

THE FLORIDA PEDIATRICIAN

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THE PRESIDENT'S PAGE

Gentle readers:

Felicitations from Tampa. I have just returned from a turbulent Spring Session of the AAP in Atlanta, as will be confirmed by anyone who had the misfortune of trying to fly there the Friday night prior to the opening ceremonies. Tornados (tornadoes, per Dan Quayle) had closed The William B. Hartsfield International Airport in Atlanta (Yes, that is really the name of the place. As a pilot, I spent quite a while looking up Hartsfield Atlanta, until I figured out it was indexed under "The.....etc." Your tax dollars at work...had it listed under "T" for "The".) for two hours, an event guaranteed to back up air traffic all the way to Kuala Lumpur. I believe Ed Zissman calculated that he and Phyllis could have bicycled there from Orlando and arrived an hour earlier, not counting the taxi situation at TWBHIAA at three a.m.

* * * * *

“...20+ of the officers and membership spend an hour or two every Sunday night during the Legislative session...”

* * * * *

Those who spend any time searching CPT Code books for recognizable diagnoses and/or procedures related to pediatrics will recognize this rather curious approach to nomenclature, possibly engendered by the cavalier approach to visualizing processing disorders by those who screen entry level Code Book Editors.

Joe Zanga, in his opening Presidential address to the Academy, reminded us that we should not think of ourselves as "just a pediatrician", but should remember that we are in fact the most important and most trusted advocates for children and their families in an environment increasingly slippery (and risky) for family stability. With more and more studies suggesting that a stable family environment is one of the most reliable predictors of a child's success in society, he wonders whether the current federal policy trends toward placing single parents in the work-force and their infants in government-subsidized day-care bodes well, not only for those

(see President, page 21 ▶)

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THE EDITORIAL PAGE

Keep our Children Safe!

Summer is approaching, the strange weather of this last winter/spring will hopefully abate, but many of our ongoing problems are still ongoing!

It is sad to realize that, for many years now, we all have been talking about and struggling with water deaths among our children. Is it not frustrating to learn that, for all our efforts, we have little to show? Stories of drownings and near drownings are still all too common.

“...water deaths
among
our children.”

With the February issue, we began this year’s “Emphasis on...” series, on tobacco use among children, a series which will continue through the remainder of 1998. With all of our individual and collective efforts, again we have little to show. As this editorial is being written, the media inform us that the tobacco companies have “declared dead” the deal for federal legislation. I recognize that, in a democratic republic (which we are, and not a democracy, there must be freedom of expression and trade, and that it is nice to consult with interested parties about pending legislation. BUT, since when must we have permission from involved parties to create legislation? I know of no such requirement. This legislation is bi-partisan, and is even supported by legislators from tobacco-growing states. Should we not be concerned with public health, and the welfare of our children, rather than the cries of an industry which has lost credibility because of its misrepresentations and lies on many occasions.

“...industry which
has lost
credibility..”

In the future, the Academy will tackle firearms safety more directly. However, later in this issue, we introduce an article from the AAP on firearm safety, and how each of us may participate. Read it, please.

And, finally, we suddenly have a new safety problem to worry us: injuries to children participating in in-line skating. In this issue, too, we offer an article about the incidence of these injuries. Please note the three most important suggestions: helmets (!), wrist guards, and attention to the physical ability and coordination skills required, as they relate to the age of the participant.

“...injuries
to children...in
in-line skating...”

Let’s keep trying to make our State a safer place for children!

-The Editor□

THE REGIONAL REPRESENTATIVES REPORT

(Each month we will provide reports from two of our eight regions)

Region I reports:

Things have been fairly quiet in Region I. Sacred Heart has been expanding its subspecialty faculty by adding a pediatric pulmonologist and a pediatric nephrologist recently. Nemours has been working to get relationships with the subspecialists. There has been a new influx of patients in the Healthy Kids Program in Leon County. This has been done with a contract with a local HMO. Several local groups in our region have been looking at how many managed care groups they are willing to deal with.

We look with interest to the future as we try to see what is new on the horizon. I hope to see many of you in May.

David A. Jones, M.D.
Regional Representative □

Region V reports:

The Region V report includes news from Hernando, Hillsborough, Pasco and Pinellas counties. The region is the home of a major pediatric training program, at the University of South Florida College of Medicine, chaired by Jaime L. Frías, M.D. Tampa General Hospital and All Children's Hospital in St. Petersburg are the main teaching facilities. Other pediatric services include the just opened Tampa Children's Hospital at St. Joseph's, University Community Hospital, and Morton Plant -Mease Hospital in Clearwater.

Local pediatric societies are active in both Hillsborough and Pinellas counties. Patricia Emmanuel, M.D. serves as President in Hillsborough. Stephen Nelson M.D. leads the Pinellas group. The Hillsborough County Pediatric Society has met twice since the last newsletter. We were privileged to hear Dr. Lewis Barness lecture on "Unusual Odors in Pediatrics" in his usual erudite yet practical style. This past March 26th, Pediatric Cardiothoracic surgeon Dr. Gary Haas and Pediatric Cardiologist Dr. James Huhta delivered an elegant presentation on "Recent Advances in Pediatric Cardiac Medicine". In addition, a retirement presentation was made to Tampa's highly respected and esteemed Pediatric Surgeon, Dr. Ralph Swank, who left active practice on March 31.

The Pinellas Society has also had successful meetings on "Humor in the Workplace" by John Morreall, Ph.D., and "New and Improved Vaccines for Children" by Stephen Chartrand, M.D.

Managed care continues to generate realignments and groupings of not only general pediatric practices but also subspecialists. Most pediatricians in the region are affiliated with some large group.

Patricia Blanco, M.D. Thomas J. Abrunzo, M.D.
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(A directory of Officers, Executive Committee, and Committee Chairmen)

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[This directory is updated in each issue. For e-mail addresses of the membership of the Florida Chapter/AAP, please consult the published Directory of Membership.]

A new feature is here:

The "Ticked Off" Column.

If you are really "ticked off" about something in your practice or about medical economics in general, write about it and send it in. Any reasonable complaint will find its way into print! □

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Child Advocate Member Report

Gerold S. Schiebler, M.D.

[This report was initially made to the Executive Committee. It is reprinted here because of its importance and to demonstrate the depth of involvement of our Child Advocate]

In my role as Child Advocate Member of the Board of Directors of the Florida Pediatric Society/Florida Chapter of the AAP, I have participated in the following activities since the last meeting of the Executive Committee.

1. Involvement with the Legislative Committee under the direction of Dr. John Curran. Of particular interest/involvement has been the legislation (House Bill 1929) which will move the Child Protection Teams, the Sexual Abuse Treatment Programs and the Child Abuse Prevention Act from the Department of Children and Families to the Department of Health/Children's Medical Services. This bill is a Committee bill of the Health Services Committee of the House of Representatives, and it recently passed unanimously in the House Government Operations Committee. It is now scheduled to be heard before the Health and Human Services Appropriations Committee. This is the final Committee stop prior to being placed on the calendar of the House of Representatives.

A similar bill has been filed by Dr. William G. "Doc" Myers, that will be the Senate companion to the House version of the bill. This bill presently is in bill drafting; after it is returned to Senator Myers we will have an additional opportunity to make an alteration/amendment in the draft copy prior to finalization.

The Poison Control/Emergency Medical Services/911 legislation encompassed in Senate Bill 302 is scheduled for the Senate Affairs Committee on Tuesday, February 17th. All involved parties have "signed off" on this legislation, and it should pass without opposition.

The House companion of the bill has passed the Health Standards Committee, and it is now ready to be replaced on the regular calendar or on the consent agenda of the House of Representatives.

Together with Dr. Paul Wharton and Francis N. "Pete" Millett, Esq., Jr., we have been able to place a whole variety of issues before both the House and Senate Appropriations Subcommittee for Health and Human Services. These relate to items that have been reviewed with the Chairman and members of the Legislative Committee. They encompass statewide initiatives as specific member projects.

2. Of import is the fact that we have placed all Children's Medical Services capital outlay projects as a bundle, i.e., encompassing all capital building projects within one request. These in aggregate total over \$7.0 million, but the Governor has recommended \$15 million for this category. That is when we will be able to fund the CMS building programs for the next several years and include within the budget an aliquot of monies for repair/renovations.

In the last several weeks it has been my special opportunity to speak to both medical students at the Tallahassee-based PIMS Program (Program in Medical Sciences) and second year students at

the University of Florida College of Medicine. In both instances, I gave them an overview of the political process in the State of Florida and items of legislation that would be coming before this session of the Florida legislature.

3. At the national level, I am involved in mobilizing various forces against the precipitous passage of legislation involving human cloning. I am pleased to report that the attempt to expedite the passage of potentially onerous legislation has been defeated in the Senate, and it has now been referred to the appropriate set of Committees so that this item under discussion may be discussed in further detail. United States Senator Connie Mack was instrumental in leading the forces against having the Senate make a precipitous decision that could have impeded vital research and a number of clinical entities.

Additionally, the involvement of your Child Advocate Member included getting a letter signed by the Deans/Vice Presidents of the four medical schools in this state to express their opposition to Congressman Charles Canady's (R-Florida, District 12) well intentioned but misdirected legislation entitled the "Pet Safety and Protection Act". This very onerous legislation would have made any kind of research on animals, particularly cats and dogs, extremely difficult and prohibitively expensive. I am delighted to report that, although this particular piece of legislation has almost 70 co-sponsors in the House of Representatives, it has yet to be scheduled to be heard in the House Agricultural Committee. Since this proposed legislation has no Senate companion, it is doubtful that it will pass this session of the 105th Congress.

4. I have been involved in coordinating the legislative agenda between the FMA/AMA, the American Heart Association and the Tri-Agency Coalition on Smoking and Health (composed of the Florida Heart Association, the Florida Division of the American Cancer Society and the Florida Division of the American Lung Association) and their role in the expenditure of the "tobacco monies".

5. In addition, I have played a coordinating role between the Florida Pediatric Society, the Florida Medical Association, the Council of Statutory Teaching Hospitals, and the Tri-Agency Coalition on Smoking and Health, together with the Department of Health/CMS in the expenditure of both the Title XXI and the tobacco monies so that, to the greatest extent possible, we might present a coordinated approach. □

Risk Adjustment: Redefining the Challenges, Opportunities, and Financial Risks of Capitation

(This is an Update from the Committee on Child Health Financing, which was published a few months ago. Its content is so important and so well thought out that reprinting here is important.)

Assume, for a moment, that the largest managed care plan in your area offers your group practice, which includes both general pediatricians, pediatric medical subspecialists and pediatric surgical specialists, a capitation rate of \$100 per child per month. Should you accept the offer and begin to enroll children from this plan? What questions should your group ask in evaluating the proposal? What strategies can your group adopt to reduce its financial risk under capitation?

Few medical schools or residency programs teach pediatricians what it means to be at risk financially for a panel of children. Yet the growing prevalence of capitated payment systems demands that pediatricians familiarize themselves with the implications of prepaid medical care, how capitation rates are established, and the financial risk they face when they accept contracts that pay them on a capitated basis.

Capitation-New Challenges, New Risks

Capitated payment arrangements between managed care organizations and pediatricians have dramatically altered the financial risks and utilization incentives of clinical practice. Pediatricians accepting these contracts agree to manage and provide a variety of health care services to a defined population of patients in return for a prepaid premium for each member each month. The sum of these per-member per-month premiums constitutes a fixed budget under which pediatricians must meet the health care needs of their children. Since pediatricians receive the same level of payment irrespective of the services they actually provide, capitation transforms every medical service provided into a cost, rather than a source of revenue, for the pediatrician. This arrangement stands in stark contrast to the incentives of a fee-for-service system, in which increasing the number of services provided translates into higher revenues for the pediatrician.

Under capitation, pediatricians assume the kinds of risk that traditional insurers have assumed in the past. For pediatricians, "risk" constitutes the potential to lose money, earn less than they had anticipated or spend more time without additional payment.¹

The nature of this financial risk is determined by the scope of services pediatricians are contracted to cover. Under "partially" capitated contracts, pediatricians are responsible only for their own professional services. If a child required hospitalization, surgery or specialty care, the managed care plan would cover these expenses by paying the other providers on a fee-for-service basis. In more mature managed care markets, pediatricians are assuming financial risk for a broader range of services such as hospitalization, specialty and home health care. This arrangement is known as "full risk capitation". Under full risk capitation, pediatricians receive substantially higher per-member per-month premiums but also face significantly higher levels of risk, since they are financially responsible for all of the possible medical services a child might require.

In theory, capitation should encourage pediatricians to reduce the volume of the services they provide. Under full risk capitation, pediatricians are also likely to control referrals to specialists and minimize hospitalizations and length of stay. In short, capitation gives pediatricians the same incentives as the managed care plan - namely, to control utilization and thereby, costs.

The Need for Risk Adjustment

The financial incentives given to pediatricians under capitation have raised concern that children might not have access to appropriate medical care. These concerns are greatest for children with chronic illnesses or other special health care needs, who are most likely to require expensive medical services.² Pediatricians specially trained in treating the chronically ill are likely to find that standard capitation rates cannot cover the comparatively expensive conditions they treat. In highly capitated markets, pediatric medical subspecialists and pediatric surgical specialists may find it difficult to join a group practice or managed care plan, since these providers are known to attract expensive patients. As a result there is a growing concern that chronically ill children will not have access to the pediatricians best trained to care for them.

In an attempt to mitigate some of these incentives, many health policy makers have advocated for refinements which try to account for the added costs of caring for the individuals with chronic illness or disability. "Risk adjustment" is the practice of establishing capitation rates that reflect the known actuarial risk of caring for a population of children. In other words, risk adjustment is an attempt to identify factors which are associated with higher expected health care costs. For example,

a child with
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cystic fibrosis is likely to require more expensive medical care than a child with no known health problems. Risk adjustment quantifies the risk for needing expensive medical care so that managed care plans and capitated pediatricians can be paid a rate that reflects the health status and expected cost of children in their panel.

It should be noted that risk adjusted capitation still places pediatricians at financial risk for the future health care costs of their patients. It is impossible to predict which specific child will be expensive and which child will cost little or nothing in the coming year. Any given child with cystic fibrosis may cost less or more than another or even less than a child with no known previous health problems in the coming year. In other words, there is considerable variation in the annual cost of treating children with a chronic illness such as cystic fibrosis. At the group level, however, it is possible to predict with much greater accuracy the expected costs. Statistically, it is almost guaranteed that 100 children with cystic fibrosis will cost more than 100 children with no known health problems in the coming year. Thus, risk adjustment attempts to adjust for cost differences between groups of children but leaves pediatricians at risk for the health costs actually incurred by specific children.

Currently, most capitated payment systems make no adjustments for the health status of the children who are enrolled - they do not include risk adjusters. A managed care plan may offer \$100 per child per month to pediatricians accepting full risk. Most of these systems make no attempt to account for differences in health status among children. Under certain circumstances this is not a problem. An unadjusted capitation rate is adequate so long as a practice receives a cross section of children representative of the population upon which the \$100 rate was based. It is completely inadequate, however, if the practice enrolls a group of children with a disproportionately high incidence of expensive illnesses.

Many health policy makers have warned that unadjusted capitated systems, health plans and providers would engage in a practice known as "risk selection" and manipulate capitated payment systems to their advantage. Plans or providers would try to selectively enroll healthy individuals and try to avoid or disenroll sick, expensive individuals while collecting the capitation rate for an average population. As a result, these plans and providers would be overpaid for a relatively healthy segment of the population. There is considerable evidence that healthy individuals choose managed care plans over indemnity insurers when there is voluntary enrollment.³

A related phenomenon can occur when families of children with special health care needs select pediatricians with recognized expertise and interest in caring for special health care needs. This selection bias, favoring some pediatricians in a community over other primary care physicians, can lead to a disproportionate capitated patient panel.

Children with special health care needs are especially susceptible to unfavorable risk selection since they are likely to be much more expensive than comparatively healthy children. Table 1 compares the annual cost to the Washington State Medicaid program of children with ten selected chronic illnesses to the costs for all children in the program. The ratios of higher costs range from 2.3 times for asthma to 48.7 times for children with chronic respiratory disease. Analyzing these selected illnesses in other populations, such as Blue Cross plans, managed care plans and other Medicaid programs, we found the ratios to be remarkably similar.

Once capitation rates are fairly adjusted for the added costs incurred by children with special needs, managed care plans, specialists and even general pediatricians will have an incentive to enroll and care for these children. They will be more likely to develop specialized, innovative delivery systems.

Evaluating Risk Adjusters

In today's medical marketplace, pediatricians would do well by learning a language once reserved for managed care administrators and health policy makers. The topic of risk adjustment boasts more than a decade of literature. Risk adjusters have been studied extensively in the compensation of managed care plans receiving capitated premiums from third party payors. Unfortunately, less work has been done to adapt risk adjustment principles to pediatricians accepting capitated contracts.

Risk adjusters must succeed on several levels. First, they must have predictive accuracy. A risk adjuster should be able to predict a large portion of the
(See *Managed*, page 20 ▶)

Special Article

Vaccines for Children (VFC)

Al Sulkes
VFC Manager
Bureau of Immunization
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The Florida VFC program is a private-public partnership that has improved the health of Florida's children by encouraging comprehensive children's health care in a medical home through facilitating timely and appropriate childhood immunization. VFC is federally financed and is administered in Florida by the Department of Health, Bureau of Immunization. VFC began in 1994, and in calendar year 1997 \$11,416,299 worth of vaccines was distributed to private physicians, hospitals and other private health care providers throughout Florida. We encourage all pediatricians to enroll in VFC. If you are interested in enrollment, please send a request on your office letterhead to the Bureau of Immunization, 1317 Winewood Blvd, Tallahassee, FL 32399-0700, You will receive the enrollment packet by return mail. When we receive your provider enrollment and profile forms we will issue you an account number and ship a starter kit of vaccines. The starter kit shipment allows us to make the connection with your office and ensures that all the information you supplied has been entered in our records correctly. All vaccines are shipped via UPS. The following questions are the ones most frequently asked by pediatricians already enrolled in the VFC program.

What are the correct procedures for storing vaccines?

Vaccines should be stored in a kitchen type or commercial refrigerator/freezer that has separate doors for each compartment, Store OPV and Varicella in the freezer at 5°F or colder. Store all other vaccines in the refrigerator (never in the door) at a temperature between 35° and 46°F. Keep a thermometer in both the refrigerator and the freezer and check the temperatures twice a day. Record the temperatures on the log mounted on the door. The VFC vaccine supply should be kept separate from other vaccines.

Which Children are eligible for VFC vaccine?

Children who are between the ages of birth and 18 years and:

- are enrolled in Medicaid (including Medipass and Medicaid HMOs); or
- have no health insurance; or
- have health insurance that doesn't cover immunizations; or
- are American Indian or Alaskan Native.

When are Vaccines Resupplied?

Private providers report vaccine usage and inventories to the Bureau of Immunization four times a year and the Bureau replaces the vaccines that were used in the previous quarter. Dade county's resupply months are January, April, July and October. Broward, Duval, Hillsborough, Orange, Pinellas and Palm Beach counties' resupply months are February, May, August and November. All other counties' resupply months are March, June, September and December. The VFC Vaccine Report Form must be submitted between the 1st and the last day of a resupply month. Use the VFC Vaccine Report Form that says

November 1997 in the bottom left hand corner.

How can I make sure I have the correct amount of VFC vaccine on hand?

The vaccine replacement system works very well for most offices. However, if your office is experiencing rapid growth, or you are doing extra outreach clinics or you want to have extra vaccines on hand for school physicals then you should let us know your needs. There is room at the bottom of the Report Form, in the "Notes" area for you to request a specific number of doses for the next quarter. The doses you request should be the total doses you want for the upcoming quarter. We have sufficient quantities of vaccines on hand and your office should never be without the vaccines needed for VFC eligible children.

What Information must be included in the child's medical record for each Immunization?

Include in the record the person who gave the shot, the shot date, the vaccine name, the lot number, the manufacturer and the date of the Vaccine Information Statement (VIS) that was given to and discussed with the parent or guardian. Use the VFC Vaccine Usage Worksheet to record the child's VFC eligibility status and to account for the doses administered to children.

What about administration fees?

No charge may be made for the actual vaccine supplied by the VFC program, However, office visits and administration fees may be billed to Medicaid and Medicaid HMOs. Families that are not covered by Medicaid or Medicaid HMOs can be charged administration fees, but these fees should not exceed \$10 to prevent the cost from becoming a barrier to an eligible child receiving immunizations.

If you have questions or need VFC information call toll free 1-800-483-2543.□

FLORIDA PEDIATRIC SOCIETY FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS GENERAL PEDIATRIC UPDATE VI

Thur./Fri./Sat./Sun., May 28-31, 1998

Buena Vista Palace Resort

Lake Buena Vista, FL

Scientific Sessions Sat./Sun., 8:00 a.m.-12-.00 p.m.

Topics

Pediatric Infectious Disease

Pediatric Neurology

Pediatric Pulmonary

Dermatology

PALS (Ped. Adv. Life Support) Course, Thur./Fri., May. 28-29

Speakers

Christopher Harrison, M.D.

William Turk, D.O.

James Sherman, M.D.

Christopher Kirkpatrick, M.D.

CATCH Meeting
School Health Seminar

Office Emergency Preparedness Workshop
First Annual Florida Pediatric Infectious Disease Meeting

Women's Section Luncheon

Florida Chapter Annual Business Meeting and Luncheon

Saturday, May 30, 1998, 12:00-2:00 p.m.

Free Cocktail Party/ Reception - Saturday, May 30, 1998, 7:30 p.m.

Meeting Objective: Update child health care providers in selected topics
related to infectious disease, neurology, pulmonary, and dermatology

For more information call: **(850) 224-3939**

For Hotel Reservations call:

Buena Vista Palace Resort **(1-800 964-9445)** by April 27, 1998

Room Rate@ \$165 + tax

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Genomic Imprinting: Remarkable New Findings and Its Clinical Relevance

R. Rodney Howell, M. D.
Professor and Chairman
Department of Pediatrics
University of Miami School of Medicine
Miami, FL

When we talk about imprinting, we tend to think of the psychological definition of this term which defines the rapid learning process which takes place early in the life of a social animal, such as the greylag goose. In this situation, a behaviour pattern is established in which there is recognition of and attraction to its own kind or a substitute.

Only recently has molecular genetic technology permitted us to trace the origin of chromosomes as they are passed from parents to children, as well as how they are expressed in various tissues of a given individual. It has been discovered that the exact same gene is expressed (functions) differently depending on whether the chromosome on which it is located came from the mother or father.

The term genomic imprinting refers to the differential expression of genetic material depending on which parent provided the genetic material. This remarkable situation leads to inheritance quite at odds with the recognized Mendelian inheritance.

This extraordinary situation has been well defined in regard to two uncommon, but well recognized syndromes seen in children, i.e. the Prader-Willi Syndrome and the Angelman Syndromes. The Prader-Willi Syndrome in childhood is characterized by marked hypotonia, hyporeflexia, poor feeding (due to poor swallowing and sucking), and hypoplastic penis and scrotum in boys or hypoplastic labiae in girls. In later childhood, the features are obesity, polyphagia, small hands and feet, short stature, hypogonadotropic hypogonadism, and mental retardation. The Angelman Syndrome is characterized by severe motor and intellectual retardation, ataxia, hypotonia, epilepsy, absence of speech and unusual facies characterized by a large mandible and an open-mouthed expression. This condition was originally termed the "happy puppet" syndrome; this derisive term should not be used.

About 60% of the patients with Prader-Willi syndrome have a deletion of 15q11-13; it is however always the paternal number 15 chromosome which is involved. Conversely, 60% of patients with the Angelman Syndrome, which is clinically quite distinct also have a deletion of 15q11-13, but in this instance the deleted number 15 chromosome is always derived from the

mother! These findings strongly suggest that there is a critical region on the paternal chromosome that can prevent Prader-Willi syndrome (not present on the maternal chromosome), and conversely there is a critical region on the maternal chromosome that can prevent expression of the Angelman Syndrome.

These remarkable observations have been clinically underlined and substantiated by a situation called uniparental disomy. This complex-sounding term refers simply to the following situation: Ordinarily, we have two pairs of chromosomes, one from the father and one from the mother. In certain circumstances, however, because of uncommon mishaps in cell division we now know that some people get both members of a pair of chromosomes either from the father or the mother. Again, modern genetic technology has recently permitted us to determine absolutely whether a given chromosome came from either mom or dad.

The Angelman Syndrome and Prader-Willi syndrome again have been most informative. We are now aware of children who have inherited both of their number 15 chromosomes from either the father or the mother. In these situations, the number 15 chromosome itself does not have any known defects, and certainly does not contain deletions as defined above.

In 3-4% of the children with the Angelman Syndrome, both of the number 15 chromosomes are inherited from the father leading to this clinical situation. At the same time, as many as 30-35% of the patients with the Prader-Willi Syndrome occur as a result of inheriting both the number 15 chromosomes from the mother. In this situation, the critical materials which can prevent these genetic disorders and which are derived from either the mother (in the case of Angelman Syndrome) or the father (in the case of Prader-Willi Syndrome) are absent.

There are a growing number of conditions where genomic imprinting is being recognized, such as Beckwith-Wiedemann syndrome. Not all chromosomes exhibit imprinting, and the lists of those which do, and the clinical effects that one observes, are being rapidly recognized.

One should suspect imprinting when a disorder is routinely inherited only from the female or the male parent. For

example, equal numbers of males or females might be affected, but the sex of the transmitting parent is always the same.

These exciting observations require fresh looks at classic molecular genetics, to examine not only the structure of the gene in question, but its cellular environment more closely.

References:

- Ledbetter, D. H., and Engel, E. Uniparental disomy in humans: development of an imprinting map and its implications for prenatal diagnosis. *Hum. Mol. Genet.* 4:1757-64, 1995.
- Hall, J. G. Genomic Imprinting: Nature and Clinical Relevance *Ann. Rev. Med.* 48: 35-44, 1997.□

(Our "Emphasis" section for the year 1998 continues this month, with more information on children and tobacco, and will continue through this year.)

USF PEDIATRIC TOBACCO EDUCATION PROGRAM

Sharon Dabrow M.D.
Assistant Professor of Pediatrics
University of South Florida

Two out of every five high school students in the U.S. regularly use some kind of tobacco and the percentage of teens who smoke is increasing despite strong efforts to reverse this trend. A recent CDC report stated that cigarette use by high school students has risen by one-third over 6 years. Particularly troubling is that smoking by black adolescents, a group that historically has had the greatest resistance to tobacco compared to white and Hispanic teens, is increasing at a far greater rate than the other groups. Risk-taking behaviors including smoking often start in early adolescence; 60% of teenagers begin smoking by the time they are 14 years old. Pediatricians will often have an opportunity to influence their patients at an age before they have begun using tobacco.

The issue of environmental tobacco smoke (ETS) on children is one that can be frequently found in the lay press as well as in the medical press. Its detrimental effect on the health of children by increasing the incidence of respiratory infections, middle ear disease, asthma exacerbations and a multitude of other problems has been well documented. We additionally know that there is a significant role modeling effect that parents have on children; children of smokers are more likely to become smokers themselves and the modeling of healthy behavior by parents can clearly influence that of one's children.

Physicians' advice regarding tobacco use can be a very important motivating factor for patients and their families. Many family practice and internal medicine programs teach smoking cessation as part of their residency curriculum and a great deal of literature exists detailing the effectiveness of physician advice and programs. However, there is little in the pediatric literature describing similar programs and until very recently, ETS and cessation information was not seen as the purview of the pediatrician.

Aside from the pediatrician's role in counseling adolescents, a unique opportunity exists to provide smoking cessation advice to our patients' families. Many parents in a pediatric practice are young and healthy, rarely seeking out primary medical care for themselves; the pediatrician may be the only physician they see routinely. There are multiple opportunities to intervene with the family since the pediatrician may see them at prenatal visits, in the nursery after birth, at sick visits and at a large number of health maintenance visits.

The above issues inspired a group of us at the University of South Florida Department of Pediatrics and the Moffitt Cancer Center to investigate the knowledge, attitudes and practice patterns of pediatric residents and general faculty regarding ETS and smoking cessation. This was done by administering a confidential questionnaire to the residents and faculty members. Subsequent to this, we created and delivered an educational intervention designed to augment knowledge and counseling skills regarding these topics.

Sixty nine surveys were completed and analyzed (77% were residents and 13% faculty). Ninety four percent of the respondents stated they always or most of the time asked about smoking in their patients' homes. Resident physicians were significantly more likely to ask about this than the general faculty. Only 31% of all respondents, however, always or most of the time recorded the parents' smoking status on the child's problem list. A clear majority (78%) always or most always advised parents to quit, advised about the hazards of ETS (92%) and suggested not smoking around the child (96%) but less than 50% offered any specific advice on smoking cessation. Less than 20% ever mentioned specific techniques such

as quitting cold turkey or setting a quit date, two of the most commonly recommended cessation tools. The survey revealed that 91% of the physicians felt it was important to offer general counseling, 69% felt it was important to counsel on cessation, 33% felt confident counseling but only 22% felt their counseling could have an impact. The results of the survey led our work group to believe that pediatricians could use some additional information about counseling as well as skill-building in practicing and performing the techniques.

A 3 hour educational intervention was created by our work group, and delivered to the USF residents at both Tampa General Hospital and All Children's Hospital in St. Petersburg during the past academic year. It consisted of a Grand Rounds delivered by Carolyn Schleder, M.D., Associate Professor of Medicine at USF and a national expert on smoking, followed by 2 one hour interactive smoking cessation workshops. The first workshop explored the physician's role in cessation counseling and reviewed general communication skills, behavior modification concepts and the stages of change. The NIH intervention method for cessation, the 5 A's (Anticipate, Ask, Advise, Assist, Arrange), was reviewed. The second session was designed as a skill-building workshop. The faculty performed real life scenarios illustrating both effective and ineffective counseling techniques. The residents were then divided into small groups to practice these techniques. The content of their message and their style was analyzed and critiqued. Materials on ETS and cessation were distributed and made available in the outpatient clinics at both institutions. An evaluation of the program revealed that all those that attended found the sessions either extremely or somewhat useful. They also felt that they had improved their confidence in counseling families.

Since the program, residents appear to be more comfortable in their knowledge and counseling skills and make use of the handouts and patient education materials. It is our hope that through this and other educational programs, we can provide the motivation and impart the knowledge needed to help both our adolescent patients and our younger patients' families to stop smoking. We hope to expand this educational program to community-based general pediatricians in our area and perhaps throughout the state as one mechanism for fighting the war on tobacco. The faculty who created the questionnaire and educational intervention include Cathy Meade, R.N., Ph.D., Linda Nelson, ARNP, Alayne Unterberger, M.A. and myself. Feel free to contact me at 272-2268 or by email at sdabrow@com1.med.usf.edu for further information.□

Note: Visit our society's permanent website at:

www.flmed.net/fps/newslett/htm for all you want to know about our society, including a summary of *The Florida Pediatrician*.

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Firearm Injury

Firearm injury has a direct or indirect impact on all of the children we serve. In 1995, almost 5300 children under the age of 20 died from gunshots. Nonfatal gun-related injuries occur more than two and a half times more frequently than gun-related deaths do. Children who are not injured or killed by firearms themselves are frequently witnesses to the violence in their homes or in their communities. The impact of firearm injury is significant and an ongoing response from the pediatric community is warranted.

The American Academy of Pediatrics, with educational grants from The Robert Wood Johnson Foundation, The Joyce Foundation, and The John D. and Catherine T. MacArthur Foundation, has embarked upon a Firearms Injury Prevention Training Project (FIPTP) to provide pediatricians with the skills and resources they need to provide effective family counseling and engage in community advocacy with the aim of reducing firearm injuries and deaths.

A central feature of the FIPTP was the Firearms Injury Prevention Training Conference which took place on March 14-15 in Chicago, IL. Conference attendees received training and materials necessary to return to their communities and conduct training sessions on firearms injury prevention for health care professionals and public audiences. As these conference participants conduct the training sessions to which they have committed, a national network of pediatricians and other health care providers with knowledge about firearms injury prevention techniques will be established. Thomas Benton, MD, Dan Riggs, MD, and Judy Schaechter, MD were selected by the Florida Chapter President to attend the conference.

Conference participants received *The Preventing Firearm Injury: Protecting our Children Speaker's Kit*. This newly developed kit contains a complete set of slides with an accompanying narrative. Sample presentations are included to assist the speaker in adapting the slides for use with a professional or public audience and to assist with developing presentations of different lengths. Also included are handouts to help the speaker deal with challenging individuals or issues they may encounter in trainings. Statistics and a Suggested Reading List are also included.

For information about hosting a firearm injury prevention training session in your community, please contact the Executive Vice

President, Louis B. St. Petery, Jr., M.D. at (850)224-3939, or e-mail him at lstpety@ibm.net.

If you would like to receive the speaker's kit described above, other materials distributed at the conference, or if you have additional questions related to the project, please contact Lori Lovett at the AAP at (800)433-9016, ext. 6779 or by e-mail at llovett@AAP.org. □

Note:

Another summary of The Florida Pediatrician is on the website for the AAP. The URL is:

<http://www.aap.org/member/chapters/florida.htm>.

AAP Recommends Measures to Cut In-Line Skating Risks

A new policy from the American Academy of Pediatrics addresses in-line skating and the increasing numbers of injuries and deaths among youth who participate in this popular sport.

According to the policy, many of these injuries could have been prevented by following proper safety measures. The AAP, together with the Centers for Disease Control and Prevention (CDC), made the following recommendations regarding in-line skating injury prevention:

- Wrist injuries could be reduced by an estimated 87 percent if in-line skaters wore wrist guards. In 1996, in-line skating sent 76,000 skaters under the age of 21 to the emergency room. One-third of all those injuries occurred to the wrist.
- Recommended safety gear includes helmets certified by ANSI, ASTM, the Snell Memorial Foundation or the U.S. Consumer Product Safety Commission, and protective pads for elbows and knees. The AAP and CDC agree that these pads could decrease the incidence of in-line skating elbow injuries by 82 percent and knee injuries by 32 percent.
- The policy statement strongly discourages any type of truck-surfing or skitching - holding on to a vehicle and skating behind or alongside the vehicle - by in-line skaters. According to the U.S. Consumer Product Safety Commission, in-line skating contributed to 36 deaths among children and

teens reported to them since 1992, of which 89 percent were from collisions with motor vehicles.

- Although the AAP suggests that most children ages 7 to 8 should have the necessary skills to in-line skate, parents and pediatricians are encouraged to take a child's individual physical and behavioral development into account when determining readiness for in-line skating.
- The AAP recommends that beginning skaters learn how to in-line skate from a teacher certified by the International In-Line Skating Association, and to practice initially at an indoor skating rink before skating outside on streets.
- The AAP also suggests that outside skating only take place on streets that are blocked off or closed to through traffic or on bike paths, sidewalks or specifically designated skating areas.

The AAP cautions that "parents need to understand both the benefits and risks of in-line skating and appreciate that injuries are particularly common in novice skaters."□

SCHEDULE OF MEETINGS OF THE AAP

Annual Meeting:

San Francisco, CA

October 17-21, 1998

Spring Session:

Chicago, IL

April 17-20, 1999

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SPECIAL ARTICLE

INTERNET, INTRANETS, AND MEDICINE

Susan Zucker, Ph.D.

Assistant Professor in Medical Education

University of South Florida College of Medicine

Historically, the government plays a leading role in the development, funding, and regulation of both communications and transportation infrastructures. The NII (National Information Infrastructure), a web of thousands of wired and unwired interconnected networks and databases (digital libraries), is funded with \$50 billion annually from private sources and \$1.2 billion from the government to build a communications infrastructure.

The NII consists of three layers that will allow users to have access to and manipulate massive amounts of information. The layers are: BITWAYS – forms the infrastructure for electronic commerce; SERVICE – provides service to healthcare, banking, manufacturing, and education; APPLICATION – provides telemedicine and health information systems derived from the SERVICE layer. It encompasses physical facilities used to transmit, store, process, and display voice, data, and images and network standards and transmission codes. Computer systems, faxes, televisions, telephones, other information appliances and services, software, and the people trained to build, maintain, and operate these systems comprise the NII.

The NII is being designed to link people, homes, schools, libraries, hospitals, businesses, and government so that information can

be created, used, and exchanged on a worldwide scale at supersonic speed. It is expected to stimulate development of new products, services, and industries, and opportunities to use information as a strategic resource – but only if groups or individuals are connected to it and know how to use it. The NII must become embedded technology so that it can support more effective healthcare and healthcare delivery.

An example of the Internet being used to deliver medical information over networks follows. At the hospital of the University of Pennsylvania, the implementation and use of the WWW (World Wide Web) in conjunction with a DICOM PACS (Picture 2 Archiving and Computerized System) incorporates information from their RIS (Radiological Information System). This allows users to query, select, move, and display images that are currently available in the PACS, and view their corresponding radiology reports. The dissemination of extensive patient demographics, exam information, and textual radiological reports and association of this information with information from the PACS is thereby made possible. Physicians can extract reports and images, possibly annotate them further, and then store them on their local hard disks or on CD-ROMS in the form of HTML documents. These can then be used for research and teaching.

Intranets

Two years ago intranets were virtually non-existent. The rate of acceptance and growth is unprecedented; today intranets are widespread and skepticism and resistance is nearly extinct (Frappaolo, 1997). Attention is now being focused on intranets as instructional tools and an alternative information resource; an instructional intranet is currently being developed for the University of South Florida Pediatrics Department.

An intranet is an internal organizational network, a private version of the World Wide Web often available only to members of a particular organization. The browser technology and communication protocol (TCP/IP) that made the Internet so popular and successful can

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be used to create an educational structure where individual curriculum components are connected into a single electronic document. Typically, an intranet offers easy access to email and can feature CAI (computer-assisted instruction) inclusive of tutorials and simulations, virtual reality applications, computer-based testing, two-way interactions, forums, and links to the World Wide Web. Intranets are particularly well suited for medical education because they offer a dynamic learning environment, contain current, pertinent information which can be easily updated, interface with many components that are learner controlled, address adult learning style learning styles theory, and may prove to be motivational.

Key benefits of an intranet include increased communication, information owner-based maintenance and dissemination of documents, information organization and preservation, decreased time to find specific information, and support for rapidly developed solutions using Internet technologies. It provides users with a single interface to a variety of information sources and is cost-effective, highly efficient, and easy to use. Moreover, the intranet provides easy integration with other applications, such as electronic mail, faxes, calendars, and videoconferences. Cost savings include the reduction or elimination of current document management processes and their associated technical support and user training processes, the reduction or elimination of producing and disseminating hard copy materials, the reduction or elimination of reproducing lost documentation, increased performance, and better informed decision making from well-informed employees.

Intranets provide inexpensive, easy access to data not only among local sites but also to those that are geographically dispersed. Using the Internet as a backbone, sharing information across the country or the world has become cheaper and faster. One of the chief benefits of intranets is, therefore, the potential cost savings over existing technologies, savings which come in the form of less money spent on mailing expenses, paper, labor costs, and travel (Brasch, 1997).

An intranet is set up to offer its users limited access. An intranet is often protected by a firewall and is available only to those inside the organization. It is important to limit access to an intranet and instill accountability among the intranet users, especially in the medical field. Security in medicine refers to network security, end-point security, patient privacy, and privacy protection in a distributed environment. Network security means that a message may be intercepted but should not be interpreted, changed or even responded to by a third party between two connection ends. Network end-point security must ensure that computers and files are not affected by a virus, that unauthorized clients will not gain access to a restricted host or information, that an outside hacker cannot sneak into a local network connected to the Internet, and that the databases are secure (Brasch, 1996).

It is imperative to assure both patient privacy and privacy protection in medicine. Privacy in medicine refers to patient privacy and privacy protection refers to preventing unauthorized access to and improper use of patient information. Privacy protection involves establishing a policy for access to and use of data, as well as computer security to verify the access and use of the data to enforce the policy. One way to achieve privacy protection is to conceal the patient's name

(see **Intranet**, page 22 ▶)

FUTURE OF PEDIATRIC EDUCATION II

A Project of the Pediatric Community

Hot Topics January 1998

Topic #1: Scope of Practice of the Pediatrician of the Future

Changes in reimbursement for health care services, site(s) of delivery of health care, advances in technology, and others will reshape the roles of the providers of pediatric care. As we look to the future:

- ◆ Which types of pediatric care will be provided by pediatric generalists and which types by pediatric subspecialists?
- ◆ How much primary care will subspecialists provide?
- ◆ Who will be responsible for the ongoing care of chronically ill children?
- ◆ How much patient care that is now provided by pediatric subspecialists -- for example, neonatologists -- will, in the future, be provided by pediatric generalists?

Topic #2: Referrals

The pediatric community will need to develop proactive strategies to meet the changes in the future environment of pediatric health care delivery. Please provide ideas as to how the following challenges can be met:

- ◆ How can we increase referrals from family physicians to primary care pediatricians?
- ◆ How can we deal with managed care utilizing adult providers of care? For example: Adult general surgeons versus pediatric surgeons?

Topic #3: Pediatric Education

The future of pediatric education -- from medical school through continuing medical education -- will need to be modified to ensure that pediatricians continue to provide optimal health care to infants, children, adolescents and young adults. As you envision the lifelong learning of the pediatrician, how would you respond to the following:

- ◆ Should there be special tracks during core pediatric training?
- ◆ Should all pediatric fellowship programs be three years in duration, and the same tracks?
- ◆ How will pediatricians keep up with the newer technologies of patient care?
- ◆ What will be the influence of the new modalities of learning (for example: The World Wide Web and/or interactive computer technologies) on the future continuing medical education of the pediatrician?
- ◆ Who should and will finance fellowship training?
- ◆ How and by whom will pediatricians be re-credentialed for hospital privileges?
- ◆ In the future, what type of CME will best suit your needs?
 - ◆ Content:
 - ◆ Format:
 - ◆ Delivery mode:

[Note: this report reached the editorial office after the February issue of this newsletter went to press. I believe that responses sent now, but with no delays, will still be appreciated by the FOPE II group.]

Please direct your response to:

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 c/o Angela Lipinski
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 141 Northwest Point Blvd.
 P.O. Box 927
 Elk Grove Village, IL 60009-0927
 Fax: 847-228-5097
 E-mail: alipinski@aap.org

ENT UNDERWAY FOR A

**NATIONAL NIH-SPONSORED STUDY
 CONGENITAL ESOTROPIA OBSERVATIONAL STUDY (CEOS)**

The Pediatric Eye Disease Investigator Group (PEDIG) is currently conducting an observational study on the early course of congenital esotropia. Such prospective data is needed to be able to determine the earliest age for surgery without concern that the esotropia will likely resolve spontaneously. The study is supported by the National Eye Institute of the National Institutes of Health.

Infants with congenital esotropia who are between the ages of 9 and 17 weeks are eligible for CEOS. Your assistance is needed in referring eligible infants as early as possible. Over 130 pediatric ophthalmologists are participating in this study nationwide. Referrals can be sent to the study investigators listed below or, to get more information, please call the PEDIG Data Coordinating Center toll free at 1-888-79PEDIG. Thank you for your support.

- Nemours Children's Clinic
 807 Nira Street
 Jacksonville, FL 32207
 (904) 390-3713
 Lee Hunter, MD, FACS, Robert Hered, MD,
 Alexander Pogrebniak, MD
- J. Bruce Hess, MD
 880 6th Street South
 St. Petersburg, FL 33701
 (813) 892-4393
- Roberto Warman, MD
 Miami Children's Hospital
 3200 SW 60th St., Suite 103
 Miami, FL 33155
 (305) 662-8390
- Mark Dorfman, MD
 2740 Hollywood Blvd.
 Hollywood, FL 33020
 (954) 431-2777
- Bruce Miller, MD
 939 University Drive
 Coral Springs, FL 33701
 (954) 344-2143
- Bascom Palmer Institute
 900 NW 17th ST.
 Miami, FL 33136
 Michelle Munoz, MD (305) 326-6555
 R. Michael Siatkowski, MD (305) 326-6019
 John Flynn, MD (305) 326-6476
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SPECIAL ARTICLE

[This contribution arrived as a Letter to the Editor. Its content suggested it might be better as a "Ticked off" note, but this very serious suggestion by a Past President deserves more recognition. Therefore, it is presented as a "Special Article", with thanks to the author]

MEDICAID EXPANSION

Kenneth H. Morse, M.D.
Past President, Florida Pediatric Society

It appears to me that the Florida Pediatric Society is taking the commonly espoused but misguided point of view that extra funding available for children's medical care should be channeled into Medicaid expansion. As a practicing general pediatrician, I do not feel this is truly the best plan. Florida Medicaid, at least as I see it, has as its major objective maximizing the quantity of people covered. I do not see emphasis on what I believe should be the major goal, a quality medical home for each child in the state. I stress the word *quality*. Some measures to ensure it might include Board certification, true 24-hour coverage and hospital privileges. I see daytime clinics owned by entrepreneurs using mid-level providers who refer kids to the emergency room when things go wrong with admission by the "real doctors" because it is their hospital responsibility. Medicaid pays about half of my usual fee and my overhead is sixty-five percent. It's not a secret that we pediatricians are not getting rich in the system. The only way I can see to give care under the system is to practice "cattle-medicin" and herd them through or hire someone who works cheaply and knows less. My concern is that good parent education and thorough evaluation must suffer. I wonder how many children get diagnosed with otitis media in those settings because there is no time to clean cerumen from the ears to make a true diagnosis. How many antibiotics are prescribed unnecessarily for the sake of speed and poor evaluation? How many viral rashes get diagnosed as allergy by phone after unnecessary medicine was prescribed. How many asthmatics get repetitive "bail out care" with no instruction on asthma management? I know how much time it takes to perform these tasks carefully and correctly and I believe full-time pediatricians still give the best "bang for the buck". If Medicaid really could compare *true* costs in quality settings using properly reimbursed pediatricians, our children's care would be enhanced and available funds would be better utilized.

In 20 years of practice, I've seen no sign of improvement in the Medicaid system. Why does the Florida Pediatric Society support the cattle-herding of our kids by going along with enlarging the Medicaid system? Indeed, it might consider supporting the Florida Pediatric Society members and the quality care they can provide under a reasonable system which does not strangle their best efforts.

I know there are insurance plans which do not really offer any better program than does the Medicaid system. Nevertheless, there are many that do. I believe the Society should support programs which allow families to make their own decisions in choosing a medical home for their children rather than forcing them into a system which has repetitively proven its inadequacy. □

Note:

If you are a Fellow of the American Academy of Pediatrics, you are automatically a member of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, and you automatically receive The Florida Pediatrician. If you have not already done so, **please pay your Florida dues**, billed through the Academy Office. □

If the premise of the Medipass system is to contain health care costs and to enhance continuity of care for patients in the Florida system - why is it that every month the Medicaid computer regenerates patient lists for providers and patients which arbitrarily moves patients from one physician to another? The beginning of each month starts with different physicians' office staff calling other offices for authorization to see patients that have been theirs for months and then were reassigned. Is there anyone out there that can explain this process to me and others?

Dr. Kelly G. Cronin
General Pediatrician
Orange Park, FL □

Add a 'pearl'... from Chuck Weiss

WILL FLORIDA BE SAFE FROM FIRE ANTS?

The press, the media and the Internet channels are speculating regarding the Environmental Protection Agency (EPA) proposed ban on organophosphates, namely chlorpyrifos. The original EPA memorandum (threat), issued in 1997, stated that chlorpyrifos "is one of the leading causes of insecticide poisoning incidents in the United States. (Apparently 4th most common of 1000 pesticides registered for use in the US.) There are no reported deaths, or near deaths reported from chlorpyrifos that didn't result from intentional ingestion; that is; suicide or attempted suicide.

The literature is very confusing. Many effects are attributed to the organophosphates, but few, if any, are documented. It is the additive/cumulative effects upon which the EPA is basing their claim. Animal LD₅₀ is observed as nearly the body weight in a single dose. Transposing animal toxicity data to man, it would require ingestion of 875 pounds of broccoli every day for the rest of his life to approach the problems chlorpyrifos causes in rodents. In the cases of reported accidental overdoses in children, all have recovered. Data is scant and possibly inaccurate and incomplete.

The organophosphates kill bugs by interfering with the nervous system. Indoors they are most useful for cockroaches, flea and termites. Outdoors they are used on most food crops. For some crops there are no approved alternatives; for others the alternatives are either less effective or more expensive. The Department of Agriculture estimates that the banning of chlorpyrifos would cost \$150 million annually and a complete ban on all organophosphates would cost \$1-2 Billion/year.

Disregarding money, and disregarding increased food costs, let us consider the negative health potential for children. Will there be an increase in cockroach related asthma, fire ant bites, Lyme disease-carrying deer-ticks, etc.? Do these discomforts and dangers outweigh the additive minimal effects claimed as cause for banning the product(s). Where is there a balance?

Perhaps some of you on the front line, collectively, may be able to fill some of the gaps, or offer data to explain the true incidence. Please send me your experience(s), any data, positive or negative on these products. Also, include your experience with the insects named. Your patient data is important, I suggest much of it never reaches a Poison Center. Neither is it reportable as are certain diseases.

I will check for Poison Control Center data, in Florida and hopefully country wide. I await your replies. Reply to cweiss@pol.net [Addendum: In checking further into the fire ant hazard, which I entered tangentially, I find a bit of interesting information. According to Richard Weisman, Pharm.D., Miami Poison Control Center, "during summer months...the center will receive calls about 25-50 stings per month. We seem to be hospitalizing as many children with anaphylactic reactions from fire ant stings as we are with hymenoptera stings." Hopefully, promised data will be available. CFW] □

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Managed

(← continued from page 7)

actual variance in health care costs among individuals or groups of individuals. Of course, no risk adjuster can account for 100% of the variance. Many health encounters are random, such as the previously healthy child requiring care after a motor vehicle accident. The predictive accuracy should improve as the size of the group increases since the effects of random events will be minimized.

Second, risk adjusters must be practical to administer. Information systems must be in place to provide the requisite data on each child or group of children. Third, risk adjusters should be resistant to manipulation by plans or providers attempting to secure higher capitation rates. Finally, patient confidentiality should be protected under any rate-setting system.

The Nitty Gritty of Risk Adjustment

Demographics, reported/ functional health status, prior utilization and clinical descriptors are some of the variables commonly used to risk-adjust capitation rates.

Demographic characteristics are the most commonly used risk adjusters today. Age, sex, race, income and welfare status are some examples of the kinds of demographic data used. One drawback to demographic risk adjusters is their poor predictive accuracy at an individual level. For example, a twenty-year-old with cystic fibrosis would fall into one of the least expensive demographic strata despite his/her high likelihood of requiring expensive medical care. In fact, demographic risk adjusters may be able to predict only a small percentage of total variation in ambulatory expenditures for children.⁴ Nevertheless, demographic data are easy to cull from existing databases and may have value in combination with other risk adjusters.

Reported and functional health status have been suggested as criteria for predicting future health care resource use. Many surveys have been developed to assess health status and have been shown to provide data that can predict future utilization. These surveys have been praised for their emphasis on the functional consequences of illness and on the individual's perception of disease, both of which are thought to affect actual use of health care resources.⁵

Prior utilization risk adjusters have captured considerable interest due to their high predictive accuracy and administrative feasibility. These risk adjusters project mean historical expenditures into the future. In other words, they assume that a child with high expenditures in year one will have similarly high expenditures in year two. These risk adjusters are objectively defined, easy to abstract from existing databases and resistant to manipulation by plans, providers and patients. In spite of their predictive accuracy, these risk adjusters have been criticized on several fronts. First, there is no way to determine whether care administered in year one was appropriate in the first place. Second, since capitation rates are adjusted year to year based on prior utilization, these risk adjusters do not create incentives for cost containment or reward efficient providers. Finally, children and especially neonates often have limited medical histories, making prior utilization adjusters difficult to apply to these populations.

Clinical descriptors are the basis of the most recent generation of risk adjustment systems. These models use an individual's clinical history, such as a diagnosis or procedure, to adjust capitation rates. Several models have been developed, including the Hierarchical Co-existing Conditions (HCC), Ambulatory Care Groups (ACGs), Disability Payment System (DPS) and a new system developed by National Association of Children's Hospitals and Related Institutions (NACHRI).⁶ The NACHRI system, entitled "Classification of Congenital and Chronic Health Conditions", identifies individuals who have a congenital or chronic health condition expected to last 12 months or longer. It classifies the chronically ill by type, severity and multiplicity of conditions and classifies the remainder of the population by age, gender, and certain at-risk indicators available through ICD-9-CM diagnosis codes. Some of the systems have been calibrated especially for children and some have actually been used by insurers and/or managed care plans.

Beyond Risk Adjusters - Reinsurance and Carve-Outs

The best of today's risk adjusters account for only a percentage of the health expenditures actually incurred by any given child. In fact, they can never predict catastrophic events such as a motor vehicle accident or a sudden decompensation in an individual with special health care needs. As a result, pediatricians negotiating even the fairest of risk-adjusted capitated contracts will still face high levels of financial risk. A single unusually expensive patient has the potential to punish the bottom line of a pediatric practice covering even a thousand children.

Stop-loss reinsurance is an insurance product pediatricians can buy to limit the downside risk of catastrophic illness. For example, a pediatric practice might have a reinsurance policy that limits the amount of money it must spend for any child to, say, \$5,000, \$10,000, or \$100,000. Any expenses beyond this threshold are covered by the

reinsurer.

The cost of reinsurance policies increases as the threshold is lowered. The level of insurance required is determined in part by the scope of services the pediatricians agree to cover. Those working under full-risk capitation must be prepared for the potentially enormous expenses of prolonged hospitalization, surgery, mechanical ventilators, etc. The number of capitated patients in the practice is the other chief determinant of reinsurance levels. As the number of capitated patients grows, a pediatric practice can underwrite a larger share of the financial risk itself.

Table 1	
Comparison of Annual Cost of Children with Chronic Illness to All Children	
Chronic Illness	Ratio of Cost of Child with this Disease to All Children
Asthma	2.3
Malignant Neoplasms	12.7
Cystic Fibrosis	13.2
Cerebral Palsy	9.2
Chronic Respiratory Disease	48.7
Epilepsy	7.8
Muscular Dystrophy	18
Mental Retardation	11.2
Spina Bifida	11.4
Sickle Cell	8.8
All Children	1
Source: Data from Washington State Medicaid Program, 1991-1992	

A pediatric practice may go to an outside insurer and treat reinsurance as an operating expense like malpractice insurance. Alternatively, a practice may negotiate reinsurance coverage into the capitated rate directly and agree to receive lower per member per month premiums.

As noted earlier, children with special health care needs are especially vulnerable under capitation. While risk adjustment and reinsurance certainly reduce the incentives of managed care plans and providers to risk select or limit care, various medical conditions still may be difficult to finance and appropriately treat under capitation.

The term "carve-out" refers to the practice of setting up a uniquely structured payment or delivery system for children perceived to have special health care needs. Until recently, most children with special needs have been "carved-out" of capitated payment systems altogether and remained in a fee-for-service system. Today, children with special needs who are carved out may be placed in an alternative capitated system designed specifically for their special needs. In either case, carve outs are typically grouped by disease-specific diagnoses consistently associated with high costs.⁶ By developing a list of such conditions, managed care plans and pediatricians can negotiate separately the payment mechanisms and covered services for populations with identifiable special needs. Isolating these high cost conditions also deters against risk selection and protects pediatricians against large financial losses from such children. The primary limitation of carve-outs stems from the wide variation of costs among children within a carve-out category. As a result, pediatricians still face considerable financial risk if they accept a single capitation rate for even a disease specific diagnosis.

Summary

So, how should you respond to the managed care plan offering you \$100 per child per month at full risk? First, it is crucial to recognize that the financial risks imposed by capitation are novel to many pediatricians and require careful scrutiny. Second, the level of the capitated payments you receive should be risk-adjusted for the kinds of patients who enroll in your practice. The pediatric specialists in your practice will attract a population that is more expensive than average and capitation rates should reflect that. Third, a reinsurance policy may be

able to protect you from losses associated with catastrophic losses unanticipated by risk adjustment formulas. And fourth, carve-outs may be valuable to you when negotiating with managed care plans

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Managed

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that have not established risk adjusters to accommodate the high costs of treating children with special health care needs.

Contributing Authors:

- Joshua Bilenker
- Gerard F. Anderson, PhD

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MEMBERSHIP ALERT!

Do you know any pediatricians, Fellows of the Academy or not, who appear to have been overlooked by the Society, and are therefore not members? **Contact the Executive Vice President.** There are several kinds of membership in the Society:

Fellow: A Fellow in good standing in the American Academy of Pediatrics - automatic membership on request.

Member: A resident of Florida who restricts his/her practice to pediatrics.

Associate Member: A physician with special interest in the care of children.

Military Associate Member: An active duty member of the Armed Forces stationed in Florida and limiting practice to pediatrics.

Inactive Fellow or Member: Absenting self from Florida for one year or longer.

Emeritus Fellow or Member: Having reached age 70 and having applied for such status.

Affiliate Member: A physician limiting practice to pediatrics and in the Caribbean Basin.

Allied Member: A non-physician professional involved with child health care may apply for allied membership.

Honorary Member: A physician of eminence in pediatrics, or any person who has made distinguished contributions or rendered distinguished service to medicine.

Resident Member: A resident in an approved program of residency.

Medical Student: A student with an interest in child health advocacy.□

Note:

If you are a Fellow of the American Academy of Pediatrics, you are automatically a member of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, and you automatically receive The Florida Pediatrician. If you have not already done so, **please pay your Florida dues**, billed through the Academy Office.□

President

(← continued from page 1)

children but for American society as a whole. I would bet that he would welcome feedback from our membership about that.

As this is being written, the legislators in Tallahassee are in closed-door session determining the allocation and distribution of funds for Florida for the next fiscal year. Many of you may not understand the weight and breadth of effort expended by a few of your peers every year on these issues (which bear directly on your practice, your lifestyle, and possibly your very professional existence, as well as the availability of medical care to all of our kids in Florida).

If that sounds a little heavy, well it should. The support from Florida pediatricians by way of PEDIPAC (as well as FLAMPAC) is pretty dismal. These funds are what fuel the lobbying efforts directed toward obtaining the right and proper results from the legislative and bureaucratic process.

And that, for anyone who pays attention, is NOT a foregone conclusion. The real need is for pediatricians to be active, to cuddle up to their local politicians (OK, OK, not in the Clinton sense, just put a sign on the lawn), to be a voice in the ear of the Tallahassee types, or to speak out on the issues. Or, if you don't have the time or stomach for that, send a few bucks to help out the people who do that for you. The FPS/FCAAP Legislative Committee, some 20+ of the officers and membership, spend an hour or two every Sunday night during the Legislative session dealing with these issues. Our advocacy group, including the Schieblers, John Curran, Paul Wharton, Nancy Moreau, Kaycie Morton, Pete Millett (and various others) spend hours and hours in Tallahassee as well as around the state promoting YOUR issues.

I have had a pediatrician tell me that physicians in his area didn't participate because all this political stuff was "bulls**t" and didn't affect "their issues". That tells me they are excruciatingly ignorant of what goes on in government. Bulls**t it may be, but you better believe it affects pediatric issues. And if you have issues you feel are not being addressed by the process, what is the approach most likely to get results?

For 1.6 hrs CME credit by the Medical College of Diego Garcia:

- 1) Grouse, whine, and complain in the Doctor's Lounge;
- 2) Grouse, whine, and complain to your office manager;
- 3) Write nasty letters to the Managed Care Company (copied, of course, to the Insurance Commissioner and the Attorney General)
- 4) Ask your professional society(ies) to look into the issue and perhaps work toward legislative relief.

BTW, if you choose the latter, please have the courtesy to pay your dues first. And perhaps contribute to the appropriate PAC.

Please mail your answers to the MC of DG, and be sure to enclose a SASE with an international Par Avion stamp.

In addition, the redistricting of the AAP is essentially a done deal. District X will be an entity in June of 1999. District X will

include Florida, Puerto Rico, Georgia, and Alabama. This will result in increased representation at the national AAP level, and will also result in an election. Keep an eye out for ballots, as they may include nominees from your home state.

Hope to see you at the Annual Meeting.

Edward T. Williams III M. D. FAAP
President □

since Vitamin C is not patentable, and frankly, this just seems too simple. ~~Wild speculation might lead one to believe that since the impoverished~~ tend to have higher blood lead levels, this may also be associated with the lack of adequate nutrition, fresh fruits and vegetables, with consequent inadequate vitamin C intake. At least it does stir the pot! □

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Intranet

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from a case being transmitted over an intranet. A series of security layers on a network offers the best protection against intruders (Li, 1996).

Clearly information technologies are here to stay. Information technologies have radically changed the way information is acquired and managed in every sector of society the benefits of technology, strategies must be developed to use it effectively (Fox, 1990). Technology coupled with the influence of ambulatory and managed care is demanding an overhaul of the way medicine is practiced and taught.

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Add a 'pearl' ...from Chuck Weiss - another one

Texas Study Shows That Higher doses of Vitamin C Removes Lead From Blood Stream in the Male Test Group.

In an abstract prepared for the American College of Nutrition, Dr. Earl B. Dawson of the University of Texas Medical Branch at Galveston reported that men who took 1,000 milligrams daily of Vitamin C dramatically lowered lead levels in their blood within one week.

In this study, dietary ascorbic acid, vitamin C, was given to 75 men aged 20 to 35 years. The men were randomly divided into three groups, receiving either 200 milligrams/day, 1000 milligrams or a placebo which had no Vitamin C content. The test lasted one month.

The results were studied weekly. Dr. Dawson and his colleagues found no changes in the placebo test group or in the group receiving only 200 milligrams per day. The group receiving 1,000 milligrams a day saw blood levels of lead drop sharply after only one week of the vitamin supplementation. Their blood lead levels remained low throughout the remainder of the test period.

Dr. Dawson said, "the results of the study would indicate that vitamin C supplementation above 200 milligrams per day results in the rapid and significant loss of blood lead"

Dr. Dawson indicated that the men in the study had no unusual exposure to lead. "It was just a normal part of the environment".

CFW Note: It is necessary to point out that the blood levels for lead were not reported. Undoubtedly, since this is a yet to be presented paper. There are many areas where men are employed in areas working with lead and lead products that have higher than normal lead levels. This would facilitate the validation of these observations. Funding may be difficult

Letters to the Editor

Letters to the Editor are welcomed at any time, and will be published in timely fashion. The Editor reserves the right to edit for space available, without change in content or context. Please send contributions to the Editorial Office.

To The Editor:

As a fellow of the AAP and an Advisory Board Member for the "Daniel Memorial Adoption Information Center", it is my responsibility to inform all Florida Pediatricians about the Center and its functions.

Adoption is a topic of high interest in the State of Florida. Record numbers of pregnant teens and young women are considering their options. While some couples are seeking reputable adoption information, other families would like to give some children, perhaps an older child or a sibling group, a loving home.

The Adoption Information Center was created by the Florida Legislature, and has been functioning out of Jacksonville, Florida since 1994. It works through a partnership with the Florida Department of Children and Families.

The Center's mission is to provide information to the people of Florida to assist in the adoption process. It does not place children for adoption.

Families, agency personnel, members of the general public and professionals can obtain information about the children available for adoption, names of nearby adoption agencies, details about current adoption processes and procedures. In addition, the Center is a valuable resource for those facing an unplanned pregnancy and for adult adoptees and birth relatives in their search. It also offers a wide variety of adoption educational materials and training programs to those that counsel adolescents and other professionals involved in the adoption process.

The center is accessible 24 hours a day through a toll free **h o t l i n e (1 - 8 0 0 - 9 6 A D O P T)**, **E - m a i l (adoptinfo@danielmemorial.org)** and web pages on the Internet (http://www.state.fl.us/cf_web/adopt or <http://danielmemorial.org>).

As children's advocates, we can help in the decision to adopt or to consider adoption as an option. "Help us find homes for the children of Florida."

Janina Abanza-Fiallos, M.D.
Tampa, FL □

Florida Poison Information Network

Created by an act of the Florida Legislature in 1989, the Florida Poison Information Network (FPIN) has rapidly grown into one of the most cost-effective models of poison center systems in the nation. During 1997, the Network achieved significant accomplishments

which have improved the quality of care and access to emergency poisoning services for all Floridians.

The Network saves \$7.00 in health care expenditures for each \$1.00 invested in the poison information system and ranks second only to childhood immunizations in its ability to save health care dollars.

Cost per call to the FPIN \$25.60

Average cost per call to a poison center in the U.S. (1995): \$31.28□

C.A.T.C.H. CORNER

The Catch Network Provides Assistance

You may know your Chapter CATCH Facilitator as your contact in the CATCH network; there are also nine volunteer, board-appointed pediatricians working at the district level to support CATCH activities.

District CATCH Facilitators are responsible for expanding the efforts of the CATCH Program and providing support to the Chapter CATCH Facilitators. District CATCH Facilitators meet four times a year. They last met January 25-26, 1998, in Charleston, SC to review and select the 1997 CATCH Planning Funds Recipients. The next District CATCH Facilitators meeting is scheduled for May 30-31, 1998.

Among the duties of the District CATCH Facilitators:

- Disseminating the CATCH message by expanding communication activities to pediatricians
- Supporting the Chapter CATCH Facilitators
- Promoting and assisting pediatricians' involvement in the CATCH Program
- Providing feedback to CATCH staff on pediatricians' activities and needs.

Our Chapter CATCH Facilitator is Patricia J. Blanco, MD. Reach her at (813)931-1679. If you would like to know your District CATCH Facilitator, contact her, or Carol Pandak at (800) 433-9016 (e-mail: cpandak@aap.org).□

Correspondence

Charles Mahan, M.D., Director
Lawton and Rhea Chiles Center for Healthy Mothers and Babies
13201 Bruce B. Downs Blvd, MDC 56
Tampa, FL 33612-3805

Dear Dr. Mahan:

On behalf of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, I am pleased to inform you that the Executive Committee, at their September 20, 1997 meeting, voted to pledge \$5000 over the next five years to the Lawton and Rhea Chiles Center for Healthy Mothers and Babies. Therefore, it is with great pleasure that I enclose this year's contribution of \$1000. Sincerely,

Edward T. Williams, MD
President

Dr. Edward Williams
Florida Pediatric Society
1132 Lee Avenue
Tallahassee, Florida 32303
Dear Dr. Williams:

I want to take this time to personally thank you for the support of one of our most vital resources...Our children. Your gift is an investment in the future. As we work to reduce infant mortality, improve infant health and enhance the quality of life for our children, it is apparent that the support of organizations such as The Florida Pediatric Society is an integral part of our success.

It is especially important for me to recognize your outstanding contribution to The Chiles Center. You have made the health and well being of Florida's families and children a priority.

We look forward to sharing our success stories with you. Thank you so much for your part in supporting this important enterprise.

Sincerely,

Rhea Chiles□

F. Y. I.

From Florida Healthy Kids Corporation

Florida's Uninsured Children, 1998

% Poverty	Age 0-12	Age 13-18	Total	
<28%	38,749 ^a	18,825 ^a	57,574 ^a	Potential Medicaid
28-100%	169,089 ^a	67,222 ^b	236,311	293,885
101-185%	169,344	73,172	242,516	Potential Child Health
186-200%	9,083	7,737	16,820	259,336
Subtotal	386,265	166,956	553,221	
201% +	183,896	76,350	270,246	
Total	580,161	243,306	823,467	

^a Eligible for current Medicaid program if apply

^b Mandatory phase-in groups for current Medicaid program (enhanced match available for accelerated phase-in)

(Based on estimates from the Rand Corporation)

Florida's Uninsured Children, 1998

Medicaid Eligible	293,885
Title XXI Eligible	259,336
Still Uninsured	270,246

[We still have a long way to go! -Ed.]□

911 Emergency Training Guide

The 911 Emergency Training Guide is now available in both English and Spanish versions. You may obtain a supply by contacting the Chapter office at 1132 Lee Avenue, Tallahassee, FL 32303, or by phone at (850) 224-3939, or E-mail at edielov@ibm.net. The guides were made possible by a grant from the Hansen EMS Foundation and are designed for children and families. They are excellent tools for education in the use and

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

THE FLORIDA PEDIATRICIAN will publish Upcoming Continuing Medical Education Events planned. Please send notices to the Editor as early as possible, in order to accommodate press times in February, May, August, and November.

Program: Meeting of American College of Sports Medicine
Dates: June 3-6, 1998
Place: Orlando, FL
Credit: 36 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: American College of Sports Medicine
Inquiries: American College of Sports Medicine, (317)637-9200

Program: Meeting of American College of Sports Medicine
Dates: June 3-6, 1998
Place: Orlando, FL
Credit: 36 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: American College of Sports Medicine
Inquiries: American College of Sports Medicine, (317)637-9200

Program: "Beyond Limitations" Medical Conference on Down Syndrome, 1998
Dates: June 6, 1998
Place: Jacksonville, FL
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: Down Syndrome Association of Florida and Baptist Medical Center
Inquiries: Laura Watts (904)346-5100, ext. 228

Program: Pediatrics for the Primary Care Physician
Dates: June 26-28, 1998
Place: Amelia Island Plantation, Amelia Island, FL
Credit: 14 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Ms. Jacquelyn A. Nolan (904)390-3638 FAX (904)390-3699

Program: Practical Pediatrics CME Course
Dates: June 26-28, 1998
Place: Sheraton New York Hotel and Towers, New York, N.Y.
Credit: Hour for hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics CME Course Registration (800) 433-9016, ext 6796 or 7657

Program: Cape Cod Conference on Pediatrics
Dates: July 31-August 2, 1998

Dates: June 26-28, 1998
Place: Trade Winds Resort, St. Pete Beach, FL
Credit: 13 Hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine/All Children's Hospital
Inquiries: Conference Administration (813) 892-8834

Credit: 13 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Ms. Jacquelyn A. Nolan (904)390-3638 FAX (904)390-3699



