THE FLORIDA PEDIATRICIAN

VOLUME 30, NO 1

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

Jefferson Memorial at Tidal Basin in Washington, DC by Nancy M. Silva, MD, FAAP

Index

Continuing Medical Education

Future of Pediatrics Conference
Orlando, FL
Hilton in the Walt Disney World Resort
Jun 29—Jul 1, 2007
Maximum 18.0 *AMA PRA Category 1 Credit(s)™*

PREP:ID—Registration Open!
Chicago, IL
Marriot Chicago Downtown Magnificent Mile
Jul 24—29, 2007
Maximum 35.25 *AMA PRA Category 1 Credit(s)™*

Pediatric Hospital Medicine
Salt Lake City, UT
Marriot Salt Lake City Downtown
Aug 2—5, 2007
Maximum 18.0 *AMA PRA Category 1 Credit(s)™*

NeoPREP—Registration Open!
Atlanta, GA
Grand Hyatt Atlanta in Buckhead
Aug 19—25, 2007
Maximum 53.0 *AMA PRA Category 1 Credit(s)™*

AM: PREP—Registration Open!
Savannah, GA
Hyatt Regency Savannah
Sept 5—8, 2007
Maximum 26.0 *AMA PRA Category 1 Credit(s)™*

PREP: The Course—Registration Open!
Philadelphia, PA
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Sept 15—19, 2007
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Practical Pediatrics CME Course—Registration Open!
Long Beach, CA
The Westin Long Beach
Oct 4—6, 2007
Maximum 16.5 *AMA PRA Category 1 Credit(s)™*

Are you *protecting* them against meningococcal disease?

Improved inventory and supply of meningococcal vaccine has prompted the Centers for Disease Control and Prevention (CDC) to reinstate the full Advisory Committee on Immunization Practices' (ACIP) recommendation for meningococcal vaccination.[1]

Health-care professionals can once again administer meningococcal vaccine to **all** of the recommended immunization cohorts:[1]

- **Young adolescents** (11–12 years of age)

And if they have not been previously vaccinated with MCV vaccine

- **Teens entering high school** (15 years of age)
- **College freshmen living in dormitories**

ACIP now recommends for all 11-18 year olds

Now that adequate supplies are available the CDC also encourages health-care professionals to continue to **call back those adolescent patients for which meningococcal vaccination was deferred.**[1]

Keep supply of meningococcal vaccine on hand and take advantage of every opportunity to immunize year round.

Brought to you as a public health service by Sanofi Pasteur Inc.

Reference: 1. Centers for Disease Control and Prevention. Notice to readers: Improved supply of meningococcal conjugate vaccine, recommendation to resume vaccination of children aged 11–12 years. *MMWR.* 2006;55(43):1177.

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In Memoriam: Herbert H. Pomerance, MD

It is my honor to provide a few comments in tribute to Herbert H. Pomerance, M.D., long time editor of the Florida Pediatrician, who passed from us in February 6, 2007 at the age of 88. Herbert made a passion of involvement in organized pediatrics with long term contributions, generally not known to the younger members. In recent years, he served as the editor of the Florida Pediatrician, always making deadlines and accepting with grace a decision to move from print copy to electronic posting. He, along with Charles Weiss, M.D., long term contributor to environmental health relative to children, will be greatly missed from our senior ranks because of their devotion and passion to the care and welfare of children.

Herb was born March 28, 1918 in New York City (NYC). From a relatively early age, he knew that he would proceed to the pursuit of the profession of medicine. He was a graduate of New York University, College of Arts and Sciences, where he graduated Magna Cum Laude with Phi Beta Kappa in 1937. In 1941 he completed his MD Degree at Columbia University, College of Physicians and Surgeons. He entered into a brief period of training at Memorial Hospital in Wilmington, Delaware, July 1941 to June 30, 1942, followed by his service as the rank of Major in the Medical Corp July 1942 to April 1946. He was indeed one of "THE GREATEST GENRATION" immortalized in the history of this nation. After discharge from the US Army, he completed a residency in pediatrics of one year duration at Gouverneur Hospital in NYC, followed by an assistant residency in what was then called "Contagion" at the Willard Parker Hospital in NYC. Then, he then followed as Chief Resident in Pediatrics at Lincoln Hospital in NYC in 1948. He achieved certification by the American Board of Pediatrics and became a fellow of the American Academy of Pediatrics both in 1951, shortly after his entry into private practice in Queens, NY where he remained through 1970.

He maintained an interest as a voluntary faculty member, rising from the rank of instructor in pediatrics to clinical assistant professor in pediatrics at SUNY Downstate Medical Center 1960 through 1970. As a pediatric physician he practiced in an era of house calls and availability 24/7 as a solo practitioner.

He was regarded as a wonderful father by his children although he was strict and had high expectations. His recreation included boating in a moderate sized cruiser built by the electric boat company. He enjoyed all of his leisure time with Ruth, his wife of many years, and his children, as a devoted father.

He got sand in his feet in 1970, changed his pace relocating to the Charleston Division of the West Virginia School of Medicine in Sept 1970 where he remained and grew through the ranks to clinical professor and professor and chairman 1973-1984 when he became Emeritus Professor of Pediatrics and relocated to Tampa, Florida and took an appointment by Lew A. Barness, founding chairman of the Department of Pediatrics, as a professor of pediatrics at USF College of Medicine.

His particular interest at that time was in Continuing Education. He was appointed Director of Continuing Education in Pediatrics 1984 and he remained as such until his death, arranging grand rounds and conferences. He became Interim Chairman of the Department of Pediatrics April 16, 1990 through November 1, 1991 when Jaime L. Frias, M.D., was recruited as Chair of the Department of Pediatrics.

His vita is replete with American Academy of Pediatrics activities, starting in 1968 as a Chairman of the Committee on Adoptions in

In Memoriam: Herbert H. Pomerance, MD

Dr. & Mrs. Ruth & Herbert H. Pomerance with sons, Glenn N. Pomerance, MD on the left, an Opthamolosit in Chatanooga, TN and Roger M. Pomerance, Esq. an attorney in Boca Raton, FL

New York State Chapter 2, Chairman of Pediatric Practice Committee, West Virginia Chapter, and Chairman of the Committee on Fetus and Newborn, West Virginia Chapter. He was an advocate for regionalization of perinatal care in West Virginia and participated in the development of standards on perinatal health and health manpower in West Virginia, an activity not generally known to the membership. He was appointed a member on the Committee of Standards of Child Healthcare of the American Academy of Pediatrics 1975-1979 and served for six years on the committee on Practice on Ambulatory Pediatrics AAP, as well as his activities in the West Virginia Chapter in 1976-1982. He was a founding member of the Chapter Chair Forum Committee, which commenced about 1980 and continued to the early 2000 years.

He held national office as a member of the Chapter Chairman's Forum Committee and was active in speaking for children; he energized creation of Ronald McDonald House in Southern West Virginia and served on many committees related to communications in pediatrics and committees on continuing medical education. Officially he served as editor of the Florida Pediatrician from January 1994 – to January 2000 with a short interlude to 2001 when he resumed responsibility for its publication. Few know that he had a major interest and was author of the textbook "Growth Standards in Children" in 1979 and co-author of "Topics in Pediatrics" in 1990.

The Tampa Tribune wrote a very nice article on Friday, February 9, 2007, which was headlined "Doctor Worked Until Day He Died". Herb would not have it otherwise, he wouldn't quit working. He worked quietly in the office on the morning of his demise, drove home from the office to his condominium where he lived alone and collapsed. He was described by Robert Nelson, Professor and Chairman of USF Dept of Pediatrics with several quotes. "In many ways, he was everybody's ideal of a general pediatrician. As a person, he was a delightful individual who loved to offer advice and support. His love and commitment to pediatrics was legendary." Summarized, "Most of us will kick back quite a bit earlier, but he kept working."

Ruth and Herbert were married for 60 years until her passing in 2001.

Herb will be missed for his attendance at every grand rounds and his diligence to assuring support of the profession of medicine, in particular child health care. All miss him and trust that others will rise in his place to carry forward ideals of children's healthcare with the same passion.

Respectfully,

John S. Curran, MD, FAAP

In Memoriam: Jay M Whitworth, MD

Jay M. Whitworth, MD passed away suddenly September 9, 2006 while in London after attending an international conference on child abuse. Born May 11, 1938 in Pendleton, Indiana, Jay was a graduate of Indiana University School of Medicine. He completed his pediatric residency and a fellowship in Pediatric Nephrology at Johns Hopkins Hospital in Baltimore. He came to Jacksonville in 1969 and was initially in private practice, but then joined the University of Florida-Jacksonville as Chief of Pediatric Nephrology.

In the mid 1970's he developed an interest in protecting children who were sexually and physically abused – which became his professional passion for the rest of his career. Jay was one of the first in the country to bring together multi-disciplinary teams of professionals to better diagnose and make recommendations for abused children. With the support of the Florida Pediatric Society and the Florida Medical Association, Jay sought legislation to begin a pilot multi-disciplinary program in Jacksonville. He developed this concept into Florida's statewide Child Protection Team system and served as the Statewide Medical Director until 2004. The Child Protection Team system now consists of 23 medically led teams who review all child abuse reports, and interview and medically examine those at highest risk. The CPT system in Florida is considered to be the premier statewide approach to child abuse with sophisticated quality assurance review, the most advanced telemedicine system, and a large number of medical child abuse providers. Unique among the states is that the Florida CPT system is located within Children's Medical Services – reflecting Jay's belief that child abuse is primarily a health problem with profound implications for health at all ages.

The Office of Attorney General Charlie Christ recognized Dr. Whitworth as Florida's Victim Advocate of the Year in 2003, in conjunction with the state's commemoration of Crime Victims' Rights Week. Jay also was awarded with a Lifetime Achievement Award by the American Academy of Pediatrics in 2004. More recently, he was recognized as one of the top 20 physicians in child abuse in the US.

Jay trained physicians and other medical professionals, as well as non-medical professionals, extensively within Florida, the US, Europe, Asia and South America on child abuse issues. He introduced child abuse prevention to China, and lectured in Colombia, England, and Ireland. In addition, he served on a number of national child abuse committees including considerable work with the American Academy of Pediatrics to develop Child Abuse as a new pediatric subspecialty.

Jay was the author of nine textbook chapters on child abuse, multiple other publications and co-authored the national guidelines for evaluation of child physical and sexual abuse for the American Medical Association and the American Academy of Pediatrics. For the last ten years he was a national leader in the development of telemedicine for child abuse assessments. He will be remembered as a champion for children who are hurt and helpless.

In appreciation of Dr. Whitworth's tireless efforts and his endless contributions to children, Florida's statewide Child Protection Team system, and the community, a fund has been established in his name. Donations may be made to the J.M. Whitworth Memorial Fund, 1650 Prudential Drive, Suite 100, Jacksonville, Florida, 32207. The proceeds of this fund will help underserved, abused children and to further the causes to which Dr. Whitworth dedicated his life.

In Memoriam: John W. Fanizzi, MD

Fanizzi , William John, M.D. , 82, Ft. Lauderdale, FL went home to be with our Lord Jesus Christ on May 25th. He died peacefully at home surrounded by his beloved family. Papa was the patriarch of our family; he lived an amazing life and we are so blessed that he was with us for so many wonderful years.

Bill was born in New York City, NY on May 31, 1924. He was the only child of Italian immigrants Domenick Fanizzi and Donatella Grande Fanizzi. Having attended grade school and high school in Manhattan, he was the first member of his family to attend college. He graduated with a B.S. Degree from the University of Notre Dame in 1945. Subsequently he received his medical degree from Georgetown University Medical School in 1948.

After interning at St. Vincent's Hospital in New York City, he began a brief career in the U.S. Navy, as a Lieutenant in the Medical Corps USNR on board the USS Bennington where he sailed the Mediterranean. His real love was working with infants and children; thus he decided to become a pediatrician. His profession took him to The St. Francis Sanitarium for Cardiac Children, the New York Founding Hospital, Bellevue Hospital in New York City and subsequently back to St. Vincent's Hospital in New York City for his residency.

In 1956 Bill and his widowed mother moved to east Ft. Lauderdale where he began his private pediatrics practice on East Broward Blvd. serving infants and children. Many generations of Broward County families were his patients and all remember his kind spirit, his wonderful bedside manner and his treasure chest filled with candy and treats that his patients were allowed to have following a successful visit to "Dr. Bill".

In 1959 he married the love of his life, Lucy Blackwood and they enjoyed 47 years of blissful marriage. He was the father of five children: Mary Fanizzi Krystoff, Christine Anne Fanizzi, William Dominic Fanizzi, Ellen Fanizzi Dalton (Dr. H. Lawrence Dalton) and Frederick John Fanizzi (Maria Eugenia Rivas Fanizzi). He was incredibly proud of his five grandchildren Austin William Krystoff, Caroline Eva Krystoff, Lucy Eileen Dalton, Jack Johnson Dalton and Joseph Daniel Fanizzi.

Dr. Fanizzi's medical career was filled with purpose. He was named Chairman of the Dept. of Pediatrics at Broward General Medical Center and Holy Cross Hospital. He served as the Medical Director of Children's Medical Services, District 10. He was the first President of the Broward County Heart Association elected for 2 consecutive terms.

Following retirement from private practice in 1987, he joined the Broward County Health Department as Senior Physician, and then became Director from 1995 - 1998. He was a member of the BCMA, FMA and AMA, a Diplomat of the American Board of Pediatrics, Fellow of the American Academy of Pediatrics. He was the Honorary Founder of Fanizzi Associates, Inc. and served as Advisor to all of his children in their various endeavors.

He loved the stock market, painting at the Studio on Saturday mornings and was an avid Notre Dame alumni and remained so throughout his life.

The family would like to extend sincere appreciation to Dr. Carroll Moody, Dr. George Salerno and staff Trish Michel, Katrina Hicks, Carmen Keeghan, Mary Hoffman, Denise Sevok, and Cindy Keating for their professional care and support; also Gold Coast Hospice, Roberta DeMarco and Sharon Morrissey.

Visitation will be on Tuesday, May 29th from 5:00 pm - 9:00 pm at Baird-Case Jordan-Fannin Funeral Home, 4343 N. Federal Highway, Ft. Lauderdale, FL 33308. Prayer service at 7:30 p.m. Mass of Christian Resurrection to be held at St. Anthony Church, 901 NE 2nd Street, Ft. Lauderdale, FL 33301 on Wednesday, May 30 at 10:00 am. Interment at Queen of Heaven Cemetery.

In lieu of flowers, kindly make donations to St. Anthony Foundation for Education, In Memory of Dr. William J. Fanizzi, 820 NE 3rd Street, Ft. Lauderdale, FL 33301 or the Notre Dame Club of Ft. Lauderdale Scholarship Fund In Memory of Dr. William J. Fanizzi, c/o Mr. Thomas Sclafani, Esq. ,2888 E. Oakland Park Blvd., Ft. Lauderdale, FL 33306.

Published in the Sun-Sentinel on 5/27/2007.

President's Page

Dr. Marcus does compassionate work with Interplast

Dear Members of the Florida Pediatric Society,

My last two years, as President of the FPS, has been enriched by the many volunteers who have donated their time, energy and expertise to improving the lives of the Children of Florida. Without my wonderful and dedicated executive committee, we could never have accomplished as much as we have. To those of you who have helped and supported me through my tenure, I give my heartfelt thanks because together we have moved the organization in a most positive direction.

Volunteerism has always been the basis of my participation and the nourishment of my soul. It constantly reminds me why I went into medicine and energizes me to keep going forward in the profession. I have worked for many years with the Florida Pediatric Society and hope to continue to work for the state, the district and the national organizations, of the American Academy of Pediatrics. It has been an honor and a pleasure to work with all of you and I hope that you are all as proud of our accomplishments as I am.

In my final address, I have been asked to share with you my experiences with another wonderful organization, like the FPS. The organization that has captured my heart is Interplast. This group has taken me to places I never would have dreamed of visiting, thereby combining two of my greatest interests. Interplast sponsors surgical trips to many countries around the world providing surgical intervention which changes the lives of those children it touches. There is no better way to give back to the world, than to improve the life of a child.

The trips usually start with the meeting of the team. Volunteers come from all over the country and sometimes the world. We start as strangers and end as friends. Because of the unknown resources of the countries we travel to, we bring all of our own equipment down to the band aids and Tylenol.

My trip started in San Francisco where the team converged and the trip boxes were collected. After twenty five hours of travel, we finally arrived at our destination, Phan Rang, Viet Nam. Phan Rang is a city of approximately 100,000 people and our team was probably the only Caucasian group in the area.

Clinic day started at 8 am and has always been an invigorating experience. When we first entered the clinic waiting room, we were overwhelmed by the

President's Page

Clinic Day in Phan Rang, Viet Nam

number of people anticipating our arrival. It is a time of hope and a time of disappointment. This is the moment that people have traveled days for, often on foot and if qualified will have life debilitating deformities corrected.

Over the following two weeks, we spent many hours in the OR and hours on the wards bonding with these strangers who radiated warmth and thankfulness. It is a feeling that can only be experienced personally, but one which I highly recommend.

During our two week stay, we operated on 59 patients; correcting burn contractures which allowed them to use a hand or arm which was previously useless and closed cleft lips and palates which allowed them to enter a society from which they were most often excluded. There were plenty of patients that had to be turned away due to lack of time but were sent off with a promise that we would return next year. On our last day we left Phan Rang, exhausted but content that we had left a mark.

Volunteerism is a fulfilling commitment, a joy, and a responsibility. My hat is off to all who volunteer. I look forward to sharing my life with all of you in the future and promise to stay committed along with you to the Children of Florida and to the Children of the World.

Sincerely,
David Marcus, MD, FAAP

Interplast
Healing Bodies, Changing Lives

For more information, please visit http://www.interplast.org/contact.php

Leaving Viet Nam

Editor's Page

Friends,

Over 15 months ago, two personal life altering events occurred. The first was the loss of a patient of mine, Katie Marchetti, at the young age of sixteen (16) years old. It hasn't been easy to lose her simply because of one moment in time, when she didn't use her seat belt.

Katie Marchetti

The second event was the birth of my son, Jonathan, within the week of the first. The two events are forever linked in my mind. Such is life; as one ends, another begins. And my passion for child advocacy was born.

As a result, I have become more involved in my community, trying to make a difference; spreading the word of safety belt awareness, and trying to get Florida a primary safety belt law. Along the way, I realized that I wanted to be directly involved in the Florida Pediatric Society and the AAP. Hence, it is which much honor that I take on my new role as editor of the Florida Pediatrician. While no one can ever truly replace Dr. Pomerance and all that he brought to pediatrics, I am proud to be given the opportunity to work with you and serve you. In essence, the torch has been passed and I hold it proudly.

This issue of The Florida Pediatrician is notably "thinner" than those from the past. Understandably, all the usual contributors were unable to formulate articles in time for this publication at June's end. The next issue is set to be published September 30th. Deadline for submissions is set for August 30th. As a result, the sections you are familiar with should return. It is my hope that after reading this issue, you will all be excited. Hopefully, this will encourage you to add your own personal touch to this Newsletter.

In my first address to you, I thank you for your patience in the arrival of this month's issue. It was a huge undertaking to present you with a new look and feel for our society's Newsletter. Also, there are several new sections waiting to be filled by readers and writers like you. I encourage you all to participate and help make this amazing Newsletter be an exciting and informative resource for us all. Although I think you'll be pleased, I realize not everyone is happy with change. I ask for your continued patience as this is still a work in progress. More changes are inevitable with the growth of this Newsletter. The most notable change you will undoubtedly notice is that our electronic Newsletter is in color, full of pictures with lots of eye candy.

My interests lie in the art and humanity of medicine. Subsequently, there will be several newly and permanently featured sections in the Newsletter which reflect this interest. You'll notice that whenever possible, there is a face behind the voice of each article. This personal touch will help us better know each other's voices.

Each of us has different ways of expressing our inner voices. As a result, "At Your Leisure" with several subsections has been created for the next issue of the Florida Pediatrician. Dr. Marcus

Editor's Page

was gracious enough to start this section in his final address. "Writer's Corner" will be a place where you can share your stories and talents. Have you had a fun vacation or volunteered somewhere that you want to share with us? Then, the "Physician Travel" section is for you. Are you a stamp collector, boater, or participate in any after hours activity that keeps you going, inspires you, or just have lots of fun with? Then, "What's Your Hobby?" is for you. Do you have a photo or artwork that is your masterpiece waiting for all to see?" Then, "Visions" is for you. All photos or artwork can be submitted with one to two paragraphs that share the meaning behind the artist's work. How does it affect you personally and/or professionally? I welcome you all to share the personal aspects of your life that affect your role as a pediatrician, perhaps enriching it, even enabling it.

You will also note that the cover page of the Newsletter has changed. It too is a work in progress. I invite you all to submit photos for the cover. Each issue will have a photo or other artwork created by one of our members.

In addition, I have a special request for assistance from our senior members. You are a voice of wisdom and advocacy. With your help, we do not need to reinvent the wheel; we can make sure it keeps on rolling. "Physician Health Thyself" has been created because we can help ourselves best from the wisdom of our peers. This section will contain information regarding disaster preparedness, retirement planning, pediatric pearls, suggestions on how to keep from burning out, and much more. You can help. Please share your wisdom with us.

Please submit your stories, poetry or prose, pictures or personal artwork to me at fps_newsletter@yahoo.com or Dawn Pollack at dawn@mgmtresources.org.

Guidelines will be available online. In the meanwhile, please submit anything you care to share or are interested in. I have an "open door" policy; I encourage you to share your opinions, questions, and suggestions to me. You may be chosen for the "Letters to the Editor" section.

Lastly, I would like to take this time to thank Dawn Pollack. She has been a valuable sounding board for this, my first newsletter. She has lots of energy and spunk. It has truly been a pleasure working with her. And I'm excited to continue to do so in the future.

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

Sincerely,

Nancy M. Silva, MD, FAAP

http://www.katiesstory.com/

Pediatric Department Chair

In our undergraduate program, we have broadened the training for our students by adding lectures in expanded system-based courses and stressing the developmental aspect of health and disease processes in children. Problem-based learning sessions have added new pediatric scenarios and are now stressing the interpretation of research data to critically validate different studies. We have presented to students cases requiring evidence-based protocols to develop appropriate treatment plans for children.

Our pediatric special interest group (http://www.nova.edu/pedsclub) has started several projects with other colleagues devoted to child health issues. Our students met with students in the College of Speech and Language to learn about techniques utilized by other professionals who care for specific children's language disorders. Our students have become involved with child life services at the Chris Evert Children's Hospital.

The pediatric ambulatory clinic at Nova Southeastern University College of Osteopathic medicine has added another faculty member, Rogerio Faillace, M.D., FAAP, who has always received exceptional evaluations from our students that he has worked with in his own practice. We are pleased that he can bring his experience to our on campus program.

Pediatric residents from the Palms West program are now doing regular rotations at our local site, the NSU clinic, where I may critically observe their ambulatory skills. Nursing students from the College of Allied Health are regularly rotating through our clinic to learn about pediatric ambulatory practices. They have developed a program for educating families on injury prevention in homes with children as a component of their experience in ambulatory training.

Our pediatric residency at Palms West continues to thrive, adding an associate program director, Ann Church, M.D., FAAP. She served as a program Director of a joint ACGME/AOA pediatric residency at Henry Ford in Detroit. She has extensive experience in postgraduate training and serves as an editor for the Ambulatory Pediatric Association newsletter.

Our campus now has a new inpatient pediatric oncology unit that will service the Palm Beach community and provide an ambulatory chemotherapy service. The Pavilion at Columbia Hospital now has a new inpatient pediatric psychiatric unit where our residents will have regular rotations and lectures in behavioral medicine. Our residents are preparing to make presentations at the first joint American Academy of Pediatrics/ American College of Osteopathic Pediatricians meeting to be held this June in Orlando. We view this meeting as a very positive step forward for our entire profession, and we look forward to future collaborative events.

The pediatric department has just completed a very interesting joint study with the Fischler College of Education on the acquisition of mathematical skills in autistic children. Our university houses the Baudhuin Preschool which has over 200 children with Autism Spectrum Disorder, offering many opportunities for students to learn more about these children. We are currently involved in a joint study with the department of osteopathic principles and practices to evaluate the impact of osteopathic manipulation on upper respiratory infections in young children. It is important to apply valid research protocols to these procedures to determine evidence based utility in their application.

I look forward reporting to the association next year. I hope to see everyone this June.

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

2007 LEGISLATIVE SESSION REPORT

Nancy Moreau

The 2007 Legislative Session began with hope for a new day in Florida. Charlie Crist, the "people's governor," was newly elected with a tone that promised greater attention to the problems of the common man. Additionally, with a new Senate President, Ken Pruitt, and a new Speaker of the House of Representatives, Marco Rubio, there appeared to be an atmosphere of cooperation that had not been present on the hill in some time. The styles of these three leaders appeared to be much different that those of the recent past with a more compromising attitude, or so we thought. All of these leaders expressed a desire to allow the process and ideas of all the representatives and senators to be heard, however, as we ultimately found this was only a charade with behind the scenes negotiations and deals as is the norm in politics.

While more genteel than in the past, differences could not be overcome on several important issues. Florida's KidCare Program legislation was one victim of the inability to come to agreement in an open forum to work out differences. We still do not fully understand what the sticking point was that derailed the important changes the Society and advocates worked tirelessly on the entire session.

The most pressing issues for the Society during this session were the KidCare Program and increasing Medicaid physician fees. As has been the case for years our pleas and that of the Florida Medical Association to increase Medicaid physician fees fell on deaf ears both with the Legislature and the Governor. While it is acknowledged that the fees are inadequate other priorities and of course the cry of "no money" prevailed once again.

The need for revisions to the KidCare Program became a focal point for committees in both the House and Senate with an interim senate report detailing inadequacies in the program and legislation was filed to address many of the concerns of the advocates and the Society.

The issue of consolidation of the program's administration was a priority of the Society and with the support and encouragement of Senator Mandy Dawson, Chair of the Senate Health Policy Committee, legislation was drafted to address this issue by consolidating the program within the Department of Health. The House, however, did not want nor did they see any need to look at the administrative structure of the program. And so it began, with numerous meetings attended by Dr. St. Petery and your lobbyist with the leadership in the House, Senate, Governor's Office and Office of the Chief Financial Officer. What ultimately transpired was a decree by the Governor's Office staff that any consolidation would be placed within the Agency for Health Care Administration since they presently handle the majority of the program through Medicaid.

This was a very disappointing turn of events given the trials and tribulations the Society has experienced with the Medicaid program. Regardless of this disappointment we continued to try and make the legislation as acceptable as possible, but in the end issues (we were not privy to) denied the legislation final approval by the Legislature. We are attempting in unison with other advocates to have KidCare placed within the call of the upcoming Special Session on property taxes.

Even though we expended the majority of our time on KidCare and Medicaid fees, other issues important to children fared better with the creation of a Children's

Committee Report: Legislative

Cabinet, increased requirements for physical education in grades K-5 and passage of the Tobacco Education and Prevention Act with constitutionally mandated funding. Unfortunately the booster seat legislation we were promoting did not make it through the process, but a new effort will be made next year.

The following is a list of bills that may be of interest to members.

SB 2 –

Unattended Child in a Motor Vehicle

This legislation amends current statute that provides penalties for leaving a child under six years of age unattended in a motor vehicle. Penalties are enhanced to make it a second degree misdemeanor (up to 60 days in jail and a fine of up to $500) for leaving a child under the age of six unattended or unsupervised in a vehicle for longer than 15 minutes or for any period of time if the vehicle is left running. If this section is violated and a child suffers great bodily harm, or permanent disability or disfigurement the penalty is increased to a third degree felony (up to five years in prison and a fine of up to $5,000).

Effective date: July 1, 2007

CS/CS/HB 967 –

Physical Education (Ch. 2007-28)

Governor Crist has signed this bill into law. It requires district school boards to provide 150 minutes of physical education each week to students in kindergarten through grade 5. Physical education is defined as the development or maintenance of skills related to strength, agility, flexibility, movement and stamina, including dance. Development of knowledge and skills regarding teamwork and fair play, nutrition and physical fitness as part of a healthy lifestyle are also included in the definition.

The State Board of Education is required to review and revise as necessary, the Sunshine State Standards to ensure the standards reflect the state-of-the-art physical education philosophy and practice in this state.

Effective date: May 17, 2007

CS/HB 461 –

High School Athletics – Steroids

A one–year, random, anabolic steroids testing program for students in grades 9 through 12 that participate in football, baseball and weightlifting is established. The Florida High School Athletic Association (FHSAA) is to administer the program during the 2007-2008 school year.

Both public and private schools must participate as a prerequisite to FHSAA membership.

Up to one percent of student athletes may be tested for steroid use. Students testing positively must be suspended immediately from participation in all interscholastic athletic practice and competition for 90 days and the student must attend a drug education program. A student's eligibility may not be restored until the student tests negative on an exit drug test. The FHSAA is required to report program results to the Legislature by October 1, 2008.

Effective date: July 1, 2007

CS/HB 509 –

Children and Youth Cabinet

The Children and Youth Cabinet is established in the Executive Office of the Governor.

It is defined as a coordinating council to ensure that Florida's public policy promotes interdepartmental collaboration and program implementation so that services for children and youth are planned, managed and delivered in a holistic and integrated manner.

Membership is detailed to include the heads of various state agencies that provide services to children and youth. The Governor is permitted to appoint an advisory board to assist the Cabinet, specifying that membership should include representatives of advocacy groups, as well as, young people who have received services funded by the state. The Cabinet is required to provide an annual report by February 1 of each year.

Effective date: July 1, 2007.

CS/HB 139 – Suicide Prevention (Ch. 2007-46)

The Statewide Office for Suicide Prevention is created as a unit of the Office of Drug Control within the Executive Office of the Governor. The Office is charged with developing a network of community-based programs to improve suicide prevention initiatives, prepare and implement a statewide plan with the advice of the Suicide Prevention Coordinating Council, increase public awareness concerning topics relating to suicide prevention, and coordinate education and training curricula in suicide prevention efforts.

A Suicide Prevention Coordinating Council is established to advise the Statewide Office on the development of a statewide plan for suicide prevention. The Office is also authorized to seek and accept grants to support its operation.

Effective date: July 1, 2007.

CS/SB1126 – Tobacco Education and Prevention (Ch. 2007-65)

Section 381.84, Florida Statutes, is created to implement s.27, Article X of the Florida Constitution that requires funding of a Comprehensive Statewide Tobacco Education and Prevention Program. The state is required to create a comprehensive statewide program consistent with the 1999 Best Practices for Comprehensive Tobacco Control Programs developed by the United States Centers for Disease Control and Prevention and specifies the components of the program.

A Tobacco Education and Use Prevention Advisory Council is created to advise the Secretary of Health regarding the direction and scope of the program. Duties of the council are specified. Contracts and grants to implement the program are to be awarded based on merit through a competitive peer-reviewed process. For the 2007-2008 and 2008-2009 fiscal years the Area Health Education Councils Network (AHEC) will be awarded $10 million after which time the network will be required to participate in the competitive peer-reviewed process.

The Department of Health is required to produce a report by January 31 of each year that evaluates the program's effectiveness in reducing and preventing tobacco use and recommends improvements to enhance the program's effectiveness. The department is also required to adopt rules to implement the program.

Effective date: July 1, 2007

CS/CS/HB 1309 – Office of Adoption and Child Protection

This legislation renames the Office of Child Abuse Prevention as the

Office of Adoption and Child Protection and revises the purpose of the Office to include the promotion of adoption and the support of adoptive families.

The director of the Office is designated as the Chief Child Advocate and authorized the Office to establish a direct-support organization to support the state in carrying out its purposes and responsibilities regarding the promotion of adoption, the support of adoptive families and the prevention of child abuse.

Effective date: July 1, 2007.

CS/HB 1269 – Infant Morality

The black infant health practice initiative is created to determine factors associated with racial disparity in infant mortality through the use of specific methodologies. The initiative will be administered through collaboration among the Department of Health, federal and state healthy start coalitions, and public universities and college with expertise in public health. The Department of Health is to develop a grant program for the coalitions to implement the objectives of the bill. Participating coalitions must develop an interdisciplinary team to oversee the process of examining infant deaths. Immunity from civil liability is provided to participating coalitions and their staff.

Effective date: July 1, 2007

CS/CS/SB 770 – Physician Workforce

This legislation requires the Department of Health to serve as a coordinating and strategic planning body to actively assess Florida's current and future physician workforce needs. The department is directed to work with multiple stakeholders to develop strategies and alternatives to address current and projected physician workforce needs. The use of existing programs must be maximized within the department and other state agencies. Additionally, the department must coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of the plan. The department must maintain a database to serve as a statewide source of data concerning the physician workforce.

All Florida-licensed allopathic and osteopathic physicians are required in conjunction with the renewal of his or her license to furnish specified information to the department in a physician survey. Information to be included in the survey is detailed in the legislation and the department is given rulemaking authority to develop the physician survey. Physicians who fail to complete the survey within 90 days after the renewal of his or her license will be issued a non-disciplinary citation. The citation is to provide a notice that any subsequent licensure renewal will not acted upon until the physician completes the survey. Specific information is required to be reported to the Governor and Legislature after analysis of the survey results by November 1 of each year.

Effective date: Upon becoming law.

CS/SB 1758 – Hospitals Off Premises Emergency Departments

This legislation places a moratorium on licensure of off-premises hospital emergency departments by the Agency for Health Care Administration until July 1, 2009, however there are exceptions for projects in the pipeline prior to April 30, 2007. Licensure standards for the

exempt projects will be those in effect before July 1, 2007.

Effective date: July 1, 2007.

CS/HB 543 –

Pharmacist Immunization Services

The Pharmacist Kevin Coit Memorial Act is created that authorizes a Florida-licensed pharmacist to administer influenza immunizations to adults under a protocol with a supervisory Florida -licensed allopathic or osteopathic physician. Specific procedures for addressing any unforeseen allergic reaction to the immunization must be contained in the protocol. Additionally, pharmacists providing immunizations must maintain at least $200,000 of liability insurance; maintain patient records using the same standards for confidentiality as for other patient records; enter into a protocol with a supervising physician which specifies certain conditions; obtain written approval to administer immunizations from the pharmacy owner; obtain training and immunization certification approved by the Board of Pharmacy in consultation with the Boards of Medicine and Osteopathic Medicine; and, complete 20 hours of continuing education approved by the Board of Pharmacy.

A task force for the study of biotech competitiveness is created within the Governor's Office of Tourism, Trade and Economic Development with a report due by January 1, 2009.

Effective date: July 1, 2007.

CS/SM 1506 –

State Children's Health Insurance Program

This is a resolution by the Florida Legislature that will be sent to the President and Congress to encourage reauthorization of funding for the State Children's Health Insurance Program (SCHIP). Copies of the memorial will be sent to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida Congressional delegation.

CS/CS/SB 2260 –

Department of Health/ State Surgeon General (Ch. 2007-40)

The promotion of health and wellness and disease prevention initiatives are added to the duties of the Department of Health. The secretary of the Department of Health is renamed the "State Surgeon General."

Effective date: July 1, 2007.

CS/SB 1508 –

Medical Informed Consent

Advanced registered nurse practitioners and physician assistants are added to the list of health care practitioners who are protected from liability in a civil lawsuit under the Medical Consent Law and the emergency examination or treatment law.

Effective date: July 1, 2007.

Committee Reports

Committee on School Health and Sports Medicine Report

Rani Gereige, MD, MPH, FAAP

As the Florida Pediatric Society/ Florida Chapter of the AAP has a new organizational structure based on the new bylaws, the Committee on School Health and Sports Medicine is under the Committee on Subspecialties under the Council on Advocacy. The COSH and Sports Medicine was restructured. Effort was made to keep representation from various geographic locations across the State and various work settings.

Below is the list of committee members:

1) Committee Chair :
   Rani Gereige, MD
2) Lisa A. Cosgrove, MD
3) Marsha Fishbane , MD
4) David Jones, MD
5) May C Lau, MD
6) Maureen Novak, MD
7) Leslie Ravago, MD
8) Antoinette Spoto-Cannons, MD
9) Karen Toker, MD

The goal of the committee is to address school health-related issues at the levels of advocacy (including legislative advocacy), education, and support. Drs Cosgrove, Gereige, and Fishbane are members of the Child Health Advisory Council which is chaired by Dr. Cosgrove.

Currently the Committee is working on drafting a resolution related to the periodicity of the school entry physical in the State of Florida.

The Committee welcomes any input, topics, requests for support, and or education from FPS members. Please feel free to share any projects or school health related success stories with the Committee by sending them to Dr. Rani Gereige at: rgereige@health.usf.edu

Medicaid Pharmacy & Therapeutics Committee Report

Lisa A. Cargrove, MD, FAAP

Hello all colleagues of Pediatrics. I recently attended and chaired the 3rd quarter meeting of the Medicaid Pharmacy and Therapeutics Committee for the State of Florida. In attendance also was Dr. Andrew Agwonobi who is the Agency for Healthcare Administration (AHCA) director. You all may remember his brother, John, who left the Florida DOH to go to the services of Deputy Surgeon General. During our meetings, we review all categories of medicines that come up on an annual basis. Medications which have had prices renegotiated by the pharmaceutical companies are allowed to be placed on Medicaid formularies if approved by the committee.

Continued on Page 37 …
Physician Heal Thyself Section

AAP DEPT. OF FEDERAL AFFAIRS

TELL CONGRESS TO PROTECT CHILDREN'S HEALTH

Dear Key Contacts,

As we head into summer, Congress is in full swing. A number of key AAP legislative priorities are moving, and we need your help to keep children's health a priority.

This message details action you can take on three critical child health issues:

- Senate legislation to reauthorize and fund the State Children's Health Insurance Program (SCHIP).
- Legislation that will test and label more medications for use in children and promote the development of pediatric medical and surgical devices.
- Emergency Medical Services for Children (EMSC) program reauthorization.

We'll also update you on an action you took on citizenship documentation requirements and the support it gained from a number of U.S. senators.

SCHIP REAUTHORIZATION LEGISLATION

The Senate is expected to begin debating SCHIP reauthorization in the coming weeks. They need to act *NOW*, or the quickly approaching Sept. 30 expiration deadline could risk serious disruptions for states, children and their families.

TAKE ACTION NOW and urge your senators to do the following:

- Take action to promote SCHIP legislation that will include at least $50 billion in new federal money as promised in the budget
- Take action to get those children who are eligible but unenrolled in SCHIP or Medicaid access to the health care they need and deserve

TAKE ACTION LATER - July 4th Recess:

- Contact both your senators and representatives now to arrange an in-district meeting with them during the July 2-6 congressional recess. Both the House and the Senate will be in the midst of crafting SCHIP legislation, and they need to know that this is an opportunity to move closer to the widely-shared goal of ensuring that all of America's children have health care coverage. Contact their offices **as soon as possible** to set up a meeting.
- When you meet with your members of Congress, use leave-behinds and background materials available from the SCHIP Reauthorization Resources Page
- If you can't arrange a meeting during recess, fax the SCHIP reauthorization leave-behind to your senators and representative's district offices with your contact information.

Grass Roots: AAP FAAN

AAP DEPT. OF FEDERAL AFFAIRS

Log on to the AAP Member Center at www.aap.org/moc, and click on “Federal Affairs” and then “Elected Officials” to look up information to contact your congressional members’ district offices directly.

For more information or if you have questions, contact Bob Hall, AAP Department of Federal Affairs, 800-336-5475, ext

PEDIATRIC DRUG AND MEDICAL DEVICE LEGISLATION

The Academy had an important victory for children's health May 9 when the U.S. Senate passed the Food and Drug Administration Revitalization Act (S. 1082).

Now we need your help to achieve a victory in the U.S. House of Representatives!

On Wednesday, June 6, U.S. Rep. Anna Eshoo (D-CA) introduced AAP-supported legislation to reauthorize the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Equity Act (PREA) (H.R. 2589). Reps. Edward Markey (D-MA) and Mike Rogers (R-MI) introduced the AAP-backed Pediatric Medical Device Safety and Improvement Act (H.R. 1494) in the House to provide incentives for developing needed pediatric medical and surgical devices.

TAKE ACTION

The House will be action on the legislation this week, and we need your help to pass these bills as soon as possible.

Contact your representative and tell him or her to **co-sponsor and urge passage of H.R. 2589 and H.R. 1494 as soon as possible**.

Contact Mark Del Monte if you have any questions or need more information - AAP Department of Federal Affairs, 800-336-5475, ext. 3305, or mdelmonte@aap.org.

EMSC REAUTHORIZATION

Sens. Daniel Inouye (D-HI) and Orrin Hatch (R-UT) and Reps. Jim Matheson (D-UT), Peter King (R-NY), and Lois Capps (D-CA) introduced the "Wakefield Act" (S. 60/H.R. 2464) on May 23, 2007. This AAP-endorsed legislation will reauthorize the Emergency Medical Services for Children (EMSC) program for 5 years.

EMSC has driven significant improvements in emergency medical care for children for over 20 years. Last summer's Institute of Medicine report on the future of emergency care in the U.S health system affirmed the importance of the federal EMSC program and stated, "the work of the program continues to be relevant and vital."

TAKE ACTION

Contact your senators and representatives and urge them to co-sponsor the Wakefield Act.

AAP DEPT. OF FEDERAL AFFAIRS

Tell them:

- Marking its 22nd year, the EMSC program has driven major improvements in children's emergency medical care in every state and has funded innovative demonstration projects to further advance pediatric emergency medical care. Significant gaps remain, and the EMSC program must be continued in order to further improve the care delivered to critically ill and injured children. **Co-sponsor the Wakefield Act!**

For more information, contact Cindy Pellegrini, AAP Department of Federal Affairs, 800-336-5475, ext. 3307, cpellegrini@aap.org.

UPDATE: Citizenship Documentation Requirements

In late May, we asked you to contact your senators and urge them to sign-on to a letter to Senate leaders authored by Sen. Russ Feingold (D-WI) seeking a fix to the destructive citizenship documentation requirements within the Deficit Reduction Act.

Due to your efforts and those of other advocates, 28 total senators have signed on to Sen. Feingold's letter as of June 12, including: Sens. Daniel Akaka (D-HI), Barbara Boxer (D-CA), Sherrod Brown (D-OH), Ben Cardin (D-MD), Bob Casey (D-PA), Hillary Clinton (D-NY), Chris Dodd (D-CT), Dick Durbin (D-IL), Dianne Feinstein (D-CA), Tom Harkin (D-IA), Daniel Inouye (D-HI), Tim Johnson (D-SD), Ted Kennedy (D-MA), Amy Klobuchar (D-MN), Herb Kohl (D-WI), Frank Lautenberg (D-NJ), Patrick Leahy (D-VT), Carl Levin (D-MI), Joe Lieberman (ID-CT), Robert Menendez (D-NJ), Barbara Mikulski (D-MD), Patty Murray (D-WA), Barack Obama (D-IL), Jack Reed (D-RI), Bernie Sanders (I-VT), Jim Webb (D-VA), and Sheldon Whitehouse (D-RI).

A recent Washington Post story highlights the fact that children are going without life-saving medical care, essential medicines, and therapies in Virginia and other states as a result of these requirements.

KEEP UP THE GOOD WORK! Thank you for your continued efforts on this and other critical child health legislative efforts. You are making a difference!

Click on the link below to Take Action on any of the previous issues. Become a key contact and you can receive this information directly via your email.

http://aap.grassroots.com/takeaction/?lk=7102125-7102125-0-27401-mFs2W5Z-oQaR69/VZ2qvDRpIqt2rj6sA

Health Care Coverage: KidCare

What Happened to KidCare?

Louis St. Petery, MD, FAAP

For the first time in several years there was genuine legislative interest in "fixing" KidCare during the 2007 regular session of the Florida Legislature. Yet nothing happened. Why?

For starters, let us review KidCare, what is wrong with it, and what fixes were proposed. When the federal State Child Health Insurance Program (SCHIP) was created in 1997, Florida adopted SCHIP by rolling it together with Florida's existing Medicaid program (a.k.a. Title XIX) and Florida's existing Children's Medical Services program (a.k.a. Title V, or the Crippled Children's Program) into a single package, known as KidCare, to provide health care for children from birth to 19 years, whose family income is at or below 200% of the Federal Poverty Level.

The legislative crafters of KidCare envisioned a seamless program in which children would move from one component to another, without a break in coverage, as their age increased and/or their family income changed. Unfortunately, this seamless system never materialized. It is true that many Florida children have received and continue to receive much needed health care as a result of KidCare. However, the application process is confusing, cumbersome, and takes entirely too long. The transitions from one component of KidCare to another are far from seamless, resulting in loss of coverage for extended periods of time. Children "fall off" of KidCare for mysterious reasons. Many families have different primary care physicians for different children, destroying the medical home concept and continuity of care. These are just a few of the myriad of problems that beset Florida KidCare.

To make matters worse, there was an inappropriate degree of bureaucratic concern over the last 3-4 years that the Feds might not reauthorize SCHIP this year which would result in Florida not having sufficient dollars to maintain the Title XXI portion of KidCare. These runaway fears led our Legislature to impose restrictions that dramatically reduced the number of children able to enroll in the SCHIP portion of KidCare, and prevented many children from renewing their SCHIP coverage in KidCare. Subsequently, outreach was canceled. A six (6) month waiting period was imposed for failure to pay premiums (later reduced to 60 days). Additional documents were required for proof of income. The passive renewal process was changed to an active one. At the federal level, the Deficit Reduction Act (DRA) imposed citizenship and identity restrictions on the Medicaid portion of KidCare, all of which has resulted in a dramatic drop in the number of eligible Florida children able to receive coverage under KidCare. At the same time, the number of uninsured children in Florida has risen dramatically. It is currently estimated that there are about 750,000 uninsured Florida children, approximately ⅔ of which have a family income at or below 200% of the Federal Property Level. Therefore, many children are eligible for, but not enrolled in Florida KidCare.

Under the previous Governor, child advocates found no interest on the part of the administration or the Legislature in fixing any of these problems. However, since the election of Governor Charlie Crist, there has been a refreshing change in attitude. Significant discussions regarding KidCare fixes ensued.

The fixes fall into two categories: centralization and streamlining.

Health Care Coverage: KidCare

Centralization would place the administration of KidCare under a single individual, correcting the current untenable situation in which KidCare is housed in four different agencies, each with its own head, its own budget, and its own list of priorities. There is no agency in charge of KidCare. As you know, Healthy Kids Corporation (HKC) processes the online and paper applications for Medicaid and SCHIP, and runs the Healthy Kids portion of SCHIP for children 5 to 19. The Department of Children and Families (DCF) processes applications and determines eligibility for Medicaid. The Agency for Health Care Administration (AHCA) administers the Medicaid program, the Medikids portion of the SCHIP program (children 1 to 5), and administers the dollars for the entire SCHIP program. Finally the Department of Health (DOH) runs Children's Medical Services (CMS), the program for children with special health care needs. Child health advocates all agreed that the most appropriate place to centralize the administration of KidCare is within Children's Medical Services in the Department of Health; this is the only agency within State Government whose sole focus is on children's health care.

Streamlining seeks to fix a number of the issues which prevent eligible children from enrolling and maintaining their eligibility in KidCare. The list includes reducing the penalty for failure to timely pay premiums from 60 to 30 days, reducing the application wait time for children who have lost employer-based health insurance from six months to 30 days (with no waiting period for certain defined exceptions), allowing electronic verification of income (to eliminate the need for finding and submitting paper documents), extending Medicaid eligibility for 60 days for children transitioning from Medicaid to SCHIP to prevent loss of coverage and the like.

The centralization and streamlining fixes were all included in a bill in the Florida Senate (SB 930), championed by Senator Mandy Dawson. SB 930 additionally expanded the program to cover legal immigrants and public workers. The federal SCHIP legislation prohibits using federal matching dollars to cover legal immigrants until after they have been in this country for 5 years. It also prohibits using federal matching dollars for any public employees. SB 930 would have used state dollars to cover both of those populations. SB 930 passed through 2 of its 3 committee stops without a hitch. It seemed destined to provide needed fixes to KidCare. However, at the final committee stop, Senator Durell Peaden, the committee chair (a retired general practitioner from Crestview, who is also an attorney), introduced an 11th hour strike-all amendment which gutted the bill, removing most of the streamlining, moving the centralization from DOH to AHCA, and removing the coverage of legal immigrants and public employees. Many observers felt that the Medicaid HMO industry and the Secretary of AHCA (Dr. Andrew Agwunobi, a pediatrician who has spent a portion of his professional life working for Medicaid HMOs) were the major players who derailed SB 930. In the end, Senate President Pruitt refused to agenda the gutted SB 930 for action on the Senate floor; the bill died. Little happened in the Florida House of Representatives until very late in the session, when a KidCare bill emerged which contained many of the streamlining issues, but delayed centralization for several years. That bill passed the House, but never got heard in the Senate.

Child advocates, following the regular legislative session, generated a revised bill, which included most of the streamlining issues. A massive effort was made to convince Governor Crist to include this non-controversial revision in the June Special Legislative Session, to no avail. Rumor has it that there may be another special legislative session in September, and perhaps KidCare can be included then. Otherwise, these issues will have to be taken up in the 2008 Regular Legislative Session.

We are all extremely disappointed to have expended so much effort and to have achieved nothing. However, for the first time in many years, we were able to surface all of our KidCare issues, have them all discussed openly, and to have the opportunity to gain insight into the opposing

forces. Few really good pieces of legislation are accomplished in a single year. Hopefully, 2008 will be the year to fix KidCare.

In closing, I would be remiss if I did not thank all of those who pitched in and helped this year. Senator Mandy Dawson led the charge by sponsoring SB 930. Our lobbying team of Mrs. Nancy Moreau and Dr. Paul Wharton were outstanding. Many of you came to Tallahassee for Children's Week, and at other times, and your assistance was invaluable. Even more of you made calls and sent letters and e-mails, all of which were immensely helpful. It was a great team effort, and I cannot thank all of you enough.

If you have the ear of your Senator or Representative between now and the 2008 legislative session, take the opportunity to bring up KidCare. Let them know of your concern that KidCare still desperately needs fixing. Send a letter to the editor of your local paper, expressing your concern.

Hope you are ready to go again next year!

Louis B. St. Petery, Jr., M.D. is the Executive Vice President of FPS

Renew Child-Health-Insurance Funding

Nancy M. Silva, MD, FAAP

Congress began the State Children Health Insurance Program (SCHIP) in 1997 to offer health insurance to children of lower-income families who do not qualify for Medicaid. Since 1997, Medicaid and SCHIP have decreased our nation's uninsured children by a third. Federal SCHIP funding will expire unless renewed by Congress by Sept. 30.

As per the U.S. Department of Health and Human Service, the 2007 federal poverty guideline for a family of four is $20,650. Florida KidCare (Healthy Kids and MediKids) expands eligibility for children whose families are at 200 percent of the Federal Poverty Guideline ($41,300).

Original federal SCHIP funding has not been enough to cover all eligible children. Financial shortfalls resulted in the need for emergency federal funding, cancelled coverage and/or prolonged waiting lists to obtain coverage.

According to research from the Robert Woods Johnson Foundation and the U.S. Census Bureau, there are 9 million children in the nation without health care. Six million of those children are eligible for SCHIP.

In Florida alone, there are more than 700,000 children who are uninsured. This accounts for nearly 15 percent of all uninsured children throughout the nation.

A SCHIP budget of $50 billion for five years would cover all eligible children. That's just $4.57 per day per eligible child. If these children do not get quality health care early in life, then their emergency care, their adult care and the resultant financial burden will be more costly.

SCHIP needs to be reauthorized and fully funded; otherwise, millions of children will not have health care in 2008.

Medicaid and KidCare payment rates average only 70 percent of Medicare rates. Increasing those rates to at least match Medicare rates would increase the number of pediatricians and subspecialists who see children covered by Medicaid or KidCare. Reaching all eligible children is a priority.

An "Express Lane" should be created. Applications for school lunch or WIC should jump-start eligibility for Medicaid or KidCare. In addition, pregnant women should be covered, as well, because prenatal care gives children the best start in life.

As a pediatrician in Brandon who still cares for children on Medicaid and KidCare, I have seen how families benefit from health care and are hurt by a lack of it. The American Academy of Pediatrics (AAP) supports SCHIP.

On a recent weekend, through the

AAP, I was one of 100 pediatricians and many pediatric residents throughout the nation who lobbied senators and representatives for SCHIP.

How are Florida congressmen helping our children?

Sen. Bill Nelson, D, a true children's advocate, has co-sponsored S. 1224 as it currently stands.

Sen. Mel Martinez, R, does support the concept of SCHIP. However, he does not support full funding for all eligible children, even questioning the actual number of uninsured children. His health-care legislative assistant stated "the senator believes there are actually only 2 million uninsured children in the country."

His office is looking into low-cost private insurance as an option in the future. However, we need to act now, because SCHIP expires Sept. 30. Otherwise, there will be an economic impact on each of us.

Rep. Gus Bilirakis, R-Palm Harbor, supports SCHIP, but funding is the main issue. His office looks forward to working on this issue in a positive way.

What can we do as Florida citizens? Protect our future, protect our children. The Senate Finance Committee meets this week to discuss SCHIP funding. It's important to act now. Please call our Sen. Nelson, 202-224-5274, and Sen. Martinez, 202-224-3041, Rep. Bilirakis, 202-225-5755, or your local Florida representative. Please thank Sen. Nelson for co-sponsoring S. 1224.

Tell them you support SCHIP, fully funded at $50 billion for the next five years, covering all 6 million eligible children. Our Florida children need health care today. If not, we will all pay for the consequence in the future

Reprinted as published in The Lakeland Ledger on June 14, 2007.

18th Annual AAP Legislative Conference:

A Private Practice Pediatrician's Perspective

Nancy M. Silva, MD, FAAP

I attended this conference hoping to learn how to be a better child advocate. Prior to the conference, I was instructed via email how to go about making appointments with my Senators and Representative. I was also given a SCHIP Primer. I was enthusiastic to learn throughout every step in the process.

Each day, the AAP members and staff slowly but surely taught us about bills, laws, lobbying, and yes, details about SCHIP, this year's cause. What I came to realize was that this was a tremendous opportunity to learn, share, and network. The AAP truly did an amazing job. They made an intensive conference pleasurable. There were many workshops to help educate us on the details of advocacy within our community and on a larger scale as well.

In addition, it was an asset to communicate with other members in different stages of their lives; some were early in their careers as child advocates and others had extensive experience, each in different ways. The passions of many pediatricians were evident. There were 100 registrants, many faculty pediatricians, pediatric residents, and AAP staff. Notably, Dr. Olson Huff, a tireless child advocate, was inspirational; he graciously shared his experiences with us. In addition, during the course of the conference, the Washington, DC premiere screening of "simple things" was shown. He and his son, David, were the executive producers of this movie which was inspired by Dr. Huff's book, "The Window of Childhood: Glimpses of Wonder and Courage." Movie stars were present, many pictures were taken, and a dessert and coffee reception followed. (www.backfortyfilms.com/simplethings/)

Our second day was just as intense, educational, and rewarding. The AAP even

Continued on Page 29 …. Advocacy Section

Resident Section: Advocacy in Residency

Advocacy in Residency

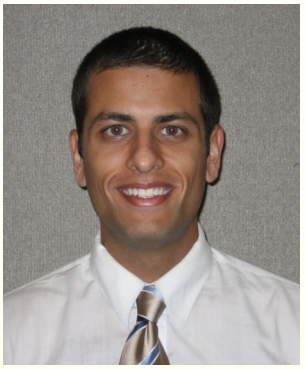
Anna Norat, DO

The definition of advocacy is the act of pleading for, supporting, or recommending. These three actions are at the heart of a pediatrician's role. Pediatric residency is not too early to start sharpening child advocacy skills. Whether a resident is doing a subspecialty elective or working in a clinic, there is always an opportunity to either teach a patient something that will improve their well-being or the opportunity to speak on behalf of the patient's best interest.

At the Nova Pediatric Residency program at Palms West Hospital in Loxahatchee, Florida, there are many opportunities to practice child advocacy. This is especially true at our clinic that is located at the Health Department in Belle Glade. Belle Glade is a town where many migrant farming families live. Many of these families are either very poor or are in the United States illegally – sometimes both of these problems occur concomitantly. This makes obtaining the proper resources more difficult. At the clinic, patients have health problems that should not be seen in a developed country such as the United States. Resources to assist them are sometimes a challenge to obtain. However, we spend more time with the patients in order to do a lot of counseling and be able to think outside of the box to help them. We have become more aware of the resources that we have available to us and we make sure that no one falls through the cracks just because they have no insurance. We spend more time with our patients than private pediatricians do, and we are thankful that we are able to do this. A few months ago, the Health Department at Belle Glade put together a huge health fair on a Saturday so that the local children who did not have insurance or a medical home could get school physicals. Two of our residents attended this event and helped the local pediatrician evaluate and interview the children. The event was a huge success. Many kids got physical examinations and their hearing and vision checked that may have not otherwise.

Advocacy is an important part of the pediatrician's role, since the young patient often does not have a voice. As resident's, learning how to advocate for our patients, no matter what their circumstances, is a vital part of our curriculum.

Anna Norat, DO is a PGY-1 in Pediatric Residency at Nova Southeastern University College of Osteopathic Medicine in Fort Lauderdale.



Annual AAP

Legislative Conference 2007: A Resident's Persepective

Sarosh Batlivala, MD

Stephanie Harrell, MD

The AAP's annual Legislative Conference was recently held in Washington D.C. The 3-day conference commenced on Sunday, June 3rd with sessions on effective lobbying, an introduction to the political process and how bills traverse the complex channels of congress to become law. There were also numerous interactive sessions such as "the art of negotiation", "meeting with

Resident Section: Legislative Conference

your representatives", and "crafting your message" among others. A very interesting scenario was also played out in which academy members assumed the role of congress members, and had to deal with their varying constituencies, with the ultimate goal of being reelected. Not to rescue politicians at large, but it really illuminated the difficulty many of them face in dealing with voters with very different agendas.

Each year, the conference tends to focus on a specific piece of legislation that the academy is backing. This year it was, of course, SCHIP which is up for reauthorization this coming September. The theme of SCHIP pervaded the entire conference, as it likely invokes the passions of nearly every pediatrician. We discussed the academy's "FAIR Plan" for SCHIP's reauthorization numerous times, and were provided with specific figures for our states, such as the number of uninsured children and those covered by SCHIP programs, to arm ourselves against a potentially obstinate political aide.

It was the preparation for our meetings that I found to be most helpful. In one of the meetings, we held mock meetings with our representatives' aides. I found the most challenging scenarios were the ones that I encountered in real life. The first was meeting with someone who agrees with our position and is very familiar with the details. How can I best further ignite their passion so, when the time comes, they will be willing to fight as hard for it as we are? The second is dealing with a party that is openly opposed to my view and establishes that from the beginning. How can I persuade someone who also likely is aware of the intricacies of the issue? In both cases, I found personalized experience to be the best weapon. The politicians, at least in regard to SCHIP, were well aware of the facts. In most cases, what they are sorely lacking is a concept of what we do and see on a daily basis. They likely are unaware that I often see the same children in the ER for similar issues because they get inadequate anticipatory guidance and infrequent appointments as they're pediatrician literally cannot afford to see them more often as each visit actually costs them money (and some philosophers believe altruism doesn't exist!). They hear that we want more money and think we want to get rich, when the truth is if riches were our primary aim we'd be in a different field as medicine has a horrible rate of return.

And so the fateful meetings took place. My meetings were exactly as above; my first was with a senator who frankly opposed the bill. The tone was collegial, but seemed almost contrived, since I doubt my efforts swayed their position. My second meeting was with a co-sponsor of our bill, and his aide actually knew considerably more than we did. But again, I think our personal stories helped bolster the senator's position. And our last meeting was with a very opposed individual who doubted the accuracy of the AAP's statistics and spoke of grand plans to change the face of health care by encouraging private parties to offer more affordable coverage to families as a whole. Again, we used our own experience to sway them and hope for the best.

One other thing we can all do is to continue to write to them. I learned that 20 separate messages from individuals is "worth more" than one message with 20 co-signors. So I encourage everyone to write their Senators and Representative requesting that they follow the AAP's "FAIR Plan" when reauthorizing SCHIP. Information and fact sheets can be found on the AAP's website at http://aap.grassroots.com/SCHIPsignon/.

Overall the conference was a wonderful experience. It was a great way to get involved with the academy and try to make a difference. It was also an excellent opportunity to network with other interesting, dedicated, and passionate fellow pediatricians. The amount of advocacy work that some have done is amazing; it provided an excellent way to get involved with their personal projects as well.

Sarosh Batlivala, MD & Stephanie Harrell, MD are each PGY-3 in Pediatric Residency at University of Florida in Gainesville.

Advocacy: Docs For Tots

Docs for Tots

Wil J. Blechman, MD

Things are moving forward quickly for young children in Florida. And pediatricians are invited to join the momentum! With interest growing from advocacy organizations, Docs for Tots is looking for ways its network of doctor advocates can be most effective in advocating for the social issues affecting children's health and development within the state. Docs for Tots Florida will be focusing on Early Childhood Mental Health (ECMH), which is synonymous with healthy social and emotional development. Another way of defining ECMH is as the developing capacity of the child from birth to three to:

(1) Form close & secure personal relationships,

(2) Experience, regulate, and express emotions, and

(3) Explore the environment & learn, all in the context of family, community, and cultural expectations for young children.[1]

It is estimated that 20% of young children experience significant psychosocial or mental health problems, unfortunately only one third of these children ever reach treatment.

Founded in March 2003 by pediatrician Dr. George Askew, Docs for Tots is a nonprofit, nonpartisan, advocacy organization specifically focused on very young children and their families. Docs for Tots was formed to encourage more doctors to fulfill their important role as active advocates for infants, toddlers, and preschoolers on the national, state and local levels. Its vision can be simply stated as "Pursuit of social justice in health and development for young children" and "Changing the nature of professionalism for children's doctors through increasing their civic engagement beyond clinical practice."

Docs for Tots has developed, supports, and is growing a nationwide network of doctors who can respond to the requests of child advocacy organizations and others to participate in advocating for policies and practices that improve the well-being of our youngest children.

Docs for Tots is particularly interested in engaging and supporting doctors in addressing issues that are not traditionally seen as directly related to health--but where doctors can serve as strong advocacy voices for young children and families if well supported. Docs for Tots provides resources, training, technical support and advocacy opportunities as well as easy entrée into the advocacy arena by linking doctors with local and national child advocacy organizations. This allows physicians to use their own experience to highlight the unique needs of young children. Resources and advocacy materials produced by the organization prepare the doctors for the task of advocacy, however the range of advocacy activities, participation and time commitment vary depending on the individual doctor.

Docs for Tots advocates for the social issues affecting the well-being of young children that fall within focus areas including but not limited to access to quality early care and education, eliminating health disparities associated with race, ethnicity and socio-economic status, and eliminating poverty.

Investments in early childhood health and development are important for the future of the state of Florida and our country. We see ourselves as a supplement to the work of organizations like the American Academy of Pediatrics and look forward to working closely with the Florida Pediatric Society as we seek to encourage and support doctors

interested in furthering their childhood advocacy efforts in Florida.

To join Docs for Tots and learn about future Florida efforts, visit http://www.docsfortots.org/ or email dft@docsfortots.org.

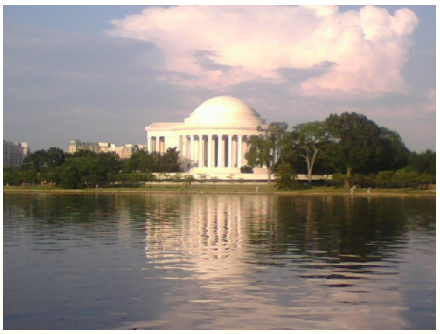
Doctors Advocating for Young Children

[1]Zero to Three, Infant Mental Health Task Force

Dr. Wil J. Blechman is the President of the Florida Association for Infant Mental Health (http://www.cpeip.fsu.edu/faimh/index.cfm) and the Director of Docs for Tots.

18th ANNUAL AAP LEGSLATIVE CONFERENCE Continued from Page 25 …

arranged for the Federal Communications Commissioner as a breakfast speaker. Her child advocacy was inspiring as well. We learned more details about SCHIP. In small three person groups, we had a mock meeting with our elected officials. And at day's end, in groups of five or more, we played a game in which we were an elected official. I was enlightened by the process.



Jefferson Memorial

That night, there was the Fun Run/Walk at the Tidal Basin. Two bus loads of pediatricians and AAP staff participated. At first, I was too tired to go. The staff encouraged me to join. They gave participants a free shirt stating, "Health Care for All Children. I Care for Kids and I Vote." Who could pass that up?

In the end, it was wonderful. The camaraderie was superb. We felt ready and united on our mission to fight for health care for children.

Washington Monument

The next day, we boarded buses for Capitol Hill. We met with our Senators and Representatives. We returned for our debriefing lunch at the hotel.

I am proud to be a member of the AAP, an organization in which all involved actively work on the behalf of children. I was initially apprehensive with the notion of speaking with our Senators' and Representative's aides. However, the AAP so well prepared me that I can honestly say I felt fully prepared and did my best speaking as at this conference. This was my first legislative conference, but I doubt it will be the last. I highly recommend this conference to all interested in learning about child advocacy. You can make a difference.

Lincoln Memorial

Healthy Teeth, Healthy Child… The AAP Oral Health Initiative

Part 1

Rani Gereige, MD, MPH, FAAP

INTRODUCTION:

The dentist-to-population ratio is declining. Of the 153,000 US dentists, only 3,600 are pediatric dentists. Many, if not most, general dentists do not feel comfortable seeing patients under 3 years of age. Dental caries (tooth decay) is the single most common chronic childhood disease and the most common infectious disease affecting children in the U.S. Tooth decay is five times more common than asthma and seven times more common than hay fever. Caries rate increases with age ranging from 18% in children 2-4 years of age, to 52% in children 6-8 years of age, and 67% in young teens 12-17 years of age. Almost 50% of tooth decay remains untreated among low-income children. The main contributing factor to this sad reality is lack of access, particularly of children living in poverty to adequate preventative and restorative dental care due to financial and system's barrier. Oral Health America estimates for every child without medical coverage, 2.6 children lack dental coverage. More than 51 million school hours are lost each year to dental-related illness. Of the population below 200% of FPL, 11.08% had access to publicly-funded or volunteer dental preventive and primary care services. Early Childhood Caries lead to:

- Extreme pain
- Spread of infection
- Difficulty chewing, poor weight gain
- Extensive and costly dental treatment
- Risk of dental decay in adult teeth
- Crooked bite (malocclusion)
- Missed school days
- Impaired speech development
- Inability to concentrate and succeed in school
- Reduced self-esteem and embarrassment
- Possible systemic illness for children with special health care needs

THE AAP INITIATIVE:

Oral Health is one of the AAP's focus areas along with Mental Health and Obesity. Pediatricians play a very important role in providing screening an anticipatory guidance to a wide spectrum of childhood diseases. Children 0-3 years of age are frequently seen and assessed by pediatricians and might not be seen by a pediatric dentist until dental caries occur which is late in the disease process. The Surgeon General has stated that "oral health cannot be considered separate from the rest of the body". The American Academy of Pediatric Dentistry (AAPD) is in agreement with the AAP's recommendation for establishment of a dental home for children by 12 months of age or by six months after the first tooth erupts. The AAPD defines a dental home as "the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family centered way".

The goals of the AAP initiative is to train pediatricians to competently assess mothers'/ caregiver's oral health, conduct the oral health risk assessment of infants and children, recognize signs and symptoms of caries, assess child's exposure to fluoride, provide anticipatory guidance and oral hygiene instructions (brush/ floss), and make timely referral to a dental home. The training can be found at http://www.aap.org/commpeds/dochs/oralhealth/training.cfm.

PROS Report

Lisa A. Cosgrove, MD, FAAP

Greetings all colleagues in the Pediatric Society,

I have just returned from the semi-annual meeting of the PROS Network or Pediatric Research in Office Setting. Many exciting projects are going on and we reviewed several in the pipeline. I must say that I was very honored by the Pediatricians in Florida. We are the largest State PROS network with 40 practices and we currently have the most practices participating in the ongoing research project named SSCIB or Secondary Sexual Characteristics in Boys. There is still room for more practices to join in and experience a little academic tickle to their brain. During this weekends festivities we were lectured on Distance Asthma Learning, Translating Violence Prevention Evidence into Practice, and Promoting Safe Teen Driving in Primary Care Practice. My favorite was the Teen driving, since I have 2 teens and am horrified every time they get in a car to drive. I was made aware of items that can help us in our practice with teen drivers including a very good contract for driving between the teen and parent. This is something for all of us to think about since MVA's are the number one killer of our teens, higher than drugs or alcohol.

We also reviewed several of the ongoing studies including SSCIB, Safety Check, CEASE (or how to stop second-hand smoke exposure), Smokebusters, and RIDS. An interesting finding is now noted since the date for RIDS (Reducing Immunization Disparities Study) is finished. The early data seems to indicate that the disparity in races for immunizations has almost gone away. There is more to come regarding this. Also, congratulations to Atlantic Coast Pediatrics who is working on Smokebusters. This study looks at teaching about smoking cessation in teens older than 14 years old. In the control wing, you teach about healthy lifestyles which are equally important. Either way, the patient wins. Anyone who wants to participate in this study, please contact me. Another study that is still recruiting is SSCIB. If you would like to help enroll the 5000 boys needed, let me know.

Finally, let me mention several papers that are being published as a result of the PROS research. The Febrile Infant Study has yielded many papers and now is working on EBM protocols for Pediatricians. Life Around Newborn is in its final manuscript submission and the wonderful data received from this can be seen on the PROS website. Many more manuscripts are in the works. And as I learned over the weekend, we are the 3rd largest producer of manuscripts in world medicine.

Scientific Update: Best for Youngest?

Are We Doing the Best for Our Youngest?

Mary E. Seay, MD; Kathleen Wilson DSN,ARNP,CPNP, Cindy Evers, LCSW, Joni Hollis RN

Approximately 20% of children have a diagnosable behavioral health condition (Costillo, Mustillo, Keller, & Angold, 2004). Post-partum depression affects 18% of mothers with consequences to the child=s developmental progress. The rapid growth and development of children necessitates frequent structured visits during the critical formative early years. Most likely pediatric providers may be the first and only natural contact for the mother. Therefore, professionals in primary pediatric settings are well positioned to screen children for early identification of developmental and behavioral concerns as well as, maternal depression which impacts child development (Roseman et al., 2005).

Clinical judgment identifies fewer than 50% of children who have developmental or behavioral concerns (Glascoe, 2000). Pediatricians generally rely on observation (81%); with only 8 percent of pediatricians routinely asking mothers about symptoms of depression. These usual techniques have been shown to detect less than half of depressed mothers. This low identification rate may represent variants in surveillance methods, thus calling for a formalized structured screening as outlined by the American Academy of Pediatrics (AAP, 2006) recommendations. Barriers of time limitations, staff issues, billing and reimbursement necessitate pediatric practices to integrate creative strategies in interfacing national recommendations with current practice realities.

Children=s Medical Services-Big Bend Region (CMS-BBR), a division of the Florida Department of Health, integrated National Goals and AAP recommendations by implementing a prevention intervention program within local pediatric medical home practices. A multidisciplinary collaborative approach was used in assisting with the care of children=s developmental and behavioral health issues. The standard modality of this program was to set up routine formalized screenings at critical points along the maternal-child health spectrum. AAP recommendations were modified within the guidelines set forth to meet the individual needs of the office.

Components of this program include providing the medical home with a maternal-child health consultant. Responsibilities for the consultant include completion of screenings shared with family and professionals, provision of enhanced anticipatory guidance based on individual needs, and facilitation of referrals to quality child developmental and mental health professionals. Identified barriers drove selection of screening tools. Low cost, simple, low literacy, short, and multilingual tools were essential. Tools selected include the Edinburgh for post-partum depression at the two month check up; Ages and Stages Questionnaire (ASQ) at 6, 12 and 18 month well child check up with ASQ Social Emotional at the 2 year visit. Families are the experts on their child, identifying concerns from their answers on the questionnaire helps to initiate sometimes difficult topics. The program allowed for flexibility in meeting the constraints and needs of the individual practice.

Whether a concern is medical or behavioral, or both, finding it early and treating it can greatly improve the child=s chances of reaching his or her full potential for physical, mental, and social health and well-being. Maternal depression has shown to be a risk factor for impeding child development. If formalized routine structured screening programs are to have sustainability, reimbursement mechanisms are needed to help facilitate provider buy in and lessening the perceived impact to the practice.

THE PREPARTICIPATION EXAMINATION

More than Just a Sports Clearance Opportunity

Rani Gereige, MD, MPH, FAAP

INTRODUCTION

The main goal of the preparticipation examination (PPE) is to promote athletes' safe and healthy sports participation in training, recreation, and competition. The athlete should be reassured that the goal of the PPE is not EXCLUSION but safe INCLUSION in sports so that they can perform the best they can during practice and competition. It is also meant to protect them from injuring themselves and/or others in the process. This is done through:

Identifying old injuries early enough to allow time for rehabilitation

Identifying, diagnosing, and treating medical conditions that might impact on the athlete's safe participation

For many, if not most adolescents, the PPE is their only contact with a medical provider in any given year. While it is not intended to substitute for the athlete's regular health maintenance visit, the PPE can facilitate general healthcare. As the summer approaches, many of practices get busy with camp physical that include PPE clearance. This is followed by a new school year with the various sports seasons. This article is not meant to cover the PPE in detail but to provide highlights of health maintenance issues and opportunities that the PPE offers.

OBJECTIVES

The AAP among other primary care and sports medicine organizations highlight primary and secondary objectives for the PPE:

A. Primary objectives: These include to

a. Screen for conditions that may be life threatening or disabling

b. Screen for conditions that may predispose to injury or illness

c. Meet administrative requirements

d. Secondary objectives: These are as important as the primary objectives and include:

e. Determine general health

f. Serve as an entry point to the healthcare system for adolescents

Provide opportunity to initiate discussion on health-related topics

The best setting for the PPE to be provided is in the context of the athlete's Medical Home. The primary care provider is the most knowledgeable in the athlete's medical condition, medications, immunizations, allergies, etc. When the PPE is done in a group setting (station-based), the team physician should coordinate the process and supervise the team of qualified healthcare professionals to ensure that all appropriate components of the assessment are met.

FREQUENTLY ASKED QUESTIONS

While most primary care physicians are comfortable with the various components of the PPE including the musculoskeletal exam and the inclusion and exclusion criteria, the following are frequently asked questions related to the PPE:

When is the ideal time to perform the PPE?

The ideal time to perform the PPE is 6 weeks prior to preseason practice. This allows enough time for treating or rehabilitating any identified problem and enough time to obtain clearance from specialists for any identified medical problem. A good option is to schedule the PPE in midsummer or at the end of the previous school year. The latter should be

Scientific Update: Preparticipation Exam

questioned prior to fall practice about any new injuries sustained in the summer. Performing the PPE in the summer gives the student that needs rehab to be able to get ready for the season without impacting school attendance.

How often does the PPE need to be repeated?

It is important to note that no outcome-based research indicates that more frequent PPEs lessen the risk of injury or death. An optimal frequency has not been established. This issue varies between states and grade levels. Colleges generally require an initial entry comprehensive health examination followed by periodic brief yearly exams focused on injuries. This is different from the high school requirements. Most states require a yearly comprehensive exam; however, few states require the comprehensive exam at entry to middle or high school followed by yearly update of an injury form. The consensus of the PPE working group is:

A comprehensive PPE should be performed every 2 years in younger student-athletes and every 2 to 3 years in older athletes

A comprehensive PPE should occur at middle and high school entry or upon transfer to a new school

Annual updates include a comprehensive history, height, weight, BMI, BP, and a problem-focused exam of any concerns in the history

Incorporating the PPE into the routine healthcare screening schedule after age 6 can help promote physical activity and sports safety in children and adolescents.

Are any routine screening tests needed as part of the PPE?

Routine laboratory, cardiac and pulmonary screening tests for PPEs remain controversial. However, the PPE working group recommends no routine screening tests for healthy asymptomatic athletes since no evidence-based studies that indicate their utilities exist. Routine urine drug testing at the elite amateur and professional levels is now fairly common and is becoming more widely used in Division 1 collegiate athletics. Mandatory HIV testing is discouraged due to the low risk of transmission although some boxing organizations require it. The physician performing the exam should be familiar with the specific sports organization rules and mandates related to drug and HIV testing. While mandatory testing of athletes for HIV or hepatitis is not recommended, voluntary testing should be encouraged for athletes who have exposure to blood products, symptoms suggestive of the disease or significant risk factors identified such as:

1. Multiple sexual partners
2. Sexual contact with known infected individuals
3. Blood transfusion before 1985
4. STIs including hepatitis B virus
5. A history of IV drug use or injectable ergogenic drugs or use of such drugs by sexual partners

Male homosexuality and girls with bisexual partners

What is the best way to handle clearance decisions?

Studies show that 3.1%-13.9% of athletes require further evaluation before a final clearance status can be determined. The initial clearance for an athlete can be divided into 4 categories:

1. Cleared without restrictions
2. Cleared with recommendations for further evaluation or treatment
3. Not cleared – Clearance status to be reconsidered after completion of further evaluation, treatment, or rehabilitation

Not cleared for certain sports or for all sports

When an abnormality is found, the physician must consider the following questions in determining clearance:

A. Does the problem place the athlete at increased risk for injury or illness?

B. Is another participant at risk for injury or illness because of the problem?

C. Can the athlete safely participate with treatment?

D. Can limited participation be allowed while treatment is being completed?

Scientific Update: Preparticipation Exam

If clearance is denied only for certain sports or sport categories, in what activities can the athlete safely participate?

What other non-sports related opportunities the PPE provides?

The PPE provide opportunities way beyond sports participation clearance. Examining physicians should use this opportunity to provide a comprehensive healthcare to the teen athlete in many aspects such as:

- Updating medical information: Such as medications, allergies
- Performing and completing the required immunizations
- Performing a psychosocial assessment using the HEADSSS format which includes questions related to high risk behavior, drugs, smoking alcohol, and sexual history.
- Identifying eating disorders
- Identifying stress, depression, and other psychiatric disorders
- Obtaining a history of ergogenic aids use: This is important since the use of ergogenic as gateway drugs has been associated with illicit drug use and other risk taking behavior
- Providing health maintenance counseling and education
- Providing the athlete with a medical home

CONCLUSION

The PPE is an opportunity to provide more than just sports clearance. It is not meant to replace the health maintenance visit but may be done as part of the routine health screening examinations by an athlete's primary care provider (ideally 6 weeks prior to the start of the season). It is worth noting that sports participation clearance ICD-9 code is a V-code and requires a secondary diagnosis for reimbursement. For healthy athletes, combining the PPE with the routine health maintenance visit, if feasible, will help overcome this issue. Athletes with medical conditions, injuries that need rehabilitation, or requiring close follow-up might need periodic exams during the season particularly if the PPE was done early in the year. The PPE provides a "teachable moment" that is not always available to teen athletes who are often involved in high-risk activities away from the playing field.

Physicians are directed to a great resource for the PPE:

AAFP, AAP, ACSM, AMSSM, AOSSM, and AOASM. Preparticipation Physical Evaluation. Third Edition. 2005. McGraw-Hill, Minneapolis MN, and NYC, NY.

Dr. Gereige is an Associate Professor at USF College of Medicine, Chairman of Committee on School Health and Sports Medicine, and an active member of the Florida Pediatric Society, Florida Chapter of the AAP.

Physician Heal Thyself: PDRP

Physician Data Restriction Program

The PDRP was created by the AMA in response to physicians growing concerns that pharmaceutical sales representatives were privy to their prescribing methods in detail. For detailed information, please visit **http://www.ama-assn.org/ama/pub/category/16266.html**.

You may click on AMA's Physician Data Prescription Program. Then, you may choose from one of the following:

"I want to record a general observation"

"I want to register a complaint"

"I want to opt out" on right hand of screen.

Facts about the physician data restriction program.
The data restriction option is valid for a three-year period. The AMA will notify physicians prior to the termination to give them the opportunity to reinstate their decision. Physicians can remove this option at any time by contacting the AMA.

If you decide to exercise the physicians data restriction option, *all* pharmaceutical sales representatives will be denied access to your individual prescribing profiles. Pharmaceutical companies will be required to check the prescribing data restriction list on a quarterly basis at a minimum. Upon checking the list, it may take a pharmaceutical company up to 90 days to restrict the individual data from their sales representatives.

The AMA's Physician Data Restriction Program does not affect the use of prescribing data by managed care providers or pharmacy benefit managers because they use their own proprietary data and are not subject to AMA data licensing rules and regulations.

If you need additional information, please call (800) 621-8335 or send an email to pdrp@ama-assn.org.

Pre-Retirement Checklist—Part 1

This document is intended to provide an overview of various considerations associated with retirement. There is significant complexity to much of this process, having to do in part with differences in local contracts, organizational rules, personal circumstances, and federal guidelines among other things. Therefore this overview will necessarily deal in generalities and might be only a part of your retirement planning process. This file is updated yearly in April by Dr. O'Halloran.

Appended to this document is a template for recording personal information and information possibly important to a person's family on one's death.

Prepared by Michael O'Halloran MD, FAAP (revised April 2007) with revisions by Jerold M. Aronson MD FAAP (AAP SFSM Webmaster) and Av Katcher MD, FAAP (AAP SFSM Chair);

I. Insurance and Retirement Funds

Department of Human Resources (Employer): If you are working where there is such a department, it is likely to be of considerable help with retirement plans and should be contacted.

Health Insurance: After retirement, clinics and organizations will sometimes continue to helping pay for this. For example, premiums might be paid for you and possibly your spouse until death, subject to age and years of service rules. If you retire prior to eligibility for Medicare, ask about COBRA Insurance from your employer.

Dental insurance: Same. Depending on your circumstances, if your coverage ends, you might consider the Cobra option depending upon your circumstances.

Life Insurance: Same, but a conversion option may also be available.

Long Term Disability Insurance: Same, also with the possible availability of a conversion option.

Retirement Plans, IRAs, Etcetera: You will likely need to contact your "Pension Carrier" regarding this. Your plan may have special rules you'll need to comply with. Also, several distribution options are usually available. These areas of legal and financial planning may require consultation with specialists in either "elder law" or

Physician Heal Thyself: Pre-Retirement

estate planning. To learn more about "elder law" view the information at public interest elder law groups such as the Connecticut Legal Services Elder Law Project or the Elder Law Center of the Coalition of Wisconsin Aging Groups or resources of the AARP.

Health Care Spending Account: If you have such an account you should learn whether there are special retirement rules depending upon such things as your organization's fiscal year, your actual date of retirement, etc.

Social Security - If you are old enough to receive benefits you'll need to check with your social security office. Contact them at least 90 days prior to retirement to discuss the initiation of benefits. Consider and make arrangements via Direct Deposit for your Bank to receive your Social Security income electronically.

Medicare – timely application is essential. Delays in applying, if age eligible, can result in delays in benefits and higher premiums, e.g. Part D – Prescription Drugs

Malpractice Insurance: The two issues that must be addressed are: i) Arranging for "tail coverage" should a claim be brought against you after retirement and; ii) professional liability coverage in the event that you choose to perform part-time or volunteer medical work. "Tail coverage" requirements depend, in part, upon whether your current insurance is for "claims made" or "occurrence" The former refers to when a claim is filed by the attorney. The latter refers to when the patient about whom the claim is filed was actually treated. In any event, check directly with your current malpractice insurer to assess your specific needs. When you check, also note the financial stability of your current malpractice insurer and inquire about arrangement for claims payment in the event of bankruptcy. Your State Department of Insurance or State Medical Society may also help in this area. Many arrangements may be available to you depending upon your circumstances. As to the need for professional liability insurance for volunteer work, you may be eligible for free malpractice coverage. Check with you existing malpractice carrier and/or contact your State Department of Health.

[Webmaster Note – for more information see the Fidelity Pre-Retirement Checklist on Social Security, Pension Benefits, Medicare, and Estate Planning.]

Reprinted from original article found at http://www.aap.org/sections/seniormembers/docs/PreRetCkLst.pdf

PHARMACY & THERAPEUTICS COMMITTEE REPORT Continued from Page 18 …

These are then approved by Dr. Agwonobi who has the last say. The following is a list of medications currently pertaining to Pediatrics that were either placed or renewed on the formulary:

Tamiflu, Acyclovir, Amantadine, Flonase, Nasonex, Nasarel, Astelin, Omnicef, Raniclor, Augmentin XR, Suprax, Cedax, Cefzil, Ketaconazole, Clotrimazole, Grifulvin V suspension, Gris-Peg, Itraconazole, Nystatin, Fluconazole, Vusion, Floxin Otic, Ciprodex Otic, Strattera, Concerta, Daytrana, Adderall XR, Focalin XR, Metadate CD, Bupropion IR, Trazodone, Wellbutrin XL, Effexor XR, Citalopram, Sertraline, Fluoxetine, Paroxetine, Exeva, Risperdal, Geodon, Seroquel, Abilify, Zyprexa, Zantac solution, Axid, Orapred ODT, and all vaginal antibiotics.

When the generics are more expensive than the brand names, the brand name will be used instead. It will usually take 1 year or more to get a brand name off after going generic. Also during the process, no drug will be considered unless they offer the state a minimum of a 29.1% rebate. It is complex but it saves the state a lot of money which can be used to expand the list to cover more chronic illness drugs such as Factor 8 and Synagis which are very expensive. The committee is always searching for long term outcomes data to help make decisions that are efficacious and correct, not just money saving. Please feel free to contact me with any questions. The next meeting is September 12th.

Coding Corner: Subtitle

Revised Billing & Coding for Florida Medicaid VFC

Edward N. Zissman, MD, FAAP

In a letter dated May 14, 2007, [see excerpt below] Florida Medicaid announced a major revision in submission for payment for VFC vaccine administration. The stated reason for the change is to bring the system into compliance with CPT coding guidelines. Currently, only the vaccine material codes (90476-90748) are submitted with physician payment set at $10 (ten dollars) as payment for the vaccine administration which is not currently submitted.

Under the revised system, effective September 1, 2007, both the appropriate vaccine (product) material code AND the appropriate vaccine administration code (90465-90474) must be submitted for each vaccine administered. Payment will be zero for the vaccine (product) material and ten dollars for the vaccine administration submitted by a physician.

This revision will require a thoughtful adjustment to most current billing systems for VFC vaccine payment.

"Effective September 1, 2007, Florida Medicaid is revising its billing procedures for reimbursement of immunization services. To be in compliance with Current Procedural Terminology (CPT) coding guidelines, providers will be required to bill both the CPT code for the administration of the vaccine (90465-90474) AND the CPT code for the vaccine product (90476-90748).

Vaccines available through the Vaccine for Children (VFC) Program will continue to reimburse the administration of the vaccine only. Vaccines not available through the VFC program will continue to reimburse the vaccine and administration. Vaccines for 19-20 year olds will continue to reimburse the cost of the vaccine.

All providers will bill the administration fee codes (90465-90474). Reimbursement will be $10 for physicians, $8 for ARNPs and PAs and $5 for CHDs and FQHCs. Procedure codes and fees for administration and vaccine products may be found online at the ACS website"

http://floridamedicaid.acs-inc.com.

FPS Leadership List

All Officers will serve 2007-2009.

Voting Positions

Officers

President: Jorge Del Toro, MD

Vice President: Jerome Isaac, MD

1st Vice President: John Donaldson, MD

2nd Vice President: Lisa A. Cosgrove, MD

Immediate Past President:

David Marcus, MD

Region 1

Rep: Robert Patterson, MD

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Resource Highlights: Safer Health Care

AAP Launches Patient Safety Website

Any medical error is disturbing, especially in Pediatrics. Reports of such errors might leave you wondering what you can do to ensure a safe health care environment for your patients.

The American Academy of Pediatrics has just launched a new ***Safer Health Care for Kids*** website (http://www.aap.org/saferhealthcare) for physicians, allied health professionals, administrators, parents, and caregivers, who are seeking pediatric patient safety information and strategies.

Check out the ***Safer Health Care for Kids*** website today at: http://www.aap.org/saferhealthcare.

If you have a question about Webinars or the ***Safer Health Care for Kids*** program, email saferhealthcare@aap.org.

Highlights include:

RESOURCES
A comprehensive, one-stop resource center for pediatric-specific patient safety guidance. Here you will find useful strategies, valuable information links, and expert advice on reducing or eliminating medical errors affecting children.

EDUCATIONAL OFFERINGS
A series of free, one-hour Web-based seminars, Webinars, on various pediatric patient safety topics. Register for an upcoming, live Webinar, and earn a maximum of 1.0 *AMA PRA Category 1 Credit*. Or, access a full archive, including audio, from one of the past Webinar offerings. Or, download just the Podcast or slide set from the Webinar library.

LATEST NEWS
Links to recent articles relating to pediatric patient safety.

EXPERT Q&A
A feature that brings the experts to you and gives you an opportunity to receive answers to your follow-up questions from the pediatric patient safety Webinars.

SAFETY TIPS
Useful tips to help you to ensure a safe health care environment for your patients and their families.

PARENTS™ CORNER
Resources to help parents understand what they can do to help ensure their optimal safety in the health care that their child receives.

E-MAIL LIST
An e-community dedicated to pediatric patient safety issues and information exchange with other clinicians.