THE FLORIDA PEDIATRICIAN

The Newsletter of the Florida Pediatric Society/Florida Chapter American Academy of Pediatrics

Volume XIX, Number 4 *November 1996*

THE PRESIDENT'S PAGE

It is fall 1996 and I am leaving the brilliant autumn colors of New England this morning, just a short six weeks before the Holiday Season, a time when we all sense a renewal of family and friends and a reaffirmation of our commitments. May I wish all of you a Happy Thanksgiving and a fulfilling Holiday Season.

The wonders of modern technology allow me to compose (but not transmit to Dr. Pomerance as the plane is not phone equipped) this message on my notebook PC at 35,000 feet on my way back from Boston and one of the finest AAP Annual Meetings that I have ever attended. It has been a time of renewal of enthusiasm in the mission that we all serve: promoting the needs of both children's health and the goals including those very pragmatic of our profession. Over 9000 registrants made this year the largest AAP meeting ever. The variety of educational sessions, the section meetings, and the plenary sessions provided a veritable treasure trove for the sampling. Florida was well represented by our Chapter membership who participated actively in many of the events.

* * * * *

"...constitutional amendment to protect the legal rights of children."

* * * * *

It is difficult to select highlights of the session as one can not due justice to the many aspects of children's health but I will nevertheless provide to you some of my own observations and highlights. A fellow Floridian, Dr. Edward Saltzman of Hollywood, Florida publicly received the Grulee Award for his outstanding contributions as one of the unsung heroes of pediatrics for many years of selfless contribution to the work of the AAP through academy committees and policy statements with regard to practice management and administration. Ed, your colleagues salute you for a career of contribution to our profession. Another Floridian, Dr. Robert Stempfel, our longtime legislative committee chair has been granted a Certificate of Special Achievement by the AAP which will be publicly recognized with presentation in Florida in the near future.

Dr. Robert Hanneman took office as the President of the American Academy of Pediatrics succeeding outgoing President Ed Keenan. In his acceptance speech he outlined two major goals of his tenure. (1.) **The Academy will immediately embark on a renewal and retailoring of the "Children First" initiative that is responsive to the anticipated bipartisan interest in the elimination of gaps in assuring the access and provision of care to all children**. The program will most likely be entitled "Health Care for All Children" and will complement the Academy initiative of a model bill for Medicaid implementation at the state level and policy guidance for the assurance of continuation of children's programs under potential Medicaid "block grants" and the recently enacted welfare reform. (2.) **Initiation of a process, which will take several years, to secure a constitutional amendment to protect the legal rights of children.** This initiative was enthusiastically endorsed at the Chapter Chair's Forum in September following an impressive presentation by a Connecticut judge who effectively articulated the issues of our legal system. where children are often treated as "chattels" rather than our national treasure to be given the inalienable

(continued on page 15)

COMMITTEE CHAIRMEN

Adolescence
Dianne S. Elfenbein, M.D.
Tampa, FL
Bioethics
Donald V. Eitzman, M.D.
Gainesville, FL
Child Abuse and Neglect
Jay Whitworth, M.D.
Jacksonville, FL
Child Health Financing and Pediatric Practice
Edward N. Zissman, M.D.
Altamonte Springs, FL
Childhood Disabilities
Stanley N. Graven, M.D.
Tampa, FL
Collaborative Research
Lorne Katz, M.D.
Coral Springs, FL
Public Relations/Information/Communications
Herbert H. Pomerance, M.D.
Tampa, FL
Education and Training Programs
TBA

Environmental Health, Drugs, and Toxicology
Charles F. Weiss, M.D.
Siesta Key, FL
Fetus and Newborn
Lance E. Wyble, M.D.
Tampa, FL
Genetics
Jaime L. Frías, M.D.
Tampa, FL
Home Health Care
F. Lane France, M.D.
Tampa, FL
Infectious Diseases
Gwendolyn B. Scott, M.D.
Miami, FL
Lay Child Advocate Groups and Legal Needs of Children
Audrey L. Schiebler
Gainesville, FL
Legislation and Government Affairs
John S. Curran, M.D. (Acting)
Tampa, FL
Membership
TBA

Multicultural Pediatrics and International Health
Ramon Rodriguez-Torres, M.D.
Miami, FL
Nutrition Committee
TBA

Pediatric Critical Care and Emergency Services
Deborah Mulligan-Smith, M.D. (Co-Chair)
Ft. Lauderdale, FL
Albert Saltiel, M.D. (Co-Chair)
St. Petersburg, FL
School Health/Sports Medicine
David A. Cimino, M.D.
St. Petersburg, FL
Scientific Meetings
Douglas J. Short, M.D.
Orlando, FL

Council of Past Presidents
George A. Dell, M.D.
Robert Threlkel, M.D.
Ken Morse, M.D.
David A. Cimino, M.D.
Robert Colyer, M.D.

Council of Pediatric Specialty Societies
Salvatore R. Goodwin, M.D.
(Pediatric Critical Care)
Augustin Ramos, M.D.
(Pediatric Cardiology)
Richard Signer, M.D.
(Pediatric Surgery)
Gaston Zilleruelo, M.D.
(Pediatric Nephrology)
Dianne S. Elfenbein, M.D.
(Adolescence)
Lance Wyble, M.D.
(Neonatal-Perinatal)

THE EDITORIAL PAGE

Another Year We Can Be Proud Of

Another year is rapidly coming to a close, and once again we must re-assess ourselves and our accomplishments. We can do this in two ways: individually and as a society.

Only the individual can measure his own successes in 1996. Did you do anything special for "Child Health Month"? If so, we would like very much to hear about your accomplishments, and we will display this in our next issue. Did you practice medicine according to the standards we all learned in our training and are proud of as Fellows of the Academy? Have you kept up with advances in pediatrics over the year, through readings and through CME programs, (including, hopefully, attendance at our excellent annual meeting!) Have you maintained the dignity we all deserve despite the changes wrought by managed care? Have you resisted the trend to customers rather than patients?

All these - and the many more which you can add to the list by yourselves - are the hallmarks of those things of which we can be individually proud.

"hallmarks of those things of which we can be proud"

We are judged also by our combined effort as a society. Can we be proud of the year? Indeed we can!

The Chapter continues to grow, as new young people enter practice and as others retire or semi-retire to Florida. Both groups have much to offer to the practice of pediatrics and to the Chapter. This growth has increased our numbers enough to upset the very balance of our District and of the Academy. This year, we have made this concern known. On the other hand, this growth, and a new system for dues collection have made us fiscally much more sound.

We now have a full complement of Alternate Regional Representatives. Our Regional Representatives and Alternate Regional Representatives play a very important rôle in our organization. The Regional Representatives are listed on Page 1, the alternates later in this issue.

With this issue, we take another step into the era of modern technology. We initiate a select e-mail directory, which will include our officers, the Executive Committee, and other key people in the operation of the Chapter. We apologize for not including everyone, but there are space limitations. Others will be included in our membership directory, and we suspect the list will become larger and larger over the next year or so.

"a select e-mail directory"

What about the future? We can look forward to another banner year of progress for our Chapter. More and more involvement by the membership at large will improve our image in the community. This should never become a "good-old-boy" society (and I know all of your have experienced this!), and it will not so long as everybody plays a part.

And this publication will improve as well, as more and more members contribute to it. Last year we had an excellent "Emphasis on Adolescence" series. This year we have had an outstanding "Emphasis on Violence Against Children" series. For next year, we are planning to match these with "Emphasis on Children's Rights".

Meanwhile, best wishes from the Editorial Staff to all of our members.

-The Editor

THE "GRASS ROOTS"

THE REGIONAL REPRESENTATIVES REPORT

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

Region III reports:

On Thursday, September 26th, the Florida Pediatric Society/ Florida Chapter of the Americal Academy of Pediatrics in Region III co-sponsored a Bike Rodeo with Shands Children's Hospital and the Alachua County Safe Kids Coalition. This Bike Rodeo was held at the Idylwild Elementary School. Approximately 120 third graders attended. The event focused on bike safety and included the distribution of free bike helmets to all students. As part of this activity, Representative Bob Casey received an award from the Florida Pediatric Society/FCAAP for his efforts in passing the Bike Helmet Law and his support of other child health initiatives, including early discharge and zero alcohol tolerance for minors who are driving. Both the rodeo and the award to Representative Casey are considered to be highly successful activities of the Region.

Richard L. Bucciarelli, M.D.
Regional Representative, Region III

E-mail

(A directory of Officers, Executive Committee, and Committee Chairmen)

Abrunzo, Thomas, M.D.	tabzo@aol.com
Barrett, Douglas J., M.D.	barrett.peds@mail.health.ufl.edu
Bartlett, John, M.D.	jbartlett@mem.po.com
Bucciarelli, Richard, M.D.	rick.peds@mail.health.ufl.edu
Cimino, David A., M.D.	ciminod@allkids.org
Curran, John S., M.D.	jcurran@com1.med.usf.edu
DeNicola, Lucien, M.D.	lnpg09@prodigy.com
Eanett, Robert, M.D.	reanett@mem.pop.com
Eitzman, Donald, M.D.	eitzman.peds@mail.health.ufl.edu
Frías, Jaime, M.D.	jfrias@com1.med.usf.edu
Friedman, Lawrence, M.D.	lfriedma@mednet.med.miami.edu
Griffis, Susan, M.D.	susgrif@mem.po.com
Howell, R. Rodney, M.D.	rhowell@mednet.med.miami.edu
Jones, David, M.D.	chpjones@mem.po.com
Katz, Lorne, M.D.	lokatz@mem.po.com
Marcus, David, M.D.	dmarcusparkland@mem.po.com
Mignerey, Thomas, M.D.	tmignerey@mem.po.com
Mulligan-Smith, Debbie, M.D.	debmsm@aol.com
Patterson, Todd, D.O.	toddp@tally.gulfnet.com
Pomerance, Herbert, M.D.	hpomeran@com1.med.usf.edu
Rubin, Jonathan, M.D.	jonathanrubin@worldnet.att.net
Schiebler, Audrey	audrey_schiebler@qm.server.ufl.edu
Schiebler, Gerald, M.D.	oag.vpha@mail.health.ufl.edu
Scott, Gwen, M.D.	gwen@pedaids.med.miami.edu
Short, Douglas, M.D.	shortdoc@aol.com
St. Petery, Louis, M.D.	peter07001@medone.org
Weiss, Charles, M.D.	cfweiss@mem.po.com
Whitworth, Jay, Mm.D.	cptboss@aol.com
Williams, E.T., M.D.	tampedi@aol.com
Wyble, Lance, M.D.	lwyble@com1.med.usf.edu
Zissman, Edward, M.D.	ziss101@aol.com

Other Important Numbers:

Edwards, Steve, M.D.(Dist. Ch)	sedwards@aap.org
Freedman, Steve, PhD.	stevefreedman@qm.server.uf.com
Lovingood, Edie	fpsfcaap@medone.org
Moreau, Nancy (Legis. liaison)	moreau1@aol.com
Riehl, Cathy (Dr. Curran's Sec)	criehl@com1.med.usf.edu

[This directory will be updated in each issue of *The Florida Pediatrician.* For e-mail addresses of the membership of the Florida Chapter/AAP, the reader is directed to the published Directory of Membership.

Region VII reports:

For the first time, Broward County pediatricians and their spouses gathered together under the auspices of the Florida Pediatric Society to honor five local legislators for their devotion to the children of Florida. On October 24, 1996, hopefully the early beginnings of a Broward County Society of the American Academy of Pediatrics met at Brooks Restaurant and were joined by Representative Mandy Dawson White, Senator Howard Foreman and administrative aides from the offices of Dr. Ben Graber and Representative Debbie Sanderson.

The evening's program was highlighted by a presentation by Ted Fisher, a Tallahassee lobbyist and V.P. for Health Care Capitol Strategies. He spoke on the current status of Medicaid and Medipass in Florida, and both he and the legislators fielded questions from the audience.

On November 14, 1996, the Palm Beach Pediatric Society will be holding its Fall Meeting at the Sheraton Hotel in West Palm Beach. The Speaker for the evening will be Dr. James Howell and there will also be a health fair with displays for services available for the children of Palm Beach County. Senator Doc Myers and Representative Lois Frankel will be honored that evening. We look forward to continued support and participation from our community pediatricians as we work together for the improvement of care for Florida's childlren.

Congratulations go to Dr. Jonathan Rubin, who was recently elected as the Alternate Regional Representative for Region VII. I look forward to working with him in the future.

David Marcus, M.D.
Regional Representative, Region VII

Congratulations

...to Edith J. Gibson-Lovingood, who recently assumed the position of Administrative Assistant to the Executive Vice President. Ms. Lovingood is a native of Pensacola and graduated from the University of West Florida in 1973. Moving to Tallahassee, she worked with the Seminole Boosters and Barnett Bank in administrative positions, then with Tallahassee Community Hospital in physician credentialling. Later, she was employed by Healthplan Southeast as Director of Provider Services. Retirement came next, and the feeling of being "brain-dead", as she puts it! Hence this position, for which she seems eminently qualified, and in which she will relieve some of the pressure from our President and our Executive Vice President. We all look forward to a long and fruitful association.

EDITORIAL OFFICE

Editor:
Herbert H. Pomerance, M.D.
Department of Pediatrics

Tampa, FL 33612
(Ph)813/272-2710
(Fax)813/272-2749
e-mail: hpomeran@com1.med.usf.edu
(Please address all correspondence, including *Letters to the Editor*, to this address)

COMMITTEE REPORTS

Edward N. Zissman, M.D., Chairman
Altmonte Springs, FL

RBRVS: What is it and how does it affect pediatrics

The Health Care Financing Administration (HCFA) implemented the Resource-Based Relative Value Scale (RBRVS) physician fee schedule on January 1, 1992. The Medicare RBRVS physician fee schedule replaced the Medicare physician payment system of "customary prevailing and reasonable" (CPR) charges under which physicians were reimbursed according to the historical record of the charge for the provision of each service. The current Medicare RBRVS physician fee schedule is derived from the "relative value" of services provided. The relative value of each physician service is quantifiable and is based on the concept that there are three components of each service: 1) the amount of physician work that goes into the service, 2) the practice expense associated with the service, and 3) the professional liability expense for the provision of the service. The relative value of each service is multiplied by a geographic adjustment factor for each Medicare locality (fee schedule area) and then translated into a dollar amount by an annually adjusted conversion factor.

The dollar amount derived from this calculation, with adjustments under certain circumstances, is the reimbursement a physician receives for the provision of a particular service. It is critical to note that many payers, including almost 40% of state Medicaid programs, have adopted components of the Medicare RBRVS to reimburse physicians, while other payers are exploring its implementation.

Elements of the RBRVS

Physician work involved in providing the service

The physician work component of the Medicare RBRVS physician fee schedule is maintained and updated by the HCFA with input from the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 26 members, consisting of 22 representatives from major medical specialty societies, and representatives from the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. The American Academy of Pediatrics holds one of the permanent 22 seats designated for medical specialty society representation. The HCFA reviews and, if necessary, modifies the RUC-recommended relative value units of physician work, and establishes payment policy, which is published in the *Federal Register*.

The physician work component (relative value units of phvsician work or RVUs) represents approximately 54% of the RVUs for each service. Physician work is divided into pre-service, intra-service, and post-service periods that equal the total value of work for each service. The total value of physician work contained in the Medicare RBRVS physician fee schedule for each service consists of the following components:

- Physician time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment, and
- Psychological stress associated with physician's concern about the iatrogenic risk to the patient.

Practice Expense

Currently practice expense estimates amount to approximately 41% of the physician fee schedule payments. This value is estimated by the HCFA based on historical allowed charge data. A practice expense study sponsored by the HCFA is expected to be completed by 1997, with implementation of the study's resource-based practice expense RVUs beginning on January 1, 1998.

Professional Liability Insurance (PLI)

Malpractice expense relative.values are currently based on cost estimates established by the HCFA account for approximately 5% of the physician fee schedule payment. The approach used by the HCFA to determine PLI relies heavily on data from a national surveyof physicians' average practice costs and the average Medicare payment for a specific service.

Geographic Practice Cost Index (GPCI)

The Geographic Practice Cost indices (GPCIs) reflect the relative costs associated with physician work, practice, and malpractice expenses in a Medicare locality compared to the national average relative costs.

- Cost of living GPCI - applied to physician work relative values
- Practice cost GPCI - applied to practice expense relative values
- Malpractice GPCI - applied to professional liability expense relative values

Conversion Factor (CF)

The Conversion Factor is a national value that converts the total RVUs into payment amounts for the purpose of reimbursing physicians for services provided. For Medicare purposes, the HCFA publishes a separate CF annually for surgical services, non surgical services, primary care services, and anesthesia services. However, anesthesia services are reimbursed under a different relative value system. The annual update to the CFs are adjusted to reflect the successful or unsuccessful adherence to the Medicare Volume Performance Standard (MVPS), a rate of increase established to help control the rate of growth in expenditures for physician services.

1996 Conversion Factors

- Surgical Services $40.7986
- Non surgical Services $34.6293
- Primary Care Services $35.4173
- Anesthesia Services $15.2800

Additional components of the Medicare RBRVS physician fee schedule factored into reimbursement structure include the following:

- Incentive payments for physician services provided to patients in Health Professional Shortage Areas (HPSAs), which are medically underserved communities, urban and rural locations that have a documented shortage of medical professionals.
- Reduced payments for physicians, called "non-participating" physicians, who do not accept "assignment," the Medicare approved amount that consists of the 80% Medicare payment and the 20% patient copayment, as payment in full for services rendered to Medicare recipients.
- Statutory guidelines indicating that revisions to the RVUs for physician services may not alter physician expenditures within the Medicare RBRVS physician fee schedule by more than $20 million from the principal expenditures that would have resulted if the RVU adjustments were never initiated. Starting with the final rule published in the *Federal Register on* December 8, 1995, budget-neutrality adjustments will be applied annually to the physician fee schedule conversion factors.

HOW TO USE THE RBRVS

The HCFA publishes RVUs for CPT codes in the *Federal Register*. To calculate the Medicare physician reimbursement for a service, the relative value units for each of the three components of the Medicare RBRVS physician fee schedule are multiplied by their corresponding GPCIs to account for geographic differences in resource costs. The sum of these calculations is then multiplied by a dollar conversion factor. When determining payment, it is important to take into consideration all the mechanisms within the Medicare RBRVS physician fee schedule incorporated in the final reimbursement for physician services. Please note that third-party payers other than Medicare may not use all of the elements of the RBRVS to determine physician reimbursement. For example, they may use their own CF or not factor in the GPCIs.

Concluding Remarks

In today's rapidly changing health care environment, it is crucial to understand the Medicare RBRVS physician fee schedule. Many third-party payers, including state Medicaid programs, Blue Cross-Blue Shield agencies, and managed care organizations are utilizing variations of the

(continued on page 15)

REPORT FROM THE 1996 REGULAR LEGISLATIVE SESSION

(This column continues the report by our legislative liaison from the August issue. Many issues are quite important to us)

CS/HS 1239 - HMO DIABETES COVERAGE (CH. 96-279)

Coverage by HMOs and prepaid health plans is mandated for all medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services certified by the patient's attending physician.

Effective Date: May 29, 1996.

CS/HB 1105 - INFANT METABOLIC TESTING (CH. 96-306)

This legislation establishes a fee of $20 per live birth to be assessed of hospitals and birth centers for infant metabolic screening. Such fee is capped at 3,000 births for hospitals and birth centers will be charged for births over 60 per year.

Effective Date: July 1, 1996.

CS/HB 2135 - TEENAGE DRIVER RESTRICTIONS (CH. 96-414)

Sixteen and seventeen year olds must hold a learner's driver's license for at least 6 months prior to applying for a driver's license. A person who holds a driver's license and is under the age of 17 years may not operate a vehicle unless accompanied by a licensed driver who is at least 21 years of age between the hours of 11 PM and 6 AM, unless that person is driving to or from work. Additionally, a person who is 17 years of age is likewise restricted from driving between the hours of 1 AM and 5 AM. A person holding a learner's license must be accompanied by a licensed driver 21 years of age or older and is prohibited from driving between the hours of 7 PM to 6 AM.

Effective Date: July 1, 1996.

SB 322 - SMOKING / SCHOOL PROPERTY (CH. 96-217)

This legislation makes it unlawful for any person under 18 years of age to smoke tobacco in, on, or within 1,000 feet of the real property of a public or private elementary, middle, or high school between the hours of 6 AM and midnight. This restriction does not apply to persons within a moving vehicle or within a private residence. Citations may be issued by law enforcement officers with penalties not to exceed $25, 50 hours of community service, or the completion of a school approved anti-tobacco "alternative to suspension" program.

Effective Date: July 1, 1996.

CS/SB 336 - BOATING SAFETY (CH. 96-187)

This legislation addresses several issues relating to boating safety. Until the year 2001, a person born after September 30, 1980, and on or after October 1, 2001, a person 21 years of age or younger may not operate a vessel powered by a motor of 10 horsepower or greater unless such person has completed a boater safety course and obtained a vessel photographic identification card and a boater safety identification card.

Effective Date: October 1, 1996.

CS/SB 200 - CHILD ABUSE / IMPREGNATION OF MINORS (CH. 96-215)

SB 200 amends the child abuse statute to make it a reportable offense for a person 21 years of age or older to impregnate a minor under 16 years of age. Such reports are to be immediately reported to the county sheriff's office or other appropriate law enforcement agency. Health care professionals are exempt from reporting requirements if such reporting would interfere with the provision of medical services. Neither the victim's lack of chastity nor the victim's consent is a defense to this crime.

The Legislature intends to ensure that paternity is determined for a dependent child whose mother was impregnated while under 16 years of age. Such mother will be required to identify the father of the child and cooperate in testing in order to be eligible for public assistance. When information obtained indicates that the father was 21 years of age or older at the time of conception, the Department of Revenue or the Department of HRS will advise the applicant or recipient of public assistance that she is required to cooperate with law enforcement officials in the prosecution of the alleged father Any person who knowingly provides false information regarding the paternity of a child in conjunction with an application for, or the receipt of public assistance commits a misdemeanor of the second degree. Access to birth certificates is granted to law enforcement agencies for the purpose of facilitating the prosecution of offenses.

Effective Date: October 1, 1996.

CS/HBs 543 7& 1317 UNLAWFUL SEXUAL ACTIVITY WITH MINORS (CH. 96-409)

This legislation states that a person 24 years of age or older who engages in sexual activity with a person 16 or 17 years of age commits a felony of the second degree. "Sexual activity" is defined and prior sexual conduct of the victim is not to be a relevant issue in prosecution. If conduct of the offender results in the victim giving birth to a child, paternity is required to be established and if the offender is determined to be the father child support will be required. Such establishment of paternity will be admissible in criminal prosecution. A convicted offender will be required to make restitution to the victim for medical, psychiatric and psychological care necessitated by the offense as a condition of probation or community control.

Effective Date: October 1, 1996.

CS/HB 347 - CHILD ABUSE / CHILD WELFARE (CH. 96-402)

Corporal punishment of a childd by a parent or guardian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child as defined within this legislation is included within the definition of "abuse". Factors which must be considered when determining whether an injury is abuse include: the child's age; prior history of injury; location of the injury on the body; the multiplicity of the injury; and, the type of trauma inflicted. Corporal punishment is to be considered abuse when it meets certain thresholds. Also specifically defined are "neglect" and "abandonment".

Effective Date: October 1, 1996, unless otherwise provided.

CS/HB 1035 - CONFIDENTIALITY / ANTITRUST (CH. 96-313)

Information which is submitted by a member of the health care community pursuant to a request for an antitrust no-action letter is deemed confidential and exempt from public records law for 1 year after the date of submission.

Effective Date: October 1, 1996.

CS/SB's 14, 30, 516, & 596 - SMALL EMPLOYER INSURANCE CONTINUATION (CH. 96-319)

Employees and their dependents of small businesses which provide group health insurance coverage are eligible to continue such group coverage at their own expense should they be disqualified from coverage due to unemployment, a cut back in hours, divorce, or other designated circumstances. Such continuation is allowable for 18 months or until they are covered by another health insurance plan. The premium for continuation coverage is limited to 115% of the applicable group premium.

Effective Date: January 1, 1997.

CS/HB 109 - HMO & HEALTH INSURANCE COVERAGE / DISCRIMINATION (CH. 96-361)

No health insurance policy or HMO contract which provides

(continued on page 16)

MEDIPASS ISSUES

Louis B. St. Petery, Jr., M.D.
Executive Vice President, FCAAP
Tallahassee, Florida

In this report, I would like to recount some of the difficulties which have been experienced by members of the Tallahassee Pediatric Foundation in dealing with the Medipass HMO. Many of these issues are also experienced by others, on a state-wide basis.

I. Statewide Issues

A. Large numbers of patients are being reassigned from one provider to another, regardless of/in spite of patient choice.

1. Patients who lose eligibility and then regain it within 90 days are supposed to be put back on with the same provider. For last 6+ months, they are instead being reassigned randomly, using Zip codes. (We have lots of patients who are signed up and have been seeing a physician, and do not request a change, but receive a letter notifying them that they have been changed, and when you run their Medicaid card in the reader they are indeed reassigned.) This is a Unisys computer issue and is statewide. Somehow, the computer program which keeps them on with the same provider has gotten changed. People from Bob Sharpe's office say they are "working on it". We discussed with Mr. Sharpe in March of 1996, and at meeting last week it was still not solved. Creates great havoc, and no end is in sight.

2. Any time Economic Services changes the type of Medicaid eligibility, the Medipass provider must be reentered by Medipass, or the case is randomly assigned by Unisys (using Zip codes). The type of eligibility can technically change several times during a month. Because the process involves canceling of the case by the Economic Services worker under one type of eligibility, and then reopening it under another, and because the computer does not honor the 90 day reassignment to the same provider, the patient is likely to be reassigned to another physician, even though the patient did not request that reassignment. The patient then shows up at the office of the usual physician, but has been reassigned, and now an authorization number must be obtained, etc. We are fortunate that we have a primary care program to take up the slack and help physicians. I imagine in areas where there is no primary care program patients really get bounced around a lot, and physicians frequently don't get paid.

B. Patients whose Medicaid eligibility file shows an impending cancellation date can not be put on Medipass. In most circumstances, the cancellation date is changed before it comes to pass (i.e., the mom fills out the paperwork to "re-up" the child ahead of the deadline). The main problem is with the child who comes for enrollment on July 1, needing care, and the Medicaid eligibility file shows an impending cancellation date of July 31. Medipass won't put them on. This is even more complicated in the case of the newborn. Newborns are, in most circumstances, eligible for 1 year, but it is common for Economic Services to put them on for only 2 months (we think this is a training issue for ES workers). When we then try to get a newborn on Medipass, they refuse, because the computer shows an impending cancellation date of 2 months hence. It does not matter that we will get the mother back to reapply before that deadline comes to pass. This means that our CMS primary care program must spend GR to get this kid care, even though he is eligible for Medicaid, and GR is an endangered species. Obviously,

the fact that Economic Services (the eligibility determination arm) is in

HRS and Medipass (the payment arm) is in AHCA makes this an especially difficult problem to solve.

II. Local Issues (probably statewide, but I have no direct proof).

A. Sabotage has caused a large number of the Tallahassee Primary Care patients to be reassigned to other providers.

1. A disgruntled employee is said to have randomly changed the Medicaid provider number in the computer (the suffix was changed from 00 to 02). This caused them to be automatically and randomly reassigned by Zip, since the 90 day / same provider item is not working. We are told that this employee has been reassigned elsewhere.

2. When multiple family members are listed on one form letter for assignment to a given physician, frequently all but one are assigned, and one is not. I don't know if this is incompetence or sabotage.

3. Recently, a stack of 48 forms with multiple family members for assignment was submitted (hand carried), but none was entered. These were handled by a single employee, and the failure to enter these patients is thought to be possibly another act of sabotage. Now we are told to "work around" this employee, by using a different telephone number, and by only giving materials to specific other staff members.

B. Forced Payment of Claims not working.

1. Several Medipass providers to whom Tallahassee Primary Care patients have been randomly reassigned routinely refuse to give authorization for the patient's chosen provider to see them (while we are waiting for them to be properly assigned). The local Medipass office has suggested sending them the claims, stating that they would force-pay. When we submitted, they rejected many for various bureaucratic reasons (we didn't notify them that the forms were coming, etc.).

C. Uncompensated work.

1. Because of all of this reassignment, the physicians who are seeing the patients are not getting the $3 case management fee - it goes to the physician chosen by the computer, not by the patient.

2. The Tallahassee Pediatric Foundation has had to hire extra help just to keep up with all of this, yet none of these positions are budgeted.

[The Tallahassee Pediatric Foundation is a not-for-profit corporation chartered by the Tallahassee pediatricians as a vehicle to contract with the state (CMS) to provide primary care to indigent (mostly Medicaid) patients through private offices. There are currently over 8000 patients enrolled. The Fooundationserves as a group provider to bill Medicaid and interface with Medipass for the pediatricians of Tallahassee.]

Note:

Visit our summary of *TheFlorida Pediatrician* in Physicians On Line. If you subscribe, look in the AAP folder under Chapters. If you do not belong, JOIN! Physicians On Line is free to all licensed physicians.

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?

Please send an update to the Executive office to assure receiving mailings. Thanks!

A Practice Guideline for Early Neonatal Sepsis

Alastair A. Hutchison, MBChB, FRACP
Professor of Pediatrics, University of Florida

Lance E. Wyble, MD
Associate Professor of Pediatrics, University of South Florida

In May 1996 the CDC published recommendations aimed at the prevention of Group B Streptococcal (GBS) disease in newborns[1]. This considerable work included input from experts in Infectious Disease and specifically inputs from the Anerican College of Obstetrics and Gynecology and the Anierican Academv of Pediatrics. Two approaches - universal maternal GBS screening at 35-37 weeks or identification of risk factors for neonatal sepsis - were adopted for evaluation and treatment of mothers with or at risk of having GBS[1]. Intrapartum antimicrobial prophylaxis (IAP) was recommended for mothers with GBS or risk factors associated with a higher risk of maternal GBS which result in neonatal infection, but a great deal of concern was presented in the early discussions regarding infants whose mothers receive IAP. The final recommendations provided an algorithm for empiric management of newborns born to a mother who has received IAP, but it is presented as "one possible algorithm" with suggestion that "other management approaches" developed by physicians may represent appropriate alternatives.

In July 1996, the State of Florida Agency for Health Care Administration (AHCA) circulated the CDC report to all Florida licensed maternal and newborn care professionals. The CDC article was accompanied by a letter which indicated that a Work Group convened by AHCA had been working on this issue for almost two years. These pioneer efforts had been recognized bv the CDC, who had invited members of the Florida AH CA Work Group to a March 1995 conference designed to provide a Consensus Approach to GBS. Part of the effort in Florida was directed by a Sub-Conunittee of the Florida Society of Neonatologists (FSN) and consisted of the development of a Practice Guideline for Early Neonatal Sepsis which included an algorithm which was circulated with the ACHA letter (Figure 1). The development of the guideline consisted of a review of the published information, the circulation of draft versions and modifications after input from academic and private neonatologists in the State of Florida. In addition, prior to dissemination, the guideline was sent to experts and academic bodies throughout the countrv with a request for their review and input.

The following will stress only the key points in the Florida Practice Guideline for Early Neonatal Sepsis. The full guideline will be released by the end of this year.

1. The Neonate with Signs Compatible With Sepsis.

The most important feature is the identification of whether or not the neonate has **signs** which are compatible with sepsis. In this situation, clinical judgment is required in deciding the degree of evaluation and whether or not to start therapy. In general, if sepsis cannot be ruled out a full work-up including a lumbar puncture (if the neonate is stable) is recommended and therapy is initiated. Neonates with clinical signs compatible with sepsis have died when antibiotic therapy was not started because reliance was placed on a normal white cell count[2,3]. **Thus, in the presence of signs compatible with sepsis, especially if evident soon after birth, the decision to start therapy, should not be guided by the white cell count.** If the physician decides on clinical grounds that the patient is not septic and the signs do not warrant investigation and therapy, this is documented in the medical record.

2. The Asymptomatic Neonate at Risk of Sepsis.

Key epidemiologic work and then randomized clinical controlled trials in the 1980s demonstrated that prevention of neonatal GBS, if possible, is dependent upon a prenatal strategy[4,5]. This strategy, consists of identification if the mother a)is a GBS carrier or b)has risk factors which are associated with an increased incidence of neonatal GBS disease. If either a) or b) pertains, then the mother is given IAP and the risks of colonization and sepsis of the neonate are ssignificantly reduced but not eliminated. It should be noted that the only controlled trial to show a significant reduction in neonatal sepsis, as opposed to bacteremia, involved not only maternal intrapartum therapy but also therapy every twelve hours to the neonate until cultures proved negative.[5,6]

After birth, the approach to the evaluation and therapy of the asymp-

tomatic neonate varies according to degree of risk, and consists of observation alone, limited laboratory evaluation and then observation, or more extensive laboratory evaluation and therapy. The decision also involves considerations of staff availability to care for the babies in the nursery and their experience in recognizing and treating neonatal sepsis. The purpose is to emphasize that clinical judgment should always play a major role in decision making.

Asymptomatic neonates at-risk for sepsis can be divided into three groups:

- Group 1: neonates at high risk for sepsis in which evaluation and therapy is recommended[7,8]: the neonate <34 weeks or the sibliiig of a neonate who had GBS sepsis this pregnancy (i.e., a twin or other multiple sib with current GBS sepsis).
- Group 2: neonates whosemothers have identified risk factors (or who have received IAP), in which the evaluation and therapy will be determined by the specific risk of sepsis according to the number and type of risk factor/factors and the adequacy of matemal I.AP (adequate therapy is defined as therapy > 4 hours prior to delivery[9]), and
- Group 3: neonates with no identified risk factors, for whom observation is appropriate. This group may include neonates whose matenial GBS status was not evaluated.

The FSN guideline recognizes the valid differences of opinion for management but recommends that asymptomatic at-risk neonates receive at least a minimal laboratory evaluation and follow-up. A normal CBC with differential at 6-12 hours is highly specific for health in the asymptomatic baby.[10] Discharge of asymptomatic at-risk neonates is not advised for at least 48 hours. Phvsicians adopting an observation protocol should consider should consider staffing numbers and experience as part of the equation. The family is informed of the plans and the management strategy is documented in the medical record.

Therapy and Discharge of the Asymptomatic At-Risk Neonate.

Opinion about the extent of investigation and when to commence therapy varies among physiciaiis and there are no clinical controlled trials to provide an unbiased answer.

With or without maternal IAP, if asymptomatic at-risk babies remain clinically well and after two to three days their blood culture report is negative and their CBCs and differentialss, are normal, then it is appropriate to stop antibiotics and discharge the babies on the same day.[11] For the treated asymptomatic neonate with a positive blood culture, experience in some institutions and private practices has led to the provision of a shorter duration of antibiotic therapy than the usually recommended 10-14 days.[12] No clinical controlled trial exists to guide the practitioner. The guideline has adhered to 10- 14 davs of therapy.

Conclusions

Today medical care teams face pressures to discharge mothers and neonates rapidly. However. in uncertain circumstances, medical wisdom dictates that we err on the safe side. Nowhere is this more true than in the case of the asymptomatic newborn babv at-risk of sepsis. Regardless of the chosen management strategy, it is recommended that asymptomatic babies at risk of sepsis should not be discharged <48 hours postnatally. It is important that the medical care team educate both the patient caregivers and medical managers that, in the case of early neonatal sepsis, the current prenatal management strategies aimed at prevention are not foolproof and that the evidence to support the current postnatal management approaches is largely of the opinion varietv. Clinical judgment remains the mainstay of our neonatal approach. The development of practice guidelines will assist us in defining and refining the basis of our therapy. However. it is advised that the guidelines be viewed as such and not be etched in any legal stone. To be useful tools in medical care, practice guidelines should be flexible, be updated as rapidly as new potentially life-saving *(continued on page 18)*

EMPHASIS ON VIOLENCE AGAINST CHILDREN

Emphasis on violence against children concludes with this issue with thanks to the contributors

Children Witnessing Violence: A Mandate For Pediatrician Understanding and Advocacy

Thomas J. Abrunzo, M.D.
Tampa, FL

"The quantity and quality of violence that we live with is a national disgrace"
Groves, Zuckerman and Marans[1]
"The United States is the most violent developed country in the world"
Osofsky [2]
"Family violence is an epidemic in America. And so America's doctors, who are on the front lines in dealing with the consequences of violence, must now be on the front lines in recognizing, treating and preventing it."
Antonia C. Novello, M.D.[3]

The Problem

We have all made the painful journey from ignorance and disbelief to recognition and understanding the direct violence of child abuse. The rewards and satisfactions of sleuthing the diagnosis and protecting the child fade quickly with the realization that we as a society have missed the opportunity to prevent a devastating medical and social disease. The scientific search for causes of intra-familial violence has led to the not-unexpected conclusion that simply witnessing violence is a major risk factor for both primary psychopathology in the child as witness and secondary perpetration of further violence by the witness-victim.

The Effects

The psychology literature is replete with reports of the negative impact of witnessing violence on a child's development, including school function, emotional stability, and orientation to the future.[4,5,6] The exposed child is thereby poised to act out with violence of his or her own. There appear to be differential effects of witnessing violence in the home vs out-of-home (e.g., school) vs through the media (e.g., television). The severity of a child's reaction to exposure to violence is thought to be related to the proximity of the violent event, the victim's and perpetrator's relationship to the child, and the presence of a parent or caretaker to mediate the intensity of the event. Early childhood is a time of complete dependence on parents for stability, control and protection. Safety and stability disappear when caretakers suddenly become out-of-control victims and perpetrators. The response of the child to this disorder is often like that of the emotionally traumatized warrior: the post-traumatic stress syndrome (Table I).

Table I: Post-traumatic Stress Disorder in Children
Re-experiencing the trauma in dreams, nightmares and fantasies
Talking over and over about the trauma
Fear that it will happen again
Compulsive re-enactments of the event
Increased aggression against self and others
Pessimism abaout the future
Withdrawal from friends
Feeling of numbness and denial
Feeling of high agitation
Unpredictable shifts from very agitated to numbness
Sense of helplessness

In a setting where violence may be otherwise unexpected, the clinician's sensitivity to the above constellation may be the only opportunity for discovery, disclosure, and treatment.

The Pediatrician's Response

Our approach to this problem must be on three levels. The first concerns direct patient care. We must focus on the witnessing of violence as part of our anticipatory guidance screening. Parents should be questioned in routine visits about their child's exposure to violence. Groves et al[1] suggest prefacing the inquiry by stating that he or she is concerned about the level of violence in our society and its impact on children, that he or she has begun to ask all patients and parents about the existence of violence in their lives. They state that such an approach normalizes the inquiry for parents. By asking whether parents worry

about violence in the life of their child, the physician communicates to parents that violence has an impact on children of all ages, and therefore an appropriate topic in a health visit. For older children, the subject can be broached by asking if the child worries about violence, if he/she has seen violent activities, and how does he/she feel about such observations. Specific questions about guns, knives, or fighting may help sour otherwise unremembered experiences. Probably the most important effort is to educate parents regarding awareness of the problem and openness to the child's emotional needs to deal with violence. The parent must be prepared and equipped as the child's most important source of support (Table II).

Table II: Parents Helping Children Feel Safe in a Dangerous World
1. Use your power as a parent to psychologically protect your child. Ask about and understand child's fear, worries and needs and help them to cope.
2. Open communication is crucial. Help your child talk about frightening events.
3. Preserve predictable time together with your children to create an atmosphere of stability.
4. Be aware of your child's daily routine to ensure safety.
5. Make the home a safe haven for children. Be a role model for non-violent conflict resolution. Protect your child from video violence.

Second, in regard to more complex cases, each pediatrician must identify mental health services in his or her community which have expertise in treating children who experience or suffer post-traumatic stress disorder from witnessing a violent event.

Third, it is incumbent on all who care for children to participate in advocacy in their local communities and legislatures. We must control the violence epidemic through management of those social issues that are recognized as contributory: violence on television and in other media; gun safety and control; and violent conflict management. In addition, those social maladies that predispose to stress and violence must also be addressed: lack of day care and after school supervision of children; drug abuse; teenage pregnancy; lack of parenting education; lack of jobs, poverty, etc. The American Academy of Pediatrics offers an excellent packet of professional and patient education materials for helping the pediatrician to deal with these problems.

References:

1. Groves B, Zuckerman B, Marans S. Silent victims. Children who witness violence. JAMA, 1993; 269:262.
2. Osofsky J. The effects of exposure to violence on young children. American Psychologist, 1995; 50:782.
3. Novello, A. (U.S. Surgeon General). American Medical News, January 6, 1992, p.3
4. Campbell C, Schwarz D. Prevalence and impact of exposure to interpersonal violence among suburban and urban middle school students. Pediat, 1996; 98:396.
5. Henning K et al. Long-term psychological and social impact of witnessing physical conflict between parents. J Interpersonal Violence, 1996; 11:35.
6. Kolbo J, Blakely E, Engleman D. Children who witness domestic violence; A review of the empirical literature. J Interpersonal Violence, 1996; 11:281.

Kudos

...to F. Lane France, M.D., on his appointment as Section Voting Member on the Committee on Practice and Ambulatory medicine. *Our congraulations!*

Vaccination Alert - Condensed from AAP PedComm

Recently completed trials conducted in Europe documented the safety and efficacy of acellular pertussis vaccines when administered as the primary series in infants. The FDA has licensed one acellular pertussis vaccine (Tripedia, distributed by Connaught Laboratories, Inc.) on July 31, 1996, for use in the initial series. Additional acellular pertussis vaccines will be licensed for use in the primary series in the near future; the following guidelines are anticipated to apply to other FDA-approved DtaP vaccines upon licensure. The guidelines supplement the previous AAP guidelines for use of acellular pertussis vaccines *(1994 Red Book: Report of the Committee on Infectious Diseases*, pp 355-367).

1. All infants should be routinely immunized with five doses of pertussis vaccine beginning at 6-8 weeks of age, or as soon as possible thereafter, unless contraindicated. Either FDA-approved DTaP, DTwP, or DtwP-*Haemophilus influenzae* type b vaccines can be used for any of the five doses, but DTaP is preferred because of the decreased likelihood of vaccine-associated reactions.
2. In those infants and children given DtwP in their primary immunization the approved DDTaP vaccine can be used to complete the schedule.
3. For those children who have had an adverse reaction to DtwP resulting in a precaution for administration of pertussis vaccine (i.e., hypotonic-hyporesponsive episodes within 48 hours, inconsolable crying for 3 hours within 48 hours, temperature of 40.5°C (104.9°F) or higher within 48 hours, or febrile seizure within 72 hours), DtaP is preferred if completion of the schedule is to be done. Since there may be circumstances (such as an outbreak of pertussis in the community) in which potential benefits outweigh risks, continuation needs to be evaluated on an individual basis.
4. Infants or children who have a serious reaction constituting a valid contraindication to pertussis immunization (i.e., encephalopathy that occurs within 7 days and is not due to another identifiable cause or an immediate anaphylactic reaction following DtwP or DtaP immunization) should receive no further doses of DtwP or DtaP. In such cases, DT (not Td) should be substituted for each of the remaining DtwP or DtaP doses.
5. Simultaneous administration of DtaP and other vaccines is acceptable. Vaccines should not be mixed in the same syringe unless approved by the FDA. On September 27, 1996, the FDA approved reconstituting Tripedia (with ActHib) and administering the vaccine as a single injection for the booster (fourth) dose of the DTP immunization series in those 15 months of age and older. Mixing these two vaccines in the same syringe for doses 1, 2, 3, or 5 is not yet FDA approved. [Underline by Ed.] *Note: ActHib (distributed by Connaught Laboratories, Inc.) is identical with OmniHib (distributed by SmithKline Beecham Pharmaceuticals).*

Other acellular pertussis vaccines may be approved soon by the FDA for use in childlren for the primary series beginning at 2 months of age. In the future, development of recommendations regarding interchangeability of these products for primary or booster immunizatin will be complicated by absence of serologic correlates of immunity and different content of various vaccines. Physicians should seek information about efficacy, rate of adverse reactins, and costs.

The Academy is sensitive to the impact these recommendations will have on the operational and financial management aspects of pediatric practice and realizes that some recommendations may require a phase-in period. Please note that the September 1995 *AAP News* articled "Vaccine reimbursement policies vary by plan" written by the Committee on Child Health Financing provides guidance on incorporating new vaccine recommendations into practice.

The complete policy stgatement will be published in an upcoming issue of *Pediatrics.*

Maurice E. Keenan, MD
President

Firearms Prevention Training Program

The AAP Division of Child and Adolescent Health has obtained funding for two years from The Robert Wood Johnson Foundation and the Joyce Foundation to implement a Firearms Injury Prevention Training Program (FIPTP). The program will bring together pediatricians from AAP chapters to provide them with the necessary tools and skills to return home to train approximately 3000 pediatricians and other health care providers throughout the U.S. in issues related to firearm injury prevention.

Need for the program stems from the epidemic levels of firearm-related injuries and deaths that exist among children and adolescents and the pediatrician's involvement in curbing this epidemic. According to a 1994 AAP Periodic Survey of members, 19% of practicing pediatricians treated or provided consultation for children with injuries due to firearms during 1993. In addition, 82% of surveyed members felt that their anticipatory guidance on firearm safety would help reduce injury and death and 67% were interested in receiving educational materials on the topic.

The program will be coordinated and implemented over a two year period and a Board-appointed Project Advisory Committee will oversee the activities of the programs, developing a training curriculum for the national training conference, and disseminating a Children's Safety Network report which provides state-by-state information on firearm deaths.

The Academy will continue its partnership with the Center to Prevent Handgun Violence in Washington, DC on a joint program entitled "Steps to Prevent (STOP) Firearm Injury", and will explore training opportunities with the Handgun Epidemic Lowering Plan (HELP) Network of Chicago Children's Memorial Medical Center.

Additional information on the Firearms Injury Prevention Training Program can be obtained by contacting Lori Lovett in the Division of Child and Adolescent Health (800/433-9016, x6779).

Have a Managed Care Question?
Call the Managed Care Resource Network

Over 60 pediatricians from 27 chapters have agreed to share their expert knowledge and experiences on a wide variety of managed care issues with their peers. The participants were identified by their state Chapter leadership based on their experience on issues such as developing and working with pediatric single-specialty and multi-specialty group practices, transitioning into Medicaid managed care, managed care contracting, group practice mergers automating the office for managed care, utilization tracking, and working in a staff model HMO. Participating pediatricians are a telephone call away, to help advise and guide pediatricians in dealing with the special demands of managed care and practice rrestructiring.

Members seeking information or a quarterly-updated Managed Care Resource Network contact list may call Edward Zimmerman, Director, Division of Payment Systems at (800) 433-9016, ext. 7917 or Pat Wajda, Division secretary at ext. 6792. If you are interesting in sharing your managed care expertise with other AAP members, contact your AAP state Chapter.

The Florida member of the Managed Care Resource Network is listed below. He is available to answer your questions on a wide array of managed care questions [condensed from the original -Ed]

FLORIDA
John S. Curran, M.D.
Committee on Child Health Financing
University of South Florida College of Medicine
MDC 49
Tampa, FL 33612

CDC ALERT - ACUTE PULMONARY HEMORRHAGE

Ruth A. Etzel, M.D., Ph.D., Chief
Air Pollution and RespiratoryHealth Branch
National Center for Environmental Health

CDC requests reports of acute pulmonary hemorrhage in infants. If you have seen any infants with acute pulmonary hemorrhage, please alert the CDC immediately. A study to determine the cause of acute pulmonary hemorrhage is beginning, prompted by a cluster of cases of this rare disease that occurred in Cleveland last year.

During January 1993-November 1994, eight cases of acute pulmonary hemorrhage/hemosiderosis were diagnosed among infants at Rainbow Babies and Childrens Hospital in Cleveland. In comparison, during 1983-1993, a total of three cases of pulmonary hemosiderosis were diagnosed among infants and children at this hospital.

For each of the eight infants (mean age: 10.3 weeks; range: 4 weeks-16 weeks), onset of hemoptysis was associated with pallor and an abrupt cessation in crying; fever was not reported for any of the infants. Other reported symptoms on admission included limpness, lethargy, and grunting. At the time of initial evaluation at the hospital, seven infants required admission to the pediatric intensive-care unit because of hemoptysis and respiratory distress. All eight infants were black, and seven were male. The median age of their mothers was 20 years (range: 15-29 years). Seven of the pregnancies and deliveries occurred without complications; one infant born at 27 weeks' gestation and weighing 2 lbs, 2 oz (950 g) had complications of severe prematurity. All infants lived within a 6-mile radius of the hospital. No infants were breast fed; before admission, all were fed cow's-milk-based formula.

Laboratory findings on admission included a normal white blood cell count (median=13.8 cells/mm3) and features consistent with a normocytic, normochromic anemia characteristic of acute blood loss with a mean hematocrit of 27.1% normal: 36.0%-47.0%) and a mean hemoglobin of 9.1 g/dL (normal: 10.0-15.0 g/dL). Red blood cell morphology was suggestive of a microangiopathic process: microscopic examination indicated that five of the eight infants had mild to moderate (1+ to 2+) hemolysis characterized by the presence of microcytes, burr cells, spherocytes, and bizarre fragments. Based on guaiac testing, occult blood was present in the stool of three infants. Results of coagulation studies included normal prothrombin and partial thromboplastin time for all infants.

Chest radiographs of all infants showed diffuse, bilateral infiltrates consistent with pulmonary hemorrhage. In six infants, the mean serum magnesium level was 2.1 mg/dL (normal: 1.4-1.9 mg/dL). Cultures of blood, urine, and bronchoalveolar lavage from seven infants were negative for bacterial, mycotic, and viral pathogens. Cultures of bronchoalveolar lavage from one infant grew Bacillus sp. Hemosiderin-laden macrophages, indicating continued pulmonary hemorrhage, were detected in each of the seven infants who underwent bronchoscopy more than 2 weeks after the acute hemorrhage.

No other site of bleeding (i.e., gastrointestinal or nasopharyngeal) was identified during endoscopic evaluation. Immunoglobulin G levels to cow's milk proteins were above normal (>20 U/mL) in five of seven infants.

Five infants required mechanical ventilation for an average of 5 days. All infants survived the first hospitalization and were discharged in stable condition without evidence of hemoptysis after a median length of stay of 10 days (range: 2-35 days). In five infants, acute hemoptysis necessitating readmission recurred within 1 day to 6 months of discharge.

One death, attributed to severe hypoxic encephalopathy secondary to recurring pulmonary hemorrhage, occurred in a 9-week-old full-term infant.

The eight cases of acute pulmonary hemorrhage/hemosiderosis described, exceed the number expected at this hospital during a 2-year period. Massive acute pulmonary hemorrhage occurs rarely in infants; it usually is attrib-

(continued next column)

FROM THE SUBSPECIALTY SOCIETIES

The Florida Society for Adolescent Medicine

Efforts continue to investigate the problem of insufficient funding of primary care for adolescents covered by HMOs. It is clear that pediatricians should insist on carve outs for immunizations and routine gynecologic care when dealing with managed health companies. Current standards would also indicate additional funding is warranted for counselling and dealing with adolescent adjustment and behavior problems.

Frank Genuardi of UF Jacksonville is planning the yearly educational meeting for Florida Regional Society for Adolescent Medicine. It will be held on Friday April 25, 1997 in Jacksonville. More details to follow. All physicians and professionals interested in the care of the adolescent are welcome. CMEs and CEUs will be provided.

Herb Pomerance of USF is planning a session on adolescent gynecology in the Issues and Advances in Pediatrics course to be held April 3-5, 1997 at Sheraton Sand Key. This will include a practical workshop on performing a pelvic exam efficiently and accurately. More details will be forthcoming.

Dianne S. Elfenbein, M.D.
Tampa, FL

Guest Article

(continued from the previous column)

uted to cardiac or vascular malformations, infectious processes, immune vasculitides, trauma, or known milk protein allergies. Cases for which the etiology is undetermined traditionally have been classified as idiopathic pulmonary hemosiderosis (IPH) and account for less than 5% of all cases of pulmonary hemorrhage during infancy.

The pathologic mechanism for IPH in children is unknown. Recent histomorphologic techniques suggest that the initial histopathologic damage occurs at the alveolar epithelial surface. IPH has been associated with circulating antibodies to cow's milk protein; however, this association has not been consistently reproduced. In addition, some reports have described familial occurrences of pulmonary hemosiderosis, suggesting a possible genetic vulnerability to a toxicant.

To identify additional cases of acute pulmonary hemorrhage/hemosiderosis, CDC has established the following provisional surveillance case definition: hemoptysis in an infant aged less than 1 year not attributed to cardiac or vascular malformations, infectious processes, or trauma. A case report form is available from CDC.

Pediatricians are asked to report possible cases through state health departments to Dr. Ruth Etzel, Chief of CDC's Air Pollution and Respiratory Health Branch, National Center for Environmental Health; Internet: RAE1@CEHDEH1.EM.CDC.GOV; telephone (770) 488-7321; fax (770) 488-7335, or beeper 1-800-582-5365.

[Forwarded by Charles Weiss, M.D., Chairman, Committee on Environmental Health, Drugs, and Toxicology]

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.

President's Message

(continued from page 1)

rather than our national treasure to be given the inalienable rights to a loving and nurturing "family", education, safety, protection from harm and access to health and age-appropriate development. This will be a multi-faceted effort working with other children's advocacy organizations and the judiciary.

As your President, I had additional opportunities to advocate for the creation of a new District X in the AAP. This is essentially an issue of balance and equity. The proposals were received quite favorably and I will formally present the pro and con to District IV membership in December and request the District to take a position in support of a "hiving-off" in District IV to create a new District X for South Carolina, Georgia, Florida and Puerto Rico.

It would also be appropriate to share with you some of the ideas gleaned and perspectives that may be of help to us in Florida. There were impressive presentations directed to the role of the pediatrician in working with family and communities on the many facets of prevention of violence in our society. A potential role for all of us in anticipatory guidance is to enquire of the family if there are guns in the home and then to emphasize gun safety by parents. Perhaps, all should incorporate this issue as frequently as we discuss car seat and bicycle helmet safety. What about roller blades and bicycle helmets - have you incorporated this in your plan? The recent information with regard to air bags and children - do you advise parents to have children under 12 ride belted in the rear? Dr. Mulligan Smith of Fort Lauderdale participated in the Committee on Pediatric Emergency Medicine and presented EMS-C parent education and awareness. She has many ideas for visible activities in your community to promote safety - one that I particularly liked was the enlisting of fire departments as a site where parents can go to learn the proper positioning and restraint of infant safety - an extension of child advocacy! At one of the plenary sessions a presentation was given with regard to the need to understand the multi cultural beliefs and expectations of immigrant populations - the discussion on asthma and the use of a blend of conventional medicine and cultural practices was impressive - I now know about Siete Jarabes and Aqua Miravilla - those of you in southern part of the state restrain your laughter - the presenter now advocates Ocho Jarabes (added Albuterol)!!

On the economic front, there is progress coming on the issue of attendance at C-sections with a separate CPT code exclusive of resuscitation. Dr. Richard Naeye, pediatric pathologist, presented new and simplified evidence for the timing of hypoxemic-ischemic events at parturition by looking at lymphocyte and normoblast ratios - if the work is replicated this may open or close more doors with regard to litigation than I like to think about! Most neonatologists were avowedly skeptical. For the neonatology members, I had the privilege of addressing the Executive Committee of the Perinatal Section with regard to the policy issues of medical necessity definitions, the COCHF position on redefining medical necessity, and a number of Medicaid policy issues - I will serve as the liaison to the Perinatal Section to the Committee on Child Health Financing.

On the Florida scene, your Chapter did not take a vacation this summer. We have been extremely active in working with Medicaid to lift the required bonding to participate in Dade and Broward Counties, we have contributed to the discussions with regard to Medipass and the Medicaid RFP process on behalf of children. Special thanks are due to the members who have promptly notified the leadership of "issues in the field". For those of you who know a little about coal mines in Wales, you are the sentinel canaries! Keep singing! Let the officers and Dr. St. Petery informed as issues develop. A meeting has been held with Medicaid leadership to request reevaluation of the Katie Beckett waiver and possible interdigitation with CMS. (The Katie Beckett Waiver is a unique program to permit home care for certain children who otherwise would remain in hospital to receive their care and permits the child to be deemed Medicaid eligible in their own right.) *In practical terms, these are children who require home ventilation and do not have insurance or Medicaid coverage - if you have such patients in your practice please let me know as we need to define the "need".* Special thanks to Dr. Deeb in Tallahassee for assisting in addressing Medicaid utilization issues. (Dr. Deeb is the State Medicaid Consultant)

As your President, I have been extensively involved in the transition to the new Department of Health by attending the Transition Advisory Group meetings all over the state. The process is ongoing and has been careful and deliberative. Nevertheless, as policy issues the Chapter will advocate for the elevation of CMS as the office for children's health within state government and the return of the Child Protection Teams to CMS. The development of a Medicaid ASN (Alternative Service Network) for children with special health care needs (CHSCN) is proceeding on schedule and the Federal Waiver Request has been submitted. The development of the ASN will remain a Chapter priority; many members are actively involved in the work groups.

Since there is almost an hour left in the flight, let me share with you the news from today's newspapers. Headlines in the Boston Globe - "Privatization of Medicaid Eyed by State: 300,000 Would be Moved to Managed Care!" - Massachusetts's vaunted "Primary Care Clinician Plan may be changed. So, are we ahead or behind Boston on this one? The article goes on to convey a rather blithe and sanguine belief that since Boston has the best HMO's in the world and that Massachusetts requires them to be not-for-profit to operate; then, the care and operation will be exemplary - *(Would you like to buy a bridge in Brooklyn?)* I don't think the pediatricians of Massachusetts feel the same way - it has been a tough year for them in physician reporting of malpractice claims etc. - in a the spring of 1997 the physician profiles and claims history in Massachusetts will be on Internet for all to peruse and certain outcomes reporting is planned to follow.

So, you see, we have much to share with our colleagues elsewhere - we are ahead experientially in some areas such as public and private sector managed care impact and behind them in consumer reporting of physician performance. It is through the Academy, your Chapter, and organized medicine that we can share, learn and strategize to address such issues. Stay involved or get involved as the case may be. It is both a time of great change and great opportunity.

John S. Curran, M.D.
President

Committee on Child Health Financing

(continued from page 6)

to determine physician reimbursement and even capitation rates. For a

[redacted]

involved in providing services need to be ascertained; these costs include physician income and benefits, practice expenses, professional liability premiums as well as the frequency of services provided. Once this information is determined and appropriate RVUs for each service are obtained, a physician will be able to calculate costs involved in the provision of each service, as well as the average cost per service provided and per member per month (PMPM) estimates.

From the Legislature

(continued from page 7)

coverage for any diagnostic or surgical procedure involving bones or joints shall discriminate against coverage for any similar diagnostic or surgical procedure

involving bones or joints of the jaw and facial region if such procedures are medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Effective Date: October 1, 1996.

CS/HB 1813 - FLORIDA HEALTHY KIDS CORPORATION ACT (CH. 96-337)

The present law is amended to name this act the "William **G.** 'Doc' Myers Healthy Kids Corporation Act." Language which designated this act as a pilot program limited to 10 counties is removed and an annual report of the corporation is required.

Effective Date: October 1, 1996.

SB 118 - MEDICAID FRAUD AND ABUSE (CH. 96-387)

The Agency for Health Care Administration (AHCA) is given greater authority to identify fraud and abuse, issue sanctions and terminate fraudulent providers from the Medicaid Program. AHCA is authorized to conduct onsite review of a proposed provider's service location prior to entering into a provider agreement. The application review may include a Florida Department of Law Enforcement background check. Specific grounds for denial of an application are enumerated.

The Office of Program Policy Analysis and Government Accountability is to review the Transportation Disadvantaged Program to determine if transportation services are being managed in the most cost effective manner and to provide maximum service. The report is to be published by February 1, 1997.

Effective Date: July 1, 1996.

HB 513 - MEDICAID PROVIDER FRAUD (CH. **96-331)**

Certified Medicaid Fraud Control Unit investigators in the Office of the Attorney General are authorized as law enforcement officers which will empower them to conduct criminal investigations, bear arms, make arrests, and execute warrants related to Medicaid fraud control. The fraud control unit is additionally authorized to refer criminal violations to the appropriate prosecuting attorney.

Effective Date: July 1, 1996.

CS/HB 283 - PATIENT BROKERING (CH. 96-152)

This legislation creates s. 817.505, F.S., which designates patient brokering as a criminal offense. Patient brokering is defined as the referral of patients to a health care provider or health care facility in exchange for an economic reward or the inducement of such referrals through the provision of economic rewards. First time convictions are first degree misdemeanors allowing a fine of $5,000; subsequent convictions are third degree felonies allowing a fine of $10,000. Certain payment arrangements that appear to meet the definition of "patient brokering" are specifically excluded from this classification.

Effective Date: October 1, 1996.

CS/HB 495 - PHYSICIAN ASSISTANTS / FOREIGN TRAINED PHYSICIANS (CH. 96-197)

This law revises various provisions of the physician assistant licensure act to make regulation of such assistants consistent and uniform between the Board of Medicine and the Board of Osteopathic Medicine. Both boards are authorized to delegate regulatory activities to the Council on Physician Assistants. Specific authority is granted to allow third party payments for covered services provided by physician assistants to be paid to the employing physician. This law also declares as state policy that licensed osteopathic physicians be accorded equal professional status and privileges as allopathic physicians and prohibits health facilities and entities providing managed care or risk-based care from discriminating against licensed osteopathic physicians. The alternate pathway to license foreign trained physicians provided in CS/HB 1363 is also contained in this law; however, certain provisions are in conflict. This law requires that applicants for this type of licensure have 2 years of active practice in another jurisdiction rather than 5 years and allows the applicant credit for successful completion of parts of the FLEX or USMLE until the year 2000. Additionally, applicants also may satisfy board requirements for completion of the medical update course with a certificate of successful completion of the course from the University of Miami or the Stanley H. Kaplan course. Another difference requires the board to allow indirect supervision of the applicant during the second year of their restricted licensure. More detail is provided in this law regarding the payment of fees, number of hours needed to satisfy course requirements and restrictions on restricted licensees.

Effective Date: October 1, 1996.

CS/HB 581 - NURSING PRACTICE (CH. 96-274)

This law revises the conditions for appointment of members to the joint committee that designates specified medical acts an advanced registered nurse practitioner may perform under protocol and supervision. Certification requirements for nurse anesthetists and advanced registered nurse practitioners are revised to require a master's degree. The Agency for Health Care Administration is directed to appoint two task forces to conduct independent studies of the impact of nursing department staffing in licensed facilities and the prescribing of controlled substances by advanced registered nurse practitioners. Specific subjects are delineated to be addressed by the latter.

Effective Date: May 29, 1996.

CS/HB 483 - MEDICAL SERVICES / SCHOOLS (CH 96-294)

This legislation specifies that only nurses, physician's assistants or physicians may provide training to school district personnel who are designated to assist students in the administration of prescribed medications. Additionally restrictions are placed on non-medical school personnel regarding the type of assistive medical services they may perform and the training required to provide such services. School district personnel are prohibited from referring or offering contraceptive services to students without the consent of a parent or legal guardian, however conflicts with Chapter 381, F.S., require that chapter 381 will control (County health departments).

Services provided in the exceptional student education program which are eligible for Medicaid reimbursement must be documented in the student's individualized educational plan and demonstrated to be medically necessary. A physician authorization order is necessary if required by federal Medicaid laws.

Effective Date: July 1, 1996.

HEALTH PROGRAMS

CS/HB 437 - SICKLE CELL PROGRAM (CH. 96-292)

The Department of Health and Rehabilitative Services is required, to the extent that resources are available, to establish a sickle cell disease program. The intent of the program is to educate Floridians about sickle cell disease by cooperating with not-for-profit centers providing community education, patient teaching and counseling and encouraging diagnostic screening. The department is authorized to make grants and enter into contracts with not-for-profit centers.

Effective Date: July 1, 1996.

MISCELLANEOUS

HB 1241 - SCHOOL BASED AIDS EDUCATION (CH. 96-307)

Beginning with the 1996-1997 school year the Department of Education is authorized and directed to award grants on a competitive basis to public school districts for implementation of AIDS education activities. School districts with high HIV/AIDS, STD and/or teen pregnancy rates will receive priority for funding. Annual reports will be required of the districts receiving such grants.

Effective Date: July 1, 1996.

CS/HB 341 - SCHOOL DISCIPLINE (CH. 96-246)

Sseveral areas are adddressed relating to discipline of students within the public school system. District school boards are authorized to expel or take disciplinary action against a student who is found to have committed an offense on school property which would be a felony if committed **by** an adult. School districts to which a student transfers are authorized to honor an expulsion or dismissal if the receiving district's code of student conduct includes the grounds upon which the disciplinary action in the student's former school was based. Recommendations for expulsion or assignment to a second chance school may be made for students found to have intentionally made false accusations that jeopardize the professional reputation, employment, or professional certification of a teacher or other member of the school staff, according to the school district code of student conduct.

SB 560 - UNIVERSITY HEALTH SERVICES SUPPORT ORGANIZATIONS (CH. 96-171)

Exemptions from the public records and open meetings laws are provided to certain meetings and records of university health services support organizations. The following records and information are confidential: contracts for managed care arrangements and any documents directly relating to the negotiation, performance, and implementation of such contracts, plans for marketing services; trade secrets, including reimbursement methodologies and rates; records of peer review panels, committees, governing board and agents of the organization which relate solely to the evaluation of health care services and professional credentials of health care providers and physicians; and, portions of meetings of the governing board and peer review panels or committees relating to the above. Documents submitted to the governing board as part of the board's approval of the organization's budget and the budget itself are not confidential.

Effective Date: May 16, 1996.

THE FLORIDA C.A.T.C.H. CORNER

C.A.T.C.H. (Community Access to Child Health) is important to all of us. We will try to include an article or comments about C.A.T.C.H. in each issue.

Shots and What Not

As many of you may have heard, Florida is striving to realize a centralized immunization tracking system. All pediatricians as well as other providers of immunizations will be asked to participate in this program once the kinks have been worked out. Obtaining full participation and support of all those who provide vaccinations for children will enable us to have an effective tracking system. Susan Lincicome of the State Health Office Immunization Program has provided us with the following update:

A new computerized Imunization Information System is being developed by the State Health Office Immunization Program to assist providers with determining a child's immunization status. The information registry will be a central repository for all immunizations provided to children. This exciting project will reduce the time needed to determine a child's immunization history by allowing access to the database by authorized participants. The project is a result of national focus on increasing immunization levels in the preschool population and is an element of the national Childhood Immunization Initiative. Following are highlights of the many benefits of registry participation.

- Patients are evaluated based on standardized patient evaluation approved by the CDC;
- Patient tracking through automatic change in county of immunization record ownership and automatic updates of current addresses for mobile patients;
- Capability to view a patient's immunization history as well as a forecast of dates for future immunizations;
- Patient look-up by a variety of identifiers including Medicaid number;
- A single source for calculating immunization levels in Florida's children;
- Capability to print out required immunization forms such as the Certificate of Immunization for school or child care center attendance.

Currently, pilot sites in the public sector are preparing to transmit immunization data to the registry by the end of 1996. Following successful pilots of the prototype in both the public and private sectors by mid to late 1997, invitations to participate will be fully extended to meet the goal of optimum registry participation by 1998. Requirements for participation include being a state licensed physician, application and approval for immunization registry participation and agreement to observe confidentiality requirements. The registry will be available through modem connection and investigation into intranet connectivity (a more secure version of internet) is being conducted as a more attractive alternative method of access for physicians whose offices are computerized. As a back-up mechanism and for physicians who do not have automated access to registry, a toll free telephone number which activates a voice response system will be available. This voice response system will both provide immunization and allow entry of immunization information for updating records.

More detailed information on the registry and recruitment for participation will be forthcoming following prototype and pilot site testing. If you need more information regarding the immunization registry, please contact Susan Lincicome of the State Health Office Immunization Program at (914)487-2755.

Reach Out and Read

The Reach Out and Read Program is an innovative nationally acclaimed early childhood literacy program which was started at Boston City Hospital and now has thirty sites throughout the United States. This program was developed in response to a 1993 Department of Education study which estimated that over 40 million Americans are functionally illiterate. In children, illiteracy is associated with school failure, juvenile delinquency, and teenage pregnancy. These are common topics of concern for the general pediatrician.

The Reach Out and Read Program has three components. In the clinic waiting room, community volunteers engage the children with books and reading. In the examination room, the pediatrician or nurse practitioner introduces an age-appropriate children's book into the conversation and offers information on the child's development. Upon leaving the office, the child is offered a new book to take home by the doctor. The action of the physician giving the child a book stresses the importance of reading far better than any words. If you are interested in starting a program such as this in your practice or clinic, please contact your Catch Facilitator or Kathleen F. Rice, M.S.Ed., Co-Director, Reach Out and Read at (617)534-4765 or Perri Klass, M.D., Co-Director, Reach Out and Read at (617)534-5701.

CATCH Planning Funds

A new cycle of CATCH planning funds becomes available each fall. A minimum of sixteen grants is awarded yearly. CATCH planning funds can be requested up to $10.000. Since 1993, the number of proposals has been increasing steadily. In 1995, 106 proposals were submitted. Nineteen of these proposals were successful. At least three Florida programs applied for CATCH grants in 1995, but none was successful in the 1995 cycle. In 1993 and 1994, one proposal was successful each year.

Grant proposals must include the following:

1. Name of the program
2. Primary contact person
3. Description of the target population and community
4. Summary of current and future community representatives collaborating on the project
5. Goals and objectives for the six month planning period
6. Summary of accomplishments to date
7. Budget and justification of line items

The most common reason for grant denial that I have found when reviewing these proposals for CATCH planning funds involves budgeting these funds for something other than planning phase of an initiative. The definition of planning need not be restrictive. It can include such items as needs assessment, a feasibility study, grant writing for future funding or implementation, or for assistanace with development of a community consensus. The most successful CATCH planning grants are those which have broad based support within the community. These have often provided the seed money for collaborative public-private ventures. Many of these ventures have subsequently obtained funding via a Healthy Tomorrows Partnership for [redacted]

For those proposals submitted this fall, the review process will take place during the months of November and December. I wish to encourage pediatricians throughout the state to work on solutions and projects for next year. If you have any questions or need assistance, do not hesitate to contact me.

Patricia J. Blanco, M.D.
Florida CATCH Facilitator

We salute the new Alternate Regional Representatives

Region I	Pamela Klein, MD (Pensacola)
Region II	Barbara O'Reilly, MD (Jacksonville Beach
[redacted]	
Region IV	Brenda Brown Holson, MD (Maitland)
Region V	Patricia Blanco, MD (Tampa)
Region VI	John Bartlett, MD (Ft. Myers)
Region VII	Jonathan S. Rubin, MD (Margate)
Region VIII	Lawrence Friedman, MD (Miami)

Welcome to increased involvement in FCAAPAffairs!

LATE BREAKING: Clarification re: W1700

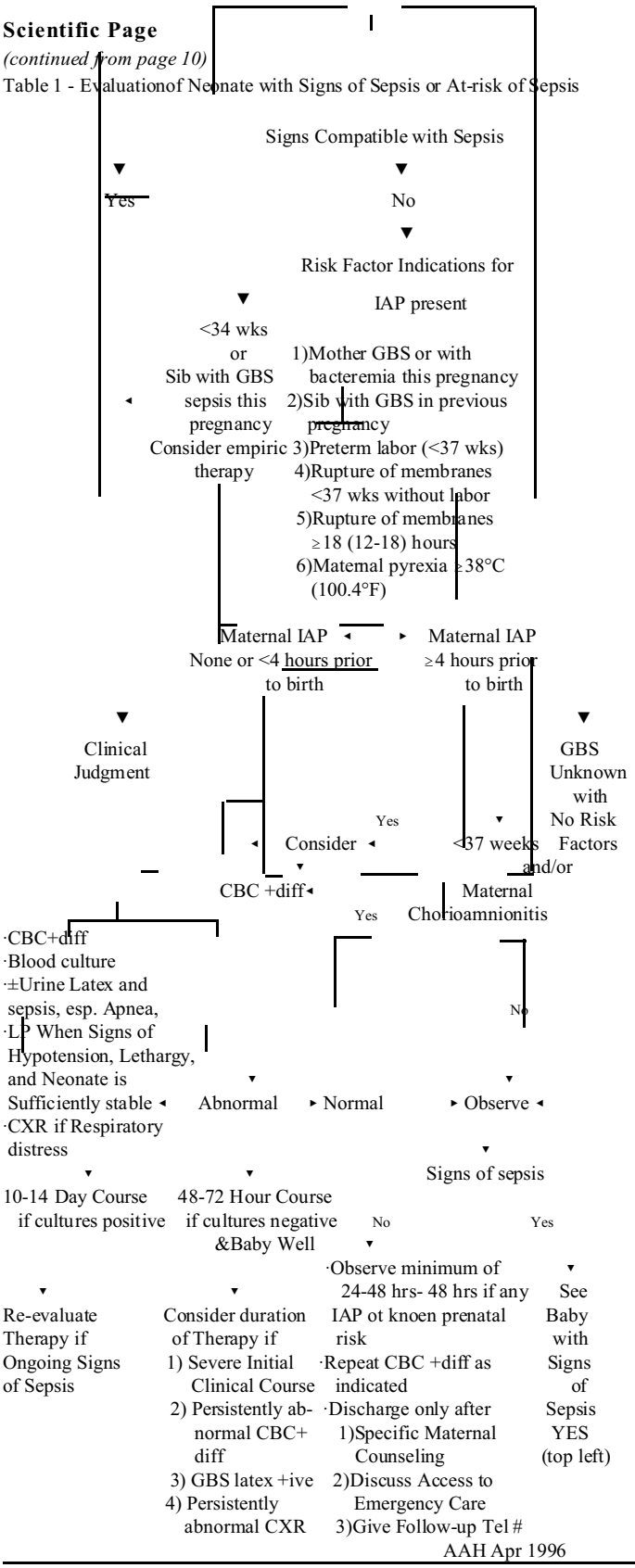
If a MEDIPASS recipient presents at the Emergency Department with an emergency medical condition as defined by Section 409.901(8), reimbursement for that patient will be made through the existing evaluation and management codes, 99281-99285, whether or not the screening exam ultimately shows that the condition was an emergency, The ER physician will indicate on HCFA 1500 whether the patient presented with an emergency medical condition. (System changes are currently underway to allow these claims to pay without authorization from the patient's Medipass provider for dates of service on or after 9/1/96 if the Medipass recipient presented at the emergency room with a condition that the ER physician

determined did not meet the statutory criteria for an emergency. For date of service on or after 7/1/96, procedure code W1700 (screening, evaluation, and examination in Emergency Room) may be billed by non-hospital employed physicians. This procedure code does not require authorization by the Medipass provider and reimburses at the same level as Code 992281. (10/30/96) -From Ed. Zissman

Scientific Page

(continued from page 10)

Table 1 - Evaluationof Neonate with Signs of Sepsis or At-risk of Sepsis



AAH Apr 1996

information surfaces, widely disseminated, and above all based, if possible, on solid research data. In this era of evidence-based medicine and computerized conmunication. practice guidelines can have a practical impact and stimulate questions and research to improve medical care while minimizing costs. The management of early neonatal sepsis is a clinical concern which is still in major need of randomized controlled trials of therapeutic approaches.

Acknowledgements

The authors wish to recognize the input of the members of the ACHA GBS Work Group, the members of the FSN Sub-Committee on Practice Parameters and many neonatologists in the State of Florida.

References

1. Centers for Disease Control and Prevention. Prevention of perinatal group B

streptococcal disease: a public health perspective. MMWR 1996; 45 (No. RR-7): 1-24

2. Squire E, Favara B, Todd J. Diagnosis of neonatal bacterial infection: Hematologic and pathologic findings in fatal and nonfatal cases. Pediatrics 1979; 64:60-64.
3. Rozycki H. Stahl G, Baumgart S. Impaired sensitivity of a single early leukocyte count in screening for neonatal sepsis. Pediatr Infect Dis J 1987; 6:440-442
4. Boyer K, Gadzala C, Burd L, et al. Selective antepartum chemoprophylaxis of neonatal group B streptococci early-onset disease. I. Epidemiologic rationale. J Infect Dis 1983;148:795-801.
5. Boyer K, Gotoff S. Prevention of early-onset neonatal group B streptococcal disease with selective intrapartum chemoprophylaxis. N Engl J Med 1986; 26:1665-1669
6. Ohlsson A, Myhr T. Intrapartum chemoprophylaxis of perinatal group B streptococcal infections: A critical review of randomized controlled trials. Am J Obstet Gynecol 1994; 170:.910-917
7. Committee on Infectious Diseases and Committee on Fetus and Newborn. Guidelines for prevention of Group B Streptococcal (GBS) infection by chemoprophylaxis. Pediatrics 1992; 90:775-778.
8. American Academy of Pediatrics. Group B Streptococcal Infections. In: Peter G, ed. *1994 Red Book: Report of the Committee on Infectious Diseases.* 23rd ed. Elk Grove Village, IL, American Academy of Pediatrics; 1994:439-442
9. Bray R, Boe R, Johnson W. Transfer of ampicillin into fetus and aniniotic fluid from matemal plasma in late pregnancy. Am J Obstet
10. Gerdes JS. Clinicopathologic approach to the diagnosis of neonatal sepsis. Clin Perinatol 1991; 18:361-380
11. Singhal K, Garnma EL. Management of 168 neonates weighing more than 2000g receiving intrapartum chemoprophylaxis for chorioamnionitis. Evaluation of an early discharge pollcy. Arch Pediatr Adolesc Med 1996; 150:158-163
12. Isaacs D., Wilkinson A, Moxon E. Duration of antibiotic courses for neonates. Arch Dis Child 1987; 62:727-728

[This article will appear in expanded form in one of the refereed journals]

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 mede 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 chld 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 do not already do so, **please pay your Florida dues,** billed through the Academy Office.

F.Y.I.

FPS/FCAAP Legislative Awards

The Florida Pediatric Society/Florida Chapter American Academy of Pediatrics wishes to honor the following legislators for their contributions to the welfare of children. Legislative awards are presented to the following:

Region I

Representative Buz Ritchie - Chairman, Appropriations Committee, safeguarded funding for various children's health programs. Resolved committee deadlocks in favor of CMS and other children's programs. Supported and assisted passage of Department of Health and supported Bicycle Helmets.

Region II

Senator Bill Bankhead - Unwavering leadership in funding Statewide Poison Control System. Sponsored HIV Reporting legislation establishing HIV testing as standard of care for pregnant women. Sponsored amendment preventing retroactive application of Statute of Limitations revisions. Responsive and supportive of quality of care issues relating to children. Supported Department of Health and Graduated Driver Licensing.

Senator Jim Horne - Sponsored Primary Seat Belt Enforcement legislation. Opposed to Statute of Limitations expansion and assisted on pediatric medical issues. Supported Bicycle Helmets and Graduated Driver Licensing.

Representative John Thrasher - Led opposition to Statute of Limitations expansion. Cosponsor and advocate for a Department of Health. Assisted FPS with amendments to legislation and the budget. Supported Graduated Driver Licensing .

Region III

Representative Bob Casey, M.D. - House sponsor of Bicycle Helmet and Underage Drinking/Driving legislation. Long time advocate for antitobacco legislation. Supported Graduated Driver Licensing, Department of Health (Cosponsor), Early Hospital Discharge of Newborns and Clinical Laboratory revisions.

Region IV

Senator Toni Jennings - Advocated expansion of CMS Pediatric AIDS Network into Orange County and the southwest coast. Cosponsor of Bicycle Helmets legislation and assured Senate action on Early Hospital Discharge of Newborns legislation. Supported Department of Health and Graduated Driver Licensing.

Region V

Representative Peter Rudy Wallace - Speaker of the House of Representatives, guided an extensive children's health and safety agenda through the House, including Bicycle Helmets, Pediatric Facility and Service Standards, Emergency Medical Services for Children, Pediatric Trauma Standards, CMS Alternative Service Network within Medicaid Managed Care, Early Hospital Discharge of Newborns, Clinical Laboratory Revisions, Infant Metabolic Testing Revisions, Funding for completion of the Statewide Poison Control System, and Graduated Driver Licensing.

Senator Donald C. Sullivan, M.D. - Sponsor and untiring advocate for Bicycle Helmet legislation. Supported Department of Health, Graduated Driver Licensing and Early Hospital Discharge of Newborns legislation.

Senator Ginny Brown-Waite - Chairperson of Senate Health Care Committee, oversaw legislation which created the CMS Alternative Services Network and other safeguards for children within Medicaid Managed Care legislation. Sponsor of Pediatric Facility and Services Standards legislation. Assisted Governor in sustaining veto which would have negated Tobacco Liability law. Opposed funding cuts to crucial children's health programs. Supported the Department of Health, Clinical Laboratory Revisions, Early Hospital Discharge of Newborns and Graduated Driver Licensing legislation.

Representative Dennis Jones - Long time advocate for children's health and safety issues. Sponsor of Primary Seat Belt Enforcement and Cosponsor of Department of Health legislation. Supported Bicycle Helmets and Graduated Driver Licensing.

Lars Hafner-- Chairman of HRS Appropriations Subcommittee, protected funding for CMS and other children's programs. Supported the Department of Health, Bicycle Helmets and Graduated Driver Licensing.

Region VII

Senator William G. "Doc" Myers, M.D. - Senator Myers has been the eminent advocate for children's health issues over a number of years. As chairman of the Ways and Means subcommittee he has been a champion of CMS funding and protection of health programs serving children. Sponsored Department of Health and legislation requiring HMO's to cover diabetes education and supplies. Supported Bicycle Helmets and Graduated Driver Licensing.

Senator Howard Forman - Sponsor of legislation creating the Autism Centers Network, Pediatric Trauma Standards and Early Hospital Discharge of Newborns. Member of the Ways and Means Committee, supported improved funding for CMS and other children's programs. Supported Bicycle Helmets and Graduated Driver Licensing.

Representative Fred Lippman - Longtime advocate for children's issues and annual host of the Child Health Dinner in Tallahassee. Sponsor of Department of Health and Primary Seat Belt Enforcement. Supported Bicycle Helmets, Graduated Driver Licensing, Clinical Laboratory Revisions, and Early Hospital Discharge of Newborns legislation. Representative Lippman is always available to assist on any issue of interest to FPS.

Representative Ben Graber, M.D. - Chairman of the House Health Care Committee who was the chief architect of the CMS Alternative Services Network and other safeguards for children within Medicaid Managed Care. Gave priority within his committee to Pediatric *(continued next column)*

SPECIAL ITEM

Florida's Medipass

In the next two to three months there will be a massive effort to enroll Florida's current Medicaid patients in one of two options for those who are relatively healthy. The options will be (1) a Medicaid HMO, or (2) Medipass. Medipass is essentially a PPO option that provides a $3 per month per member case management fee to the physician for functioning as the case manager to order and authorize specialty care referrals and emergency room authorizations. It has been moderately successful in controlling costs, but is currently entering a crisis phase in view of aggressive anticipated Medicaid HMO marketing efforts that under recent legislation provide for an enrollment ratio of 60% Medicaid HMO and 40% to Medipass for those patients/families that do not indicate a choice. Currently, approximately one-third of Florida's Medicaid recipients are enrolled in a Medicaid HMO and there are many of them.

Each patient/client will be offered choice counseling and there will not be direct marketing, but with the anticipated relatively poor response in choice of providers, it is very likely that the HMO option will rapidly become a preeminent/predominant mode for provision of services. Each quarter after the initial mandatory enrollment, those whose eligibility has expired or non-previous clients who do not provide a choice, will be enrolled in the same 60/40 proportion.

I believe that it is extremely important that Florida's pediatricians recognize that there is a choice and that it is important to educate your patients who are currently Medicaid participants with regard to their option to choose you as a Medipass provider. I believe this gives the practitioner substantially greater freedom for providing a medical home and providing options for referral to your choice of pediatric specialists/facilities. Please emphasize this to your patients and the parents.

Medipass has been fraught with significant difficulties, particularly noted in the Tallahassee area and well documented by Louis St. Petery Jr., M.D., our Executive Vice President. Definite efforts are underway to further define the Medipass system and to correct many of the glitches that have been encountered. For a list of some of the outstanding issues I will simply note some of the problems that your Florida Pediatric Society/Florida Chapter are currently addressing:

- Patients whose eligibility is lost and then regained are supposed to be placed with the same provider. Frequently they are assigned by computer to alternates.
- There have been problems with the reentry of Medipass Provider when Medicaid eligibility changes and cases have been randomly assigned to a different provider using zip codes, thereby disrupting a plan of care and the usual and customary relationship to the provider.
- Patients whose Medicaid eligibility shows an impending cancellation date cannot be put on Medipass. Newborns share a similar problem.

Your Pediatric Society will continue to address these problems. The Florida Medical Association has also recently indicated an interest and has provided an opportunity for your leadership to meet directly with the Director of the Agency for Health Care Administration and the Director of the Medicaid program.

Please don't hesitate to provide examples of problems which you may encounter to Louis St. Petery Jr., M.D., who is our liaison with Medicaid. Help us to make the program "Medipass" not "Medipast".

John S. Curran, M.D.

(continued from previous column)

Facility and Service Standards, Emergency Medical Services for Children and Pediatric Trauma Standards legislation. As a member of the Appropriations subcommittee supported funding of CMS and other children's health programs. Supported the Department of Health, Bicycle Helmets, and Graduated Drivers Licensing.

Representative Mandy Dawson-White - Sponsor of numerous child health bills including: Emergency Medical Services for Children, Pediatric Facility and Service Standards, Pediatric Trauma Standards and Infant Metabolic Testing Revisions. Supported Bicycle Helmets, Department of Health, Graduated Driver Licensing and Early Hospital Discharge of Newborns legislation.

Representative Lois Frankel - Long time child health advocate who has pursued anti-tobacco issues with zeal. Chairperson of the Ad Hoc Committee on Child Abuse, worked to protect children and sponsored legislation creating the Commission on Fatherhood. Supported Bicycle Helmets, Graduated Driver Licensing and Early Hospital Release of Newborns legislation.

Representative Debby Sanderson - A member of the House HRS Appropriation Subcommittee who has been a powerful advocate for children's issues particularly those related to CMS. House sponsor of legislation requiring HMO's to cover diabetes education and supplies. Supported Bicycle Helmets, Graduated Driver Licensing, Department of Health and Early Hospital Discharge of Newborns legislation.

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

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

Program: Advances in Pediatric Hematology/Oncology
Dates: November 21-23, 1996
Place: Wyndham Harbour Island Hotel, Tampa, FL
Credit: undetermined
Sponsor: Florida Association of Pediatric Tumor Programs, Inc.
Inquiries: Susan Easter, Program Administrator, (813)632-1309.
12901 Bruce B. Downs Boulevard
MDC Box 15CE
Tampa, FL 33612

Program: Practical Pediatrics
Dates: January 16-19, 1997
Place: Keystone Resort, Keystone, Colorado
Credit: 18 hours Category I for AMA Physicians Recognition Award.
Sponsor: American Academy of Pediatrics
Inquiries: CME Registration, AAP, (800)433-9016, ext 7657 or 6796.

Program: Second International Symposium on Growth Hormone Secretagogues
Dates: February 13-16, 1997
Place: Sheraton Grand Hotel, Tampa, FL
Credit: 19 hours Category I for AMA Physician Recognition Award
Sponsor: University of South Florida, Department of Pediatrics
Inquiries: Herbert H. Pomerance, M.D., Organizing Secrretary, (813)272-2710

Program: Pediatric Update 1997
Dates: February 15-22, 1997
Place: Camino Real Hotel, Puerta Vallarta, Mexico
Credit: 21 hours Category I for AMA Physician Recognition Award
Sponsor: Schneider Children's Hospital and AAP New York Chapter 2
Inquiries: Schneider Children's Hospital, Office of CME, (718)470-8650

Program: Issues and Advances in Pediatrics - 1997
Dates: April 3-5. 1997
Place: Sheraton Sand Key Resort, Clearwater Beach, FL
Credit: 18 hours Category I for AMA Physicians Recognition Award.
Sponsor: University of South Florida and Tampa General Healthcare
Inquiries: Ms. Rebecca Scott (813)272-2744

Program: 1997 Legislative Conference
Dates: April 13-15, 1997
Place: Ritz Carlton Pentagon City, Arlington, VA

Credit: 9 hours Category II for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics Washington Office
Inquiries: Conference Registration, AAP Washington Office (800)3365475 or (202)347-8600