps or authentication codes to another individual. *It should be noted that some insurers and*

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

*other payers may have a policy prohibiting the use of rubber stamps as a means of authenticating the medical records that support a claim for payment. Medicare payment policy, for example, no longer permits such use of rubber stamps. Thus, while the use of a rubber stamp for signature authentication is not prohibited under the CoPs and analysis of the rubber stamp method per se is not an element of the survey process, hospitals may wish to eliminate their usage in order to avoid denial of claims for payment.*

Where an electronic medical record is in use, the hospital must demonstrate how it prevents alterations of record entries after they have been authenticated. Information needed to review an electronic medical record, including pertinent codes and security features, must be readily available to surveyors to permit their review of sampled medical records while on-site in the hospital.

When State law and/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules and regulations must address counter-signature requirements and processes.

A system of auto-authentication in which a physician or other practitioner authenticates an entry that he or she cannot review, e.g., because it has not yet been transcribed, or the electronic entry cannot be displayed, is not consistent with these requirements. There must be a method of determining that the practitioner did, in fact, authenticate the entry after it was created. In addition, failure to disapprove an entry within a specific time period is not acceptable as authentication.

The practitioner must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated. For certain electronically-generated documents, where the date and time that the physician reviewed the electronic transcription is automatically printed on the document, the requirements of this section would be satisfied. However, if the electronically-generated document only prints the date and time that an event occurred (e.g., EKG printouts, lab results, etc.) and does not print the date and time that the practitioner actually reviewed the document, then the practitioner must either authenticate, date, and time this document itself or incorporate an acknowledgment that the document was reviewed into another document (such as the H&P, a progress note, etc.), which would then be authenticated, dated, and timed by the practitioner.

## **Survey Procedures §482.24(c)(1)**

Review a sample of open and closed medical records.

- Determine whether all medical record entries are legible. Are they clearly written in such a way that they are not likely to be misread or misinterpreted?
- Determine whether orders, progress notes, nursing notes, or other entries in the medical record are complete. Does the medical record contain sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers?

# PHYSICIAN HEAL THYSELF: STANDING ORDERS

- Determine whether medical record entries are dated, timed, and appropriately authenticated by the person who is responsible for ordering, providing, or evaluating the service provided.
- Determine whether all orders, including verbal orders, are written in the medical record and signed by the practitioner who is caring for the patient and who is authorized by hospital policy and in accordance with State law to write orders.
- Determine whether the hospital has a means for verifying signatures, both written and electronic, written initials, codes, and stamps when such are used for authorship identification. For electronic medical records, ask the hospital to demonstrate the security features that maintain the integrity of entries and verification of electronic signatures and authorizations. Examine the hospital's policies and procedures for using the system, and determine if documents are being authenticated after they are created.

# SPOTLIGHT! NICOLE CAMERON, MD

## Julius B. Richmond AAP/ FAMRI Visiting Lectureship Program Grantees 2008-2009



**Nicole Cameron, MD**

The Julius B. Richmond Center of Excellence is pleased to announce that an AAP resident member in your chapter is a recipient of the 2008-2009 Julius B. Richmond AAP/ FAMRI Visiting Lectureship Program Award. The Visiting Lectureship grants support 2-day educational programs with the goal of providing pediatric trainees, child advocates, academic and/or community pediatricians with an opportunity to interact with leading academic pediatricians on topics related to children and secondhand smoke exposure.

Nicole Cameron, MD of the Orlando Health Pediatric

Residency Program was one of four applicants chosen to receive this award. The goals she proposed for the visit are:

To educate community physicians, residents, medical students, and attending physicians about the health effects of tobacco smoke exposure in pediatrics.

To instruct community physicians, residents, medical students, and attending physicians how to address health concerns related to secondhand smoke exposure with patient caretakers.

To train community physicians, residents, and attending physicians to maintain appropriate follow up on a patient's or a patient caretaker's progress with smoking cessation.

To inform community physicians, residents and medical students, and attending physicians about available community programs to assist families with smoking cessation.

We would like to recognize Dr Cameron for building awareness on this important issue by providing an opportunity for trainees, community physicians and advocates to connect with experts on the topic of tobacco prevention and control. We hope you will encourage other

chapter members to attend some of the events Dr. Cameron is planning. The speaker and date for the visiting speaker will be determined sometime in the coming weeks. Dr Cameron can be reached at 407/456-0852 or by email at [Nicole.Cameron@orlandohealth.com](mailto:Nicole.Cameron@orlandohealth.com).

The Richmond Center's mission is to improve child health by eliminating children's exposure to tobacco and secondhand smoke by changing the clinical practice of pediatrics. For more information please visit: <http://www.aap.org/richmondcenter/>.

# SPOTLIGHT! COMMUNITY PEDSCARE

## Community PedsCare Wins Prestigious National Award

JACKSONVILLE, Fla. — Community PedsCare®, the community pediatric palliative and hospice program in Northeast Florida, is a recipient of the 2008 Quality in Palliative Care Leadership Award. The award is presented annually to recognize organizations which have enhanced their palliative care services by implementing the palliative care principles supported by the National Consensus Project for Quality Palliative Care and the National Quality Forum. Community PedsCare is one of nine palliative care programs in the United States selected for this prestigious award. Community PedsCare was established in 2000 to coordinate community-based services for children with life-limiting and life-threatening conditions. A program of Community Hospice of Northeast Florida® in collaboration with Wolfson Children's Hospital, Nemours Children's Clinic and the University of Florida, Community PedsCare is comprised of a dedicated team of pediatric professionals who offer medical, social service, spiritual, psychological and volunteer support to children and their families. This holistic type of care is designed to relieve pain, provide

comfort and improve quality of life.

In addition to being recognized as a model for others in the rapidly growing field of palliative care, which seeks to prevent or relieve physical and emotional distress for individuals who may be seeking curative or life-prolonging treatments, Community PedsCare will receive a \$2,500 monetary award to continue this work.

Terry Eason, program manager for Community PedsCare, has been invited to officially receive the award during the 2009 American Academy of Hospice and Palliative Medicine/Hospice and Palliative Nurses Association Annual Assembly, March 25-28, 2009 in Austin, Texas, and participate in a panel presentation on palliative care.

Says Judi Lund Person, MPH, Vice President of Regulatory and State Leadership for the National Hospice and Palliative Care Organization, "As the field of palliative care is becoming an integral part of America's healthcare system, it is essential that we monitor the quality of care and identify exemplars of excellence."

Established in 1979 as the first hospice program in Northeast Florida, Community Hospice of Northeast Florida® helps nearly 1,000 patients live better with

advanced illness each day in Baker, Clay, Duval, Nassau and St. Johns counties, through the support of more than 700 employees and nearly 900 volunteers. The nonprofit organization has served more than 48,000 children and adults — at home, in long term care facilities, hospitals and through four inpatient centers throughout Jacksonville. Community Hospice Foundation™ generates philanthropic and community support for patient care services, family needs and community programs such as Community PedsCare®, a pediatric palliative and hospice program, and the programs and services through the Charles M. Neviasser Educational Institute. Care is available to all patients who need it, regardless of their ability to pay.

**Community Hospice and Community PedsCare are registered trademarks and Community Hospice Foundation is a trademark of Community Hospice of Northeast Florida, Inc.**

### **Please contact:**

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# CONTINUING MEDICAL EDUCATION

## **Protecting Our Next Generation, 0-3**

As many of you already know, public resistance to childhood immunizations is increasing on both a community level as well as in our state's legislature. This January 30<sup>th</sup> and January 31<sup>st</sup> Nova Southeastern University College of Osteopathic Medicine in Fort Lauderdale will hold an important pediatric conference. This will be a two-day conference with one entire day devoted to how to respond to parental and community concerns regarding childhood immunizations. The program will feature national authorities from the CDC, NIH, ACIP, and the National Immunization Alliance who will discuss safety procedures with vaccines, barriers to obtaining and administering childhood immunizations on the public end, the legal front, and manufacturing supplies. The session will feature training in advocating for public support of vaccinations. A unique seminar will complete the program where attendees will receive training in how to approach parents that are worried about vaccinating their children. After receiving the training, the participants will have an opportunity to counsel simulated parents regarding immunization concerns. Each participant will then be able to review the counseling session with a National Immunization Alliance expert.

This will be an event of international importance with the experts regarding this issue together for the first time. Our own Florida State Surgeon General will be amongst those presenting. The conference will conclude with a workshop directed by Dr. Humiston a pediatrician from Rochester who has an autistic child and wrote a text counseling physicians on how to talk with families about immunizations. Dr. Offit (who was featured this week in the New York Times) will be bringing his new book. We will have Florida Shots workshops and simulated patient parents that physicians can practice their skills working with counseling families regarding immunization fears and resistance. Registration is available at [www.medicine.nova.edu/ce](http://www.medicine.nova.edu/ce). We have extended early registration to January 23<sup>rd</sup>. This conference is approved for 12 1-A credits by the ACCME. I do hope to see all of you at the meeting this January. Please spread the word to your students, colleagues, and professional associations. Featured faculty at the program will include (Many others are not listed):

### **Paul Offit, M.D.,**

Chief of Infectious Diseases  
Director of the Vaccine Education Ctr  
Children's Hospital of Philadelphia  
Professor of Vaccinology & Pediatrics  
University of Pennsylvania School of Medicine

### **Melinda Wharton, M.D.**

Deputy Director of the National Center for Immunizations and Respiratory Disease

### **Lawrence Gostin, J.D.,**

Associate Dean, Georgetown University Law Ctr.  
O'Neill Institute for National & Global Health Law

### **Ana Viamonte Ros, M.D., M.P.H.**

State Surgeon General  
Florida Department of Health

### **Sharon Humiston, M.D., M.P.H.**

Associate Professor of Emergency Medicine and Pediatrics  
Dept. of Emergency Medicine,  
University of Rochester  
School of Medicine and Dentistry

### **Gerry Shiebler, M.D.**

Child Advocacy Expert

The program has been approved for 12 hours towards the AMA Physician's Recognition Award Category 1 Credit(s)™.

Registration for the program is available online with an early registration fee reduction at: [www.medicine.nova.edu/ce](http://www.medicine.nova.edu/ce)

I hope to see all of you at this unique and important conference this winter.

Edward E. Packer, D.O., FAAP,  
FACOP  
Chair, Department of Pediatrics  
Nova Southeastern University  
College of Osteopathic Medicine

**All Officers will serve  
From 2007 through 2009.**

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the next page.**

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RR, Region 2	James Cheek, MD, FAAP	<a href="mailto:jcheek@carithersgroup.com">jcheek@carithersgroup.com</a>	<b>Region 2</b> Baker, Clay, Duval, Nassau, St. Johns
ARR, Region 2	David Wood, MD, MPH, FAAP	<a href="mailto:David.wood@jax.ufl.edu">David.wood@jax.ufl.edu</a>	
RR, Region 3	Carolyn Carter, MD, FAAP	<a href="mailto:Cgcarter1@aol.com">Cgcarter1@aol.com</a>	<b>Region 3</b> Alachua, Bradford, Citrus, Columbia, Flagler, Gilchrist, Hamilton, Jefferson, Lafayette, Levy, Madison, Marion, Putnam, Suwanee, Taylor, Union, Volusia
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RR, Region 4	Randall Bertolette, MD, FAAP	<a href="mailto:Randall.berতোlette@med.fsu.edu">Randall.berতোlette@med.fsu.edu</a>	<b>Region 4</b> Brevard, Indian River, Lake, Okeechobee, Orange, Osceola, Polk, Seminole, St. Lucie, Sumter
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