The Florida Pediatrician

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

August 2001
Volume XXIV Number 3

In this issue.....

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Dear Colleagues:

I am both honored and excited about assuming the Presidency of the Florida Chapter of the American Academy of Pediatrics. Before I describe my vision and my priorities for our Chapter for the next two years, I want to reflect on how we have gotten to where we are today.

Without a doubt, Dr. Ed Zissman's leadership has positioned us to be more effective advocates for pediatricians and children than we have ever been before. Ed revitalized and focused our chapter through the strategic planning process. He encouraged several younger members of our organization to become active in leadership and as a result we have an incredibly talented group of officers and members of our executive committee. Our regional representatives are strong and engaged. During Ed's term of office, the membership has grown and is getting stronger. He created the Pediatric Council to address the problems with insurance companies and managed care and was the force behind the creation of the residents' section, which will produce the future leaders of this organization. Very importantly, he directed the chapter's search for non-dues sources of revenue. All of these initiatives are a direct result of Ed's leadership and dedication to our organization. We all owe Ed our sincerest thanks and I assure you that we will continue to utilize Ed's talents during the next two years as he serves as Past-President.

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"...an aggressive agenda, which I think will result in better care for our patients..."

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Now, as I look forward to the next two years, I hope you join me in supporting an aggressive agenda, which I think will result in better care for our patients and in improvements in the way we deliver care to our patients and their families.

First, I know that we all appreciate the state's commitment to reduce the number of uninsured children in Florida through the KidCare program. However, KidCare has several serious flaws, which must be corrected. Today, KidCare exists as four separate and distinct programs arranged in a patchwork quilt. Eligibility, benefits, reimbursement, and oversight vary significantly between programs making KidCare impossible to navigate for families and pediatricians. As a result far too many children fall through the cracks and remain uninsured. One of the highest goals of the Chapter is to work with the Department of Health, ACHA, the Healthy Kids Corporation, and legislators to make KidCare seamless to patients, parents, and pediatricians. There must a single point of eligibility determination, which can be accomplished rapidly at the site of service and is continuous for at least one year.

Making KidCare a single, seamless program is just the first step in expanding access. We must also redouble our efforts at improving the low reimbursement rates paid by Medicaid and by many of the managed care organizations participating in KidCare. The increases in Medicaid reimbursement realized in recent years must be considered only the first steps. The Chapter must become even more proactive with the legislature and the

*(See **President,** page 18 ▸)*

New Regimes vs. Lots on the Table

The year 2001 is an important one for all of us in Florida. Much has happened and is happening.

...leadership of our Society...

First, we have just recently had a change in the leadership of our Society/Chapter, with Rick Bucciarelli "ascending" to the presidency. This resulted in the end of the era so well presided over by Ed. Zissman for the last two years. These years saw great progress in many areas for the Society, including its organization and operation, and its advocacy for children. We know that Rick will continue the momentum., as suggested by the message just preceding this page.

Secondly, we did not have a very good year in the State Legislature. Nancy Moreau's report, which begins in this issue, lists the initiatives which did not survive - despite the best efforts of our advocates in Tallahassee, who pushed very hard, as usual. However - there is always next year.

Our State is pretty divided now on many issues, although oil-drilling off the coast is pretty unique in its unifying effect. Abolition of the Board of Regents had its proponents (who prevailed) and its opponents. On a personal basis, I cannot visualize that having each of the Universities (specifically for us, the Medical Schools) fighting for its own funding rather than having a unified front in a unified system, can possibly be a better way. Not everyone agrees with me, however. Time will tell. We all have until next year to sort out our convictions and voice our opinions, one way or the other!

...The Board of Regents...

Third, there is the national scene. We have a new party in the presidency and an unexpected change in the leadership of the Senate. As many thought initially, we are, as of this writing, beginning to hear that the all-important surplus is shrinking, because of the economic slow-down. Will the economy pick up again, and allow for expansion of the surplus again, or will we lose valuable programs (for children?). Again, time will tell.

A very important step for us is the Patients' Bill of Rights. The press, both written and visual, is making the most of the problem. I am amused, in a way, that the major argument against it that I hear is that it will make a lot of lawsuits and the attorneys will get rich while premiums will go so high that people will not be able to afford coverage (this has already happened to a degree!). Does no one believe that the HMOs also have people who think, and who might come to the conclusion that, between settlements and those (tsk,tsk) lawyers fees which they will have to expend, it might be better to change their ways. Such a change could have the result of actually reducing the number of lawsuits, and the premiums might not go up - or little at best. Much as I personally dislike the whole concept of the HMO, I do not think that they would willingly price themselves out of existence!

...Patients' Bill of Rights...

As in the past, we include in this issue an article about Managed Care. It is interesting!

These are the important issues for now. Of less significance is the fact that I have agreed to be your editor again, until Carol Lilly's work-load lightens and gives her the time for this labor of love.

Herb Pomerance
Editor□

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THE REGIONAL REPRESENTATIVES REPORT

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

Region VII reports:

In the past year, 25 new members joined Region VII to bring the total number of members up to 341. Broward County and Palm Beach County maintain active pediatric societies. Highlights of Region activities by county are as follows:

Broward County:

The Broward County Pediatric Society remained active, with current membership at 60 pediatricians and subspecialists.

The North Broward Hospital District announced the appointment of Elizabeth Ostric, FACHE, as Vice President, Women and Children's Services for Chris Evert Women's and Children's Center at Broward General Medical Center, Ft. Lauderdale. Ms. Ostric was formerly with the Medical College of Georgia as Administrator of Georgia Children's Medical Center, and Assistant Adjunct Professor, Department of Pediatrics, Medical College of Georgia, in Augusta. She has served on the Americal Academy of Pediatrics Committee on Hospitals and on NACHRI , and is a past member of the Governing Council, Section for Maternal and Child Health, American Hospital Association.

Chris Evert Women and Children's Center became of member of the Association of Florida Children's Hospitals.

Joe DiMaggio Children's Hospital received the award as best Children's Hospital in Broward County for pediatrics, given by South Florida Parenting Magazine, for the sixth consecutive year. The South Broward Hospital District started a children's mobile health center, a van which provides free preventive health care for schools, day-care and youth centers as an outreach effort for children who do not have access to regular medical care.

Palm Beach County:

Palm Beach County Pediatric Society Spring Meeting was held in April. There were presentations by Dr. DelToro on the importance of local and state chapter membership and advocacy, and Dr. Lou DeNicola of the University of Florida, regarding an update of the activities of the Florida Poison Control Center.

Respectfully submitted,

Jorge DelToro, MD — Regional Representative

Marshall Ohring, MD — Alt. Regional Representative☐

As of August 1, Robert D. Christensen, division chief of Neonatology at the University of Florida, will begin his new duties as Lewis A. Barness Chairman of the Department of Pediatrics and Professor of Pediatrics at the University of South Florida and Physician-in-Chief at All Children's Hospital. He has also been directed to develop a National Institute of Health Sponsored Clinical Research Center at the University of South Florida and at All Children's Hospital, similar to the one he helped direct at Shands Hospital at the University of Florida. Dr. Christensen will replace Dr. Bernard Pollara, Interim Chairman and Division Chief of General Pediatrics.

There is no new news on the ongoing courtship between the All Children's Health System and Bay Care Health Systems to develop a Regional Children's Health System.

Patrick Yee, MD☐

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 or Membership Director. 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 child health advocacy.☐

Region V reports:

Report of Practice Support Committee
June 2001

Tommy Schechtman, M.D.•

The Florida Chapter has established a statewide Pediatric Council, consisting of State Chief Medical Officers from the largest managed care payors (Blue Cross/Blue Shield, Aetna, United Healthcare, Cigna, AvMed, Beacon/HIP) and practicing pediatricians.

We have already met on two occasions and plan to continue to meet on a quarterly basis. The discussions have been enlightening and challenging. The intention of this forum is to begin a regular dialogue between pediatricians and managed care in order to support and advocate for the pediatrician and his/her practice.

The mission of the council is to serve as a vehicle• for problem-solving/resolution of global issues involving pediatricians and MCOs. Several issues that have already been explored include adoption of the AAP's periodicity• schedule, vaccine administration issues, managed care's online information capabilities and physician acceptance of elecctronic communication, pediatric formulary issues and enhancement of general communication and involvement between physicians and insurers.□

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Report of Committee on
Environmental Health, Drugs, and Tosicology

Charles F. Weiss, M.D.
Chairman

HOME IS NOT A HAVEN

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The following is a synopsis of the New Scientist Article of May 5, 2001, entitled "Curse this House."

"Theme: children inhale 2 to 3 times as much as their parents."

Home is not a haven, safe from life's hazards.

PLAYTIME:

- Children are in constant motion !
- under the table , playing on the floor, eating Cheerios from the carpet.
- Johnny, 2 years, may put 76 things in his mouth in• the course of an hour: toys, his fingers, someone else's fingers–
- Emma, 4 years, has more self-control, but she may still put 38 things in her mouth every hour.

Emma and Johnny, like all kids, are little guinea pigs testing the toxicity of whatever pollutants are in their home.

Submitted by: POLLUTANTS

Exposure to most toxic pollutants is between 10 and 50 times higher in indoor environments than it is outdoors according to studies in the late 1980s. Levels in house dust would trigger a clean-up operation if they were found outside. Household carpet dust sent to an environmental lab would ring regulatory alarm bells for high concentrations of heavy metals such as lead, cadmium and mercury, polycyclic aromatic hydrocarbons (PAHs), pesticides and polychlorinated biphenols (PCBs), says John Roberts, an environmental engineer in Seattle, Washington.

RISK

Children are more at risk than adults, due to their higher metabolic rate and their still developing organs.

Kilogram for kilogram, Emma (4yrs) and Johnny (2yrs) inhale 23 times as much air as their parents. Even relatively low levels of the poisons in dust could irritate their lungs, damage their developing nervous systems, retard their growth and hearing, or lead to cancer.

Americans ingest 110 nanograms of the most toxic PAH, benzo(a)pyrene, which is found in tobacco smoke and cooking fumes. That's the equivalent of smoking three cigarettes a day. The problem may be far more extensive than people think. Fortunately there is an easy--if tedious--remedy close at hand.

Carpets are one of the biggest sources of toxic substances. Normal vacuuming leaves in more dust than it picks up so that, over time, dust accumulates in carpets. "The carpet is the largest reservoir of dust in a house. -- a house with bare floors and a few area rugs will have about one-tenth of the dust found in a house with wall-to-wall carpet, all other things being equal." This is bad news for people living in cold climates, where most houses have wall to wall carpets.

Most of the children are playing under the table. Johnny, who has been licking his hand, then rubs it on the carpet. A rub that transfers about 1 per cent

See ***"Environment"***, page 18 ▸)

Report of the Collaborative Research and PROS Committee

Lloyd N. Werk, MD, MPH, FAAP
Orlando, FL

Report

The AAP's network of practices involved in practical and relevant research has grown to 1600 practitioners and 600 practices nationwide. In Florida, 61 practitioners and 26 practices are PROS network members.

Multiple PROS presentations at meetings and research articles in journals have appeared over the last year. The febrile infant study demonstrated that general pediatricians do better in both assessing and treating these infants than any academic model. The immunization delivery study has revealed practical information, for example that increasing the number of vaccinations at a visit is well tolerated by parent and child and results in improving immunization rates. Contrary to expectations, appointment reminders fail to improve rates. Further information is available at the AAP website under Research/Center for Child Health Research/PROS or www.aap.org/pros.

Have you wondered what concerns families have once they arrive home with their newborn infants? What factors spoil the perinatal experience? Is there some way to reduce the office work and number of unnecessary telephone calls from new parents confused with the medical system? LAND (Life Around Newborn Discharge) is the largest, national prospective study of newborn discharge ever conducted. Practices across the country are contributing data collected over 8 weeks (or until 40 – 60 newborn-mother pairs are enrolled). Recruitment from within established PROS practices has not yet reached our goals. Your participation in this study would make a difference – to the success of the project, to finding ways to facilitate the transition from hospital delivery to home, and to reducing unnecessary hassles to our office. Preliminary results confirm our suspicions that mothers with shorter hospital stays require greater pediatric services. The study is identifying other important

policy and practice issues. The secretary of Health and Human Services, Congress, and the Maternal and Child Health Bureau are anxious to see completion of this study. Currently, 6 practices in Florida have volunteered for the study. For more information about this study, call 800-433-9016, extension 7626 or Email: pros@aap.org. You can learn more about PROS and the LAND Study on the web at www.aap.org/pros.

Please contact me if you are interested in having a 12-minute slide presentation about PROS at your local hospital or pediatric society meeting.

Coordinators from the PROS network met at the semi-annual PROS coordinator's conference at the end of March. New projects in the pipeline include a violence prevention intervention study, stimulant medication outcomes study, survey of secondary sexual characteristics in boys, and others. At our Spring meeting, we reaffirmed the network's aim to improve the health of children by conducting collaborative practice based research to enhance primary care practice.

Lloyd N. Werk, M.D., MPH
Orlando, FL

FYI

The AAP will no longer print the tax deductibility disclosure statement on their membership dues invoice. Since we are incorporated as a 501 (c) (6) organization, we are required by the IRS to notify our members of the amount of dues that can be deducted as a business expense:

Dues remitted to the Florida Chapter are not deductible as a charitable contribution but may be deducted as an ordinary necessary business expense.

However, 30% of the dues are not deductible as a business expense for 2001 because of the chapter's lobbying activity.

Please consult your tax advisor for specific information.

Note:

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

Sinusitis – Treating the holes in the head

Magdalen Gondor M.D.
Pediatric Pulmonary Associates
St. Petersburg, FL

[This timely paper is condensed from the presentation by Dr. Gondor at the Annual Meeting of the FPS/FCAAP in June-Ed]

Sinusitis, inflammation of the sinuses, is a common disease affecting children as well as adults with a significant impact on the healthcare system. Sinusitis affects 35 million Americans (14% of the US population) and is the most frequently reported chronic disease in the US. In addition it is the fifth leading reason physicians order antibiotics, accounting for 11.5 million office visits per year, 73 million restricted activity days and costing the US healthcare system an estimated two billion dollars yearly, (not counting costs for radiographs, CT scans or outpatient surgery).

The possible functions of the sinuses, literally holes in the head, are air conditioning, reduction of skull weight for better balance, heat insulation, flotation of the skull in water, increase of the olfactory area, mechanical rigidity, vocal resonance and diminution of auditory feedback. The paranasal sinuses are divided into basic groups: frontal, maxillary, ethmoid and sphenoid, all of which drain through small openings called ostia. The maxillary and ethmoid sinuses form during the third and fourth gestational months and although tiny are present at birth and can be seen on x-ray in infancy. The frontal sinus, which begins to pneumatize at approximately two years of age but is not completely developed until adolescence, is visible on x-ray at three to five years. The sphenoid begins to pneumatize by age three and is visible on x-ray by ages five to seven.

The osteomeatal complex (OMC) is the confluence of the frontal, ethmoid and maxillary sinuses. The OMC is often a focal point for infection of the sinuses. Three key areas are important for the normal physiological function of the sinuses: patency of the ostia, normal function of the hair cells of the ciliary apparatus, and the quality of the nasal secretions. Swelling of the nasal mucosa can result in outflow obstruction (obstruction of the sinus ostia or OMC), reduction in the number and function of the cilia and overproduction or change in the viscosity of the secretions. These processes result in stasis and secondary bacterial infection.

Sinusitis is defined as inflammation of the mucus membranes of the nose and lining of the sinus cavities. Abbasi and Cunningham point out that patients have sinusitis each time they have a common cold or flare of allergic rhinitis. Clinically, the term implies a bacterial infection that requires treatment with antibiotics. Sinusitis is classified as acute or chronic. Acute sinus disease typically follows an upper respiratory infection or a flare of allergic rhinitis. In adults, 0.5%-2.5% of viral upper airway infections (URI's) result in a secondary bacterial infection. In the US, children can experience 3 to 8 acute viral respiratory illnesses yearly, of which 5% to 10% are complicated by acute bacterial sinusitis.

Most uncomplicated viral URI's produce symptoms that last for 5-7 days. Although children may not be asymptomatic by the tenth day, their condition is virtually always improved. Patients with a common cold usually report some combination of these symptoms: fever, sore throat, cough, and nasal drainage. The duration of symptoms tends to resolve in 5-7 days; however, nasal symptoms and cough may persist for two to three weeks.

When are antibiotics necessary in managing children with sinusitis following a URI? Nasal congestion, sore throat and cough can be seen in acute uncomplicated sinusitis and may not be noticeably different from a cold. How does one decide if the symptoms are related to bacterial infection with a minimum of costly tests, referrals, potentially harmful procedures and unnecessary antibiotic treatment?

There are two clinical presentations of acute bacterial sinusitis. With the severe form, the child appears ill with a temperature of more than 102˚F and purulent nasal discharge for more than three days. With the persistent form, symptoms last at least 10-14 days but < 30 days with a nasal discharge and a daytime cough that may worsen at night. Acute sinusitis is defined by symptoms that last three to four weeks. Older children and adults frequently experience nasal congestion, purulent rhinorrhea, post nasal drip, headaches and cough. Parents may tell you that children are experiencing increasing irritability, vomiting associated with gagging on mucus, or prolonged coughing, especially at night. All ages may experience fever, malaise, fatigue, halitosis, hyposmia or sore throat.

Major complications of acute bacterial sinusitis are rare and involve contiguous spread of infection to the orbit, bone or central nervous system (CNS). Orbital complications include preseptal or periorbital cellulitis, orbital abcesses and optic neurosis. Intracranial complications include epidural abcess, subdural empyema, cavernous or sagittal sinus thrombosis. There can be osteomyelitis, frontal sinusitis (Pott's puffy tumor) or involvement of the maxillary sinus.

Recent guidelines published jointly by the Centers for Diseases Control and the American Academy of Pediatrics prompted recommendation of judicious use of antimicrobial agents in treating acute bacterial sinusitis, stating that a simple URI does not require antibiotic treatment. It is important for pediatricians to teach families that mucopurulent secretions can accompany simple URIs. Nasal secretions that accompany a common cold can be thin and clear, but may become more mucoid prior to resolving.

The three most common pathogens associated with acute sinusitis in children are *Streptococcus pneumoniae, Haemophilus influenzae,* and *Moraxella catarrhalis*. In the US, 20 to 30% of the *Streptococcus pneumoniae* is resistant to penicillin. 30 to 40% of *Haemophilus influenzae* and almost all (75 to 90%) of *Moraxella catarrhalis* are beta-lactamase producing and therefore resistant to

(See ***Scientific***, page 19 ▸)

Legislative Report

[Our annual presentation of the Legislative Report, with thanks again to our Legislative liaison, Nancy Moreau]

The 2001 Legislature

Nancy Moreau, Legislative Liaison
Tallahassee

The 2001 Legislative Session began with hope that the Society would finally reach its goal of raising Medicaid physician fees to Medicare levels. However, the Governor had different plans and much of the Session was spent defending Medipass and budget cuts to various children's programs. The Florida Medical Association joined the Society in proposing that Medicaid physician fees for the 0-21 age group be increased to Medicare levels as a first step in increasing all physician fees, however as the session progressed the Agency for Health Care Administration's proposal to increase Medicaid physician fees was ignored and we were unable to get anything more than a 4% increase beginning in April, 2002 for physician services for the 0-21 age group, a woefully inadequate response to years of neglect.

It was also difficult to accept that, after several years of attention to children's health care due to the enactment of the federal SCHIP legislation, children's health care issues were set aside as care for the elderly, particularly in nursing homes, was addressed. Additionally, the continued escalation of costs for prescription drugs once again outstripped resources within the Medicaid program and dwarfed the Medicaid physician fee issue as legislators tried to find answers to moderate an ever increasing price tag for drugs.

As the Session concluded we were successful in saving Medipass as a managed care option in the Medicaid program and new opportunities were legislatively directed to establish Children's Provider Networks. Many thanks to all the Pediatricians who responded to our requests for information about the Medicaid program and in particular about Medicaid HMO's. Without proof that problems we spoke to were statewide issues the Society could not have swayed legislators to our point of view.

Despite our disappointments with the Medicaid program and our inability to generate interest in addressing concerns with the KidCare program several other children's issues were favorably addressed by the Legislature. However, the Governor again threw us a curve ball as he vetoed legislation which would have required helmets for under 16 year old motorized scooter riders; required children under the age of 8 to use booster seats in motor vehicles; enforced consumer product safety standards for infant cribs; and, created an integrated community based system for children with learning disabilities. The Governor also vetoed funding and proviso language within the budget which would have eliminated the local funding match requirement for the Healthy Kids portion of the KidCare program for the upcoming fiscal year.

Some years are harder than others, this one has been particularly rough, but we never give up and are now preparing for the 2002 Legislative Session which begins January 22, 2002.

The following are laws which have an affect on children, patients or the practice of medicine.

CS/HB 475 — Public Health (CH. 2001-53)

Numerous provisions of public health law are amended as follows:

- Exempts from "conflict of interest " restrictions applicable to public employees, physicians employed by or under contract to Children's Medical Services who provide services to CMS patients under specified conditions;
- Expands sites and personnel who may accept abandoned newborns to paramedics and emergency medical services stations;
- Expands use of Emergency Medical Services Trust Fund monies to injury prevention programs;
- Grants rulemaking authority to the Department of Health to define cardiopulmonary resuscitation courses for emergency medical technicians and paramedics;
- Clarifies that medical consent for a minor under a power of attorney (ch. 743, F.S.), includes the power to consent to necessary surgical and general anesthesia services;
- Requires school health programs to be consistent with statutes governing state school health services;
- Revises requirements for supervision of nonmedical school district personnel performing health-related services;
- Makes the Florida Patient's Bill of Rights and Responsibilities applicable to all handicaps;

Effective Date. July 1, 2001

CS/SB 1558 — Health Care / Professional Regulation (Ch. 2001-277)

This law amends numerous provisions relating to medical and health care practitioners and programs. Among the provisions are the following:

- Requires the Florida High School Activities Association to adopt bylaws which require all students participating in interscholastic athletic competition or who are candidates for an athletic team to pass an annual medical evaluation before participating in practices, tryouts, workouts, competitions, or any other physical activity associated with a position on an athletic team. Evaluations must be performed only by medical physicians, osteopathic physicians, advanced registered nurse practitioners, or chiropractic physicians. Additionally, the law directs that if an abnormality of the cardiovascular system is detected participation in athletic activities may not be allowed unless an electrocardiogram (EKG) or other cardiovascular assessment indicates the abnormality will not place the student at risk during athletic activity. Students may be exempted from the evaluation if parents object, in writing, to the evaluation due to religious beliefs and no person is held liable in the event the student is injured.
- The definition of infants qualifying for coverage under the Neurological Injury Compensation Act (NICA) is changed to 2,000 grams for cases of multiple gestation born after July 1, 2001. Funeral expense awards not to exceed

*(See **Legislative**, page 22 ▸)*

Region's Largest HMOs Suffer Painful 1st Quarter

Greg Groeller
Staff Writer, Orlando Sentinel

Note:

The Florida Pediatrician has had and continues to have a policy to print an article on Managed Care in each issue. This policy will be adhered to so long as suitable articles are submitted. Both sides of the issue will be represented.

Publication of an article does not indicate any endorsement of the opinion by *The Florida Pediatrician* or by the FCAAP/FPS.☐

[Greg Groeller is a staff writer for the Orlando Sentinel. This article appeared on July 16, 2001, and has information which should be of interest to all of our readers.]

For Central Florida's five largest health-maintenance organizations, the first quarter of 2001 was a painful reminder of the industry's losing battle to rein in costs.

Prudential Health Care Plan Inc., Cigna HealthCare of Florida Inc. and United Healthcare bled red ink, while Aetna US Healthcare and Blue Cross and Blue Shield of Florida Inc.'s Health Options saw their profits decline significantly.

The plans' results were included in data released earlier this month by the Florida Department of Insurance. The data painted a bleak financial picture for Central Florida's largest plans:

- Prudential had a loss of $18.4 million, compared with a $29.1 million loss for the year-ago quarter.
- United Healthcare lost $2.9 million, compared with a profit of $5.5 million.
- Cigna had a first-quarter loss of $387,013, compared with a profit of $4.5 million a year ago.
- Blue Cross' Health Options saw its first-quarter profits drop 79 percent to $3.9 million from $19 million.
- Aetna US Healthcare saw its profits fall 90 percent to $551,960 from $5.7 million in the first quarter of 2000. Aetna Inc., which purchased Prudential Health Care Inc. in 1999, plans to integrate the money-losing Prudential HMO into Aetna US Healthcare in the next few years.

Prudential, Cigna and United Healthcare were among a dozen plans to lose money in the first quarter, according the Insurance Department.

Collectively, Florida's 31 HMOs lost $19.9 million in the first quarter, compared with a profit of $11.4 million in the first quarter of 2000. The industry has lost money for three of the past four quarters.

Nationwide, HMOs are struggling to control rising health-care costs. In Florida, the industry's combined first-quarter revenue rose 17 percent to $3.5 billion from $3 billion. But payments to doctors and hospitals rose 19 percent to $3.1 billion from $2.6 billion.

On the bright side, the first-quarter loss was much smaller than the $114.9 million the industry lost in the fourth quarter of 2000, in part because of premium increases -- averaging 12 percent -- that took effect in the first period.

First quarters generally are the best for HMOs because that is when rate increases kick in and contracts with new commercial customers begin.

Briefly. . .

U.S. Medical Group Inc. says it has been awarded a one-year contract renewal with the North Carolina State Department of Corrections, effective July 1. It is the third consecutive contract renewal for the Orlando-based company, which provides mobile surgical operating rooms to prisons. . . .

Bio-One Corp. of Lake Mary says it has signed a letter of intent to acquire a nutritional-supplement manufacturer. Bio-One did not disclose the name of the target company, which it said has annual revenue of $7 million. Bio-One announced in June that it had been formed recently by a group of executives to build a nutritional-supplement company through acquisitions. . . .

Humana Inc. said it relocated an office that serves Volusia and Flagler counties from Ormond Beach to Daytona Beach. Effective today, 85 employees will begin working in a 31,536-square-foot building on Executive Circle in Daytona Beach. The office will offer new services such as retirement planning to Humana's 38,000 members in the two-county area.

F.Y.I. - Seniors

*[Some of the best known names in Pediatrics in the latter half of the last century are remaining active by their participation in the Section for Senior Members. Their **Bulletin** contains the collective thoughts of many of these pediatricians, and is commended to the reading of the younger members of AAP as well. The Bulletin Editor is Bob Grayson, from our own Chapter. We would like to publish their thoughts at intervals, and a recent edition contained a great little piece of philosophy. Here it is:]*

"The greatest dangers to democracy seem to me to be apathy, a lack of persoal responsibility and inability to look courageously at the world. [Other dangers] are not fundamental but they become dangerous because people are indifferent and cowardly".

Eleanor Roosevelt☐

The "Ticked Off" Column

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

[Each issue will focus on a different Pediatric Residency Program. In this issue, we feature the University of Florida-Jacksonville]

The UF-Jacksonville Pediatric Residency Program

Nicole Mark, M.D.
Jacksonville, FL

The UF-Jacksonville Pediatric Residency Program would like to highlight some of its community service/advocacy activities. During the 2000 Christmas season the ER collected aluminum cans that were recycled for money, and bought turkeys with the revenue. One of the ER nurses prepared the turkeys and the Pediatric Residents and staff served a feast for families living at a local public housing project. Pediatric residents have also visited a homeless shelter and helped plan activities for the children. They are currently in the process of incorporating the Florida resident safety issues into their community rotation. They are working with a public health department serving the indigent in Jacksonville as well as at a local high school for ten mothers and their babies.

FCAAP RESIDENT SECTION UPDATE

Joe Jung, D.O.
Tampa FL

The Resident Section of the Florida Pediatric Society/FCAAP was organized last year with the goal of improving communication between Florida's seven residency programs. It also serves as a network for exchange of ideas and resources.

Over the past year, we have embarked on several activities. The group identified areas of importance, and created plans to address each goal. We wanted to assist residents in the post-training employment hunt and created a jobsite on the FPS website. Here, practices seeking physicians may enter demographic information about an opportunity. Residents seeking employment may also enter CV's for review.

Pediatric residents are often not aware of the services available to them through the AAP and FPS. To this end, we created a "speakers bureau" of local physicians with experience in AAP business to speak at each residency program. We will be repeating this program annually and invite any interested parties to contact the residency program near you.

We have held monthly teleconferences to keep programs up to date. Each program has two representatives to participate in calls. In addition, we felt it important to have some face to face meetings. Each program sent a representative to the AAP annual meeting in Chicago. We also held our first resident section meting at the FPS annual meeting in Orlando in June.

Finally, we identified community involvement as an area of importance. Several programs adopted ideas from each other. In this way, Reach Out and Read, a program that encourages family reading, and Not One More, a gun violence awareness program,were spread to other areas of the state. We also participated in our AAP District X project focusing on child safety issues.

We accomplished a lot during our first year and look forward to the upcoming year with plans to build upon existing programs along with establishing new ones. For more information about the Resident Section, contact Dr. Joe Jung, Chairman, at jjung@hsc.usf.edu

Please Note

The resident section of the Florida Pediatric Society welcomes you to visit our website. There, you have access to a job posting directory. Simply fill in some simple information regarding the position you have available, and residents completing their programs from all over the state will have instant access to your information. How to enter the info? Go to the home page - fcaap.org, and click on "residents". From there click on the icon for employers to enter info. It's as easy as that. Thank you for your help - we hope it helps you! -The Resident Section.

Congratulations to

Dr. Chuck Weiss for a whirlwind month of surprises: He turned the great age of 80 years, won the AAP election for appointment to the SCOT Executive Committee and received a promotion to Clinical Professor at the USF Department of Pediatrics!
Cheers, Dr. Weiss!

[Dr. Weiss is also a regular contributor to *The Florida Pediatrician. Look for "Add-a-Pearl" in later pages.]*

The 2001 AAP Elections

Elected:

Dr. Steve Edwards - President Elect

Dr. David Tayloe - District IV Chairman
Dr. Iris Snider - District IV Vice Chairman
[FYI: we are in District X

Congratulations are in order!

AAP Supports Stem Cell Research

To help inform and hopefully shape the public debate on human stem cell research, the American Academy of Pediatrics has released a new policy statement (dated July 13th) stating that human embryo research should be permitted under certain conditions, given the anticipated benefits such research could have for children.

"Human Embryo Research," a statement written by the AAP Committee on Pediatric Research and AAP Committee on Bioethics, declares that stem cell research could, for children, lead to "treatments for spinal cord and bone injuries, diabetes, primary or acquired immunodeficiencies, cancer, metabolic and genetic disorders, and a variety of birth defects." In addition, long-term benefits of such research "could potentially provide insights into the approximately 40 percent of anatomic defects in infants for which there are currently no explanations."

Human embryo research must only be done under certain, limited conditions. The American Academy of Pediatrics recommends a policy that would:

- Allow federal funding for research using donated frozen embryos produced during the process of in vitro fertilization that would otherwise be discarded by the individual or couple. The Academy does not support the creation of embryos for research.

- Have the U.S. Department of Health and Human Services (DHHS) establish an oversight committee, in addition to the study sections of the National Institutes of Health and Institutional Review Boards (IRBs), to review compliance with scientific and ethical guidelines of all proposed and funded research on human embryos.

- Have DHHS develop guidelines for IRBs about the appropriate conduct of research involving human embryos.

The statement lists the conditions under which embryo research should be conducted, as well as recommendations for the informed consent process for embryo donors.

The American Academy of Pediatrics will send a letter and a copy of the policy statement to President Bush and key members of Congress urging them to support federal funding of human embryo research.

Copies of the AAP policy statement “Human Embryo Research" can be obtained on the web. The statement will also be published in the September issue of the peer-reviewed journal Pediatrics.

Nutramigen Recall

The AAP listserve announced the recent recall of Nutramigen 16-ounce powder infant formula and 32-ounce ready-to-use infant formula. *Please note that there was nothing wrong with the formula*. There was an error in the Spanish-language usage instructions! The AAP referred readers to the Mead Johnson press release:
http://www.meadjohnson.com/about/pressreleas/nutramigenengpr.html

Immunization Update

DTaP supplies may experience a slight “hiccup” in distribution. Although we do not foresee major problems, we encourage you to keep abreast of the situation by monitoring the Members Only Channel of the AAP Website. To keep up-to-date on influenza vaccine supply now and throughout the coming season, please see:
http://www.cdc.gov/nip/flu

Your Executive Committee

[The Executive Committee, by the Constitution of the Society, is responsible for carrying on the business of the Society between meetings of the society-as-a-whole]

At present, the Executive Committee includes:

Officers:		Term of Office
President	Richard L. Bucciarelli, MD	2001-2003
President-elect	Deb. Mulligan-Smith, MD	2001-2003
1st Vice President	David Marcus, MD	2001-2003
2nd Vice President	Patricia Blanco, MD	2001-2003
Immediate Past President	Edward N. Zissman, MD	2001-2003
Regional Representatives:		
Region I	Thomas Truman, MD	2000-2002
Region II	Donald E. George, MD	2001-2003
Region III	Thomas Benton, MD	2001-2003
Region IV	David E. Milov, MD	2001-2003
Region V	Patrick Yee, MD	2000-2002
Region VI	Bruce Berget, MD	2201-2003
Region VII	Jorge Del Toro-S., MD	2000-2003
Region VIII	Charles R. Bauer, MD	2001-2003
Alternate Regional Representatives		
Region I	Randall Reese, MD	2000-2002
Region II	James A. Waler, MD	2001-2003
Region III	Jyoti Budania, MD	2001-2003
Region IV	Lloyd Werk, MD	2001-2003
Region V	Carol Lilly, MD	2000-2002
Region VI	Emad K. Salman, MD	2001-2003
Region VII	Marshall Ohring, MD	2000-2002
Region VIII	Kimberly Schwartz, MD	2001-2003
Ex-Officio Members:		
Pediatric Department Chairmen		
UF Pediatric Chair	Douglas J. Barrett, MD	
UM Pediatric Chair	R. Rodney Howell, MD	
USF Pediatric Chair	Robert D. Christensen, MD	
Nova Southeastern Pediatric Chair	Cyril Blavo, DO	
Key Strategic Plan Chairmen		
Advocacy Committee	Richard L. Bucciarelli, MD	
Communications	Deborah Mulligan-Smith, MD	
Practice Support	Jerome Isaac, MD	
Member and Leader Development Committee	Thomas Abrunzo, MD	
Organizational Development Committee	Edward T. .Williams, MD☐	

From Our Communications Chairman

NEW STUDY SHOWS INCREASE IN WELL-CHILD VISITS LEADS TO LESS HOSPITALIZATIONS

There is very limited information on the effectiveness of well-child care on health outcomes in children. A new study published in the July issue of the Journal of Pediatrics provides evidence that good preventive care is beneficial to the health of young children. Examining the Medicaid records of over 300,000 children in California, Georgia and Michigan during the first 2 years of their lives, the authors found that adherence to the American Academy of Pediatrics guidelines on well-child visits was related to a decrease in avoidable hospitalizations among poor and near-poor children, regardless of race, family poverty-level or health status of the child.

In California and Georgia, children who were up-to-date with their well-child visits were more than 40% less likely to experience an avoidable hospitalization. In Michigan, children with up-to-date well-child visits were about 20% less likely to experience such hospitalizations. The authors conclude that "every child needs to be in a health care system in which they can be assured of continuous primary care, the providers actively engage in outreach, a personal bond is formed between the physician and the family, and education and support are provided to > families."

Source: Hakim RB, Bye BV. Effectiveness of compliance with pediatric preventive care guidelines among Medicaid Beneficiaries. 2001, J Pediatrics 108(1):90-97

Deborah Mulligan-Smith, M.D.☐

Note:

Visit our society's permanent website at:

http://www.fcaap.org

for all you want to know about our society, including a summary of The Florida Pediatrician.☐

Note:

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

http://www.aap.org/member/chapters/florida.htm. ☐

[The Florida Physicians Insurance Company (FPIC) is endorsed and sponsored by the Florida Chapter of the American Academy of Pediatrics as its exclusive carrier of malpractice insurance for its members. In each issie, FPIC will present an article for our readers on matters pertaining to risk management]

Managed Care Plans; Pick One, *But Not Any One*!

By Cliff Rapp
Vice President of Risk Management, FPIC

. Implementing effective loss prevention measures in their practice of medicine helps physicians avoid unnecessary liability exposure. When participating in managed care, the same approach must be taken. Loss prevention measures should begin with a careful evaluation of the managed care entity before a "Provider Agreement" or contract is signed. Concern should be focused on the plans history with regard to provider payment and should include confirmation of the overall financial soundness of the plan as well as the type of enrollees that it seeks. It is also wise to determine if other physicians affiliated with the plan are supportive of its administrative, incentive, and utilization review aspects. And specifically, plan accessibility.

After an evaluation of the organization itself has been done, physicians should further investigate the plan's *payment provisions*. Determine if there are provisions that will limit your compensation to the largest amount accepted for the same service by another affiliated provider. Also consider the extent and scope of quality assurance activities and how *quality assurance documentation* of the plan and provider will be protected from discoverability. Be cautious of ambiguous contractual language and determine how the plan defines *medical necessity*. The *credentialing process and utilization review* activities are often overlooked. An inadequate system could leave you exposed to administrative-type liability, which is not covered by most malpractice insurance policies.

An important question to ask is: What constitutes *covered services*? Carefully review this aspect of the plan! There have been many cases where physicians not completely aware of what services are covered, have been held financially responsible for medical care and treatment that they could not possibly provide within the confines of their medical specialty or practice setting. Alternatively, standard of care issues could arise.

Termination of the contract may not top the evaluation list right now. However, should unexpected changes in your practice or professional association take place, physicians may need to exercise thier *termination option* or *agreement*. Be careful of any limitations set forth pertaining to plan termination in light of the potential exposure to breach of contract, which could include patient abandonment.

Remain cognizant of the fact that the "Provider Agreement" is a legally binding contract. It is imperative that physicians negotiate their managed care contract correctly in order to promote success of that relationship and avoid unnecessary liability exposure. When necessary, seek guidance from your personal attorney or professional liability carrier.

The above article is provided by FPIC for informational purposes only and is not intended as legal advice. For more information, please contact FPIC's Risk Management department at 800-741-3742, extension 3016.□

F.Y.I. - Seniors

Free Audio Tapes on Financial Planning Available!

Courtesy of the AAP Section on Seniors, all seniors are eligible to receive a set of complimentary audiotapes on Financial Planning from the AAP's 2000 Annual Meeting. The session was sponsored by the AAP Section on Seniors and includes talks from The Motley Fools Group, Morningstar, Inc., and TIAA-CREF

To request your set of tapes, please send an e-mail to jburke@aap.org or call (800)433-9016 ext 4759 or send a fax to 847-228-7035.

Jackie Burke
Staff, AAP Senior Section□

C.A.T.C.H.

Report from Our C.A.T.C.H. Facilitators

The main news this quarter from CATCH is our success with the 2000 planning grants. Nationally there were 212 regular grant applications (62 eventually approved and funded) and 33 resident grant applications (20 eventually approved and funded). Florida had 10 regular applications and 2 resident applications. Three regular grants and one resident grant were eventually approved and funded. The four grants and their primary pediatrician applicants are as follows:

1. Christina Canody, MD, Tampa, for Everyone Belongs: Connecting Kids to Medical Homes ($5460)

2. Ana Maria Hernandez-Puga, MD, Ft. Lauderdale, for Access to Medical Home:Bonding High Risk Families to Community Health ($7500)

3. Robert H. Threlkel, MD, Jacksonville, for Healthy Child Care Jacksonville ($6000)

4. Michele Lallouz Fisher, MD, Miami Beach, ($3000)—our resident grant.

Our state therefore received a total of $21,960 from the CATCH program this year. It should be remembered that the national office has found that there is a $68 return in child health programs for every dollar spent from the CATCH planning grant funds (from programs developed from these planning teams).

Karen H. Toker, MD
Deise Granado-Villar, MD
Florida CATCH Co-Facilitators☐

Florida C.A.T.C.H. Past and Present

The first statewide Florida C.A.T.C.H. meting was held on September 20, 1997, at Amelia Island Plantation in Fernandina Beach, Florida. Pat Blanco, M.D., our first Florida C.A.T.C.H. Facilitator, organized the meeting, which was very successful. Pat remained as the state C.A.T.C.H. Program Facilitator until January, 2000, when she moved to become the new District X C.A.T.C.H. Facilitator. Deise Granado-Villar, M.D. and Karen H. Toker, M.D. became the new Co-Facilitators for the state. At this time, a new organizational structure, that of regional C.A.T.C.H. facilitators, was established. These regions correspond with FCAAP Regions: Dr. Toker is responsible for Regions 1 - 4 and Dr. Granado-Villar for Regions 5 - 8.☐

On a national basis, planning grant funding has been an active process. Statistics are as follows:

Grant applications received nationally - 212
Grants funded nationally - 62
Grant applications from Florida - 10
Grants funded from Florida - 3 (see above)
Resident grant applications nationally - 33
Resident grants funded nationally - 20
Resident grant applications from Florida - 2
Resident grants funded from Florida - 1 (see above)

Drs. Granado-Villar and Toker reviewed all of the applications from Florida.☐

Immunize for Healthy Lives

For the eighth year in a row, the AAP is joining forces with McDonald's restaurants and the National Association of County and City Health Officials on the "Immunize for Healthy Lives" campaign, a national immunization program. Last year nearly 2,500 McDonald's restaurants across the country participated in the effort. Nearly one in five American toddlers remains vulnerable to disease because he or she is not fully immunized. Through this public education effort, which includes distributing immunization education materials on trayliners and in leaflets, the campaign partners hope to increase awareness and immunization rates in communities across the country.

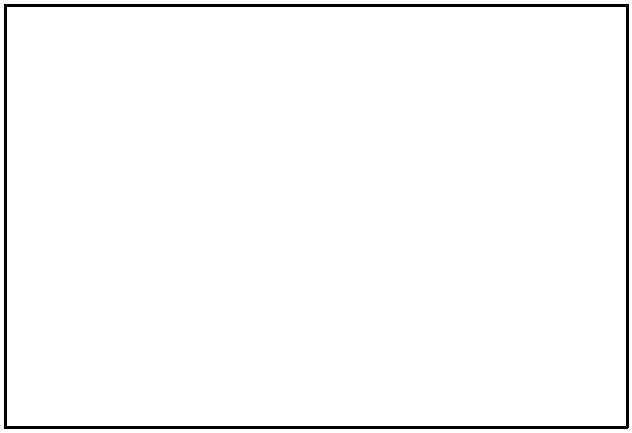
From the AAP☐

Deliver the Dream

Deborah Mulligan-Smith, M.D.
President-Elect
Coral Springs, FL

"She doesn't understand being in the hospital and why "daddy" can't fix everything and then we all go home…"

As health care professionals we know all too well, that almost all families are touched by illness or crisis during the course of a lifetime, but some families are struck particularly close to home. When a child develops a life-threatening disease, or a spouse is diagnosed with a debilitating illness, the impact on the entire family is intense and often overwhelming. While there are camps that assist children in coping, there are very few facilities specifically designed to help the entire family gain strength, mend spirits and learn how to be families again. Deliver the Dream is a non-profit mountain retreat and enrichment center providing unique development experiences and support for children and families in crisis and individuals in need.



From the left: Drs. Versa Myers, Bill Cosby, Ora Wells, Deborah Mulligan-Smith, Karen Moffitt

The program was inspired by Pat Moran, president and CEO of JM Family Enterprises, Inc., a company that is ranked as the 18th largest privately owned business in the U.S. by Forbes magazine.

Bill Cosby, PhD supports Deliver the Dream as national spokesperson. Country music artists, Craig Moran, Jeff Carson and Suzy Bogguss sing to support the cause. Other special Deliver the Dream friends include Susan Sarandon and Goldie Hawn.

More than 200 acres of beautiful landscape, majestic waterfalls, streams and mountain trails provide the perfect year-round setting for this unique mountain retreat. Deliver the Dream is working now to open its doors in the Spring of 2002.

Medical Advisory Board Members include Drs. Deborah Mulligan-Smith, Versa Myers and Ora Wells of the Florida and North Carolina AAP Chapters and Florida Diagnostic and Learning Resources Systems Director Karen Moffitt. Valuable AAP and Emergency Medical Services for Children (EMSC) policy statements, education programs and products are pillars in constructing the programmatic direction of the organization. Among these resources are the PEPP Course, Office Based Preparedness for Pediatric Emergencies, How to Prevent and Handle Childhood Emergencies, the Family Readiness Kit, Family Centered Care, Children with Special Health Care Needs Kit just to name a few. Deliver the Dream meets a vital need for Florida families suffering from trauma -- a need that has been unfulfilled until now.☐

FYI - Important

[Received from Kelli Walker-Ferrell, R.Ph., Senior Pharmacist, Medicaid Pharmacy Services]

Mr. Bob Sharpe asked me to respond to your concerns regarding counterfeit-proof prescription blanks.

As you are aware, on July 1, 2001, Florida Medicaid began requiring medical practitioners who prescribe drugs to use counterfeit-proof prescription blanks when writing prescriptions for Medicaid patients. However, during the transition period of ordering and receiving these counterfeit-proof prescription blanks, you may write prescription orders on traditional blanks. This transition period will be effective through September 30, 2001. After this date, pharmacies will no longer be reimbursed for hard copy prescription orders on traditional blanks.

Prescriptions that are transmitted by other means, such as facsimile, electronic, telephone, or transfers, are exempt from this new requirement.

Again, we appreciate the service you provide to Medicaid recipients and your efforts to help us conserve scarce resources by working with us to stop fraud and abuse.☐

President

(◂ Continued from page 3)

administration to ensure that reimbursement for all programs in KidCare is at least equal to reimbursement for similar services under Medicare. But KidCare and Medicaid are just the beginning. Our Pediatric Council will continue to meet with several managed care organizations and will advocate for legislation, which will increase payment and decrease the hassle associated with all forms of managed care.

Third, while we continue to work with the legislature to improve the safety of our children by addressing violence, booster seats, cribs, and seat belts, we must also become more aware and active in responding to the emerging evidence of environmental hazards facing our children.

Finally, we must remember that we are a chapter of the American Academy of Pediatrics. The Chapter must work to have more our of members appointed to national committees and those who have national appointments must share their experiences with the rest of our membership. As a Chapter we must carefully analyze the Academy's proposal for universal coverage, the Medikids Act of 2001, and be prepared to actively work with our state and national representatives for its enactment.

This agenda can not be accomplished by the Chapter acting alone. We must continue to reach out and form coalitions with other professional and grassroots advocacy groups such as the Center for Florida's Children and Florida's Child Health Coalition as well as the FMA, the FAFP, and our pediatric subspecialty societies.

I know the list is long and the challenges are great, however I honestly feel that we have the talent and the dedication of our membership to accomplish these goals and much more in the next two years. I appreciate the confidence you have shown in me by electing me President and I look forward to serving you, with your officers and the other members of our executive committee. Together we can make a difference for you and for the patients and families we serve.

With warmest regards,

R.L. Bucciarelli, MD
President, Florida Chapter
American Academy of Pediatrics.□

Environment

(◂ Continued from page 7)

of the surface contamination to the hand, reported at a meeting of the International Society of Exposure Analysis last October. Many contaminants come from the vast array of indoor chemicals that Emma's parents take for granted, such as cleaning products, solvents, deodorizers and air fresheners. Also, residues left on dry-cleaned clothes. Even cooking fumes are loaded with toxins. When Emma's mother made blackened catfish last night, for example, some of the PAHs in the smoke found their way into the living room carpet. Cigarette smoke, pet hair, dust mites and mold add to the load of indoor pollutants.

- Researchers at Stanford University videotaped 80 children at normal play for up to eight hours each, then painstakingly noted every move they made. The kids' hands touched something 340 times per hour on average, and they were in contact with some surface 65 per cent of the time, or 6 ½ hours out of a 10-hour day.
- Pollutants from outside are tracked in. The dog, runs in from playing with the older brother and sister in the back yard. This brings in some of the pesticides sprayed on the lawn a few weeks ago. The pesticide residues on dog paws are between 55 and 250 times the background concentration. Today 80 to 90 per cent of US house holds use three or four different pesticide products, either indoors or outdoors, per year. Shoes and paws increase the pesticide loads in carpet dust as much as 400 fold.
- "grasshopper effect" – Pesticides, PAHs and other semi-volatile compounds don't stay put once they are in the carpet. They evaporate, drift from place to place and then precipitate back onto the carpet, toys or other household objects, where the cycle starts again. This means that people who use pesticides indoors may inadvertently expose small children to significant contamination, even if they're careful to keep kids and research suggests that for children mouthing the toys, or touching the toys and then mouthing their hands, the dose could be significant. The potential for exposure would persist for many days after the application.
- Toys, he says, are ideal for accumulating pesticides. Sampling is done with with fuzzy toys because they pick up the pesticides so well." Semi-volatile pesticides such as malathion and propoxur probably spread the same way
- pesticide lurks in fitted carpets between 10 and 33 years, in one case 1+ gram of permethrin was found in 1 square meter of carpet. It was not uncommon to find two to five different pesticides at concentrations of between 10 and 100 milligrams per square meter, many times the amount applied in a single application.
- All seems well in this healthy family. But in the US, Britain and other developed countries, the incidence of children's diseases that have a significant environmental component, including asthma, allergies and even cancer, continues to rise. And according to researchers carpets may be one of the major causes.

The above is an extract from an article published by Rebecca Renner, a science writer based in Williamsport, Pennsylvania From New Scientist magazine, 05 May 2001

Full version available upon request.

(◂ Continued from page 9)

penicillin (PCN). When making antibiotic choices it is important to "go local". In other words, knowing the local resistance patterns is the key to successful antibiotic treatment of sinusitis.

Recommendations for initial therapy in children with mild symptoms and no history of receiving antibiotics in the last 4 to 6 weeks are shown in Table 1. Amoxicillin is acceptable and preferable first line therapy for the treatment of uncomplicated sinusitis, starting at 45-90 mg/kg/day, (divided b.i.d.). For individuals who are penicillin-allergic, macrolides such as Azithromycin, Clarithromycin or Erythromycin could be considered. Alternatively, Bactrim (trimethoprim and sulfamethoxazole) can be used.

When treating children with moderate symptoms who have not previously received antibiotics or have mild symptoms and have received antibiotics within 4-6 weeks, Augmentin (amoxcillin/clavulanate) is recommended as the first line agent. Clavulanic acid is a broad-spectrum irreversible inhibitor of beta-lactamase. Combinations such as amoxicillin/clavulanic acid are useful in treatment of bacteria such as *Haemophilus influenzae* and *Moraxella catarrhalis*. If amoxicillin is chosen, start with a dose of 80-90 mg/kg/day (divided b.i.d.). Additionally, Cefpodoxime proxetil (Vantin) and Bactrim can be used. For children who are PCN-allergic, use Azithromycin, Clarithromycin, Erythromycin, or Bactrim. Clindamycin is also recommended.

For children with more moderate disease who have received antibiotics in the last 4-6 weeks, use Augmentin or a combination of high dose amoxicillin or clindamycin which provide gram positive coverage plus Vantin or Suprax (cefixime) therapy to provide gram negative coverage. For PCN-allergic individuals, Bactrim plus clindamycin is recommended.

Most patients will have a brisk response to antimicrobial intervention. Parents will frequently report a dramatic improvement within 3-4 days. Sinus disease should be treated for seven days after the child is well. The treatment of sinusitis usually requires a 10 to 14 day course of therapy, but frequently longer courses are required. Switching therapy is recommended if there is a lack of response in 72 hours after initiation of therapy. Table 1 provides therapeutic options if there is a lack of response or worsening symptoms in 72 hours.

Table 1
Treatment of Acute Sinusitis

No prior antibiotics		No improvement in 72 hours
Amoxicillin	→	Add Augmentin
Ceftin	→	Augmentin/Amoxicillin
Vantin	→	Augmentin/Amoxicillin
Augmentin	→	add Amoxicillin
Rx within 4-6 weeks		No improvement in 72 hours
Augmentin/Amoxicillin	→	Clindamycin/Bactrim
Amoxicillin 90 mg/K	→	Clindamycin/Bactrim
Penicillin-allergic		No improvement in 72 hours

Most authorities believe that sinus x-rays and CT scans are not needed to diagnose uncomplicated cases of acute sinusitis. Standard x-ray views include Waters view, best for imaging the maxillary sinus and the ethmoid; Caldwell view, better for ethmoid and frontal; and the lateral view, best for the sphenoid. The goal of obtaining standard views is to place the sinuses close to the film and at an angle so that the temporal bone shadows are not superimposed. Common radiologic abnormalities consistent with sinusitis include air fluid level, suggesting an acute process, and opacification, suggesting secretions, polyps or retention cysts. When evaluating for thickening of the mucosa, which suggests chronic inflammation, one should look at the lateral maxillary walls. Mucosal thickening is positive if there is 4 to 6 mm of opacification.

Two main controversies surround the imaging of sinusitis in the pediatric population. The first is the use of plain radiographs versus coronal CT scan. Plain radiographs are less costly and more widely available, but they both under- and over diagnose sinus soft tissue changes. The second controversy in imaging pediatric sinusitis is that there is a high incidence of soft tissue findings on plain films or CT in patients who have no evidence of sinus disease. When acute sinusitis is diagnosed and appropriately treated, no imaging studies are indicated if full clinical resolution occurs.

Patients with acute sinusitis persisting after ten days of appropriate therapy, or with chronic sinusitis needing evaluation should undergo coronal CT scans of the sinuses because these scans are more specific than plain films and allow better assessment of the OMC. CT scan provides better assessment of the ethmoid sinus, and in complicated cases of acute sinusitis with CNS or bony or orbital extension, helps a surgeon plan an approach. Proptosis, impaired vision, limited extra ocular movement, severe facial pain, notable

(Continued next page ▸)

(◂ Continued from page 19)

swelling of the forehead, deep-seated headaches or toxic appearance are all symptoms for which a CT scan is indicated.

Chronic sinusitis is defined as sinus symptoms persisting more than four to six weeks. These individuals have symptoms similar to those of acute sinusitis. The role of bacterial infection in chronic sinus disease is less certain and the optimal management has not been defined. Chronic sinus disease may be related to anatomic abnormalities, allergy, tension headaches, temporal mandibular joint disease, vasomotor rhinitis, immunodeficiency or asthma.

A child should be referred to an allergist when there is a consideration of allergic or immunologic basis for their sinus disease, such as food allergies or environmental factors. Allergy tests, allergy shots or an immunological work-up may be necessary.

Reasons for referral to Otolaryngology include nasal polyps that can cause obstruction and lead to sinusitis by obstructing the nasal ostia. If there are resistant organisms, a sinus biopsy can help you identify them, and thereby direct antibiotic therapy. Biopsy can identify diseases such as ciliary dyskinesia.

Various adjuvant therapies may be used to treat children with chronic sinus disease. Steam inhalation or humidification help liquefy secretions. There are decongestants which include topical agents such as Afrin (Oxymetazoline). This agent is associated with rebound nasal congestion and should not be used longer than three days. Systemic/oral agents include Sudafed (pseudoephedrine). Antihistamines can be helpful in individuals with allergy. Sedating agents include Benadryl (diphenhydramine) or Atarax (hydroxyzine); non-sedating antihistamines include Claratin (loratadine) or Zyrtec (cetirizine). Nasal steroids are frequently used to reduce nasal swelling and may be particularly effective in individuals with allergies. Nasal saline lavage prior to inhaled steroids may be used. For individuals with significant inflammation oral steroids may be prescribed.

Antibiotic treatment for chronic sinusitis consists of broad spectrum single agents with or without the addition of anaerobic coverage. As in acute sinusitis, antibiotics should be continued for seven days past the resolution of symptoms. Frequently antibiotics are needed for 4 to 8 weeks.

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Kudos....

to Gary Birken, M.D.

Dr. Birken, a Hollywood, FL pediatric surgeon with Joe DiMaggio Children's Hospital, has written *"Error in Judgment"*, the first of three books. This book is a medical/legal thriller published by Vista Publishing, Inc., Long Branch, NJ.

to Elisa Zenni, M.D.

Dr. Zenni, a Clinical Assistant Professor of Pediatrics at the University of Florida, is one of two new members inducted into the Society of Teaching Scholars. The Society is designed to acknowledge and reward faculty for leadership, innovation and excellence in teaching.□

UPCOMING AAP MEETINGS

AAP NATIONAL CONFERENCE AND EXHIBITION
(Formerly AAP Annual Meeting)

2001	San Francisco, CA	October 20-24
2002	Boston, MA	October 19-23
2003	New Orleans, LA	November 1-5□

Deborah Mulligan-Smith, M.D.
Communications Committee
Coral Springs, FL

[Dr. Mulligan-Smith found this article and shares it with us.]

Insurance Lobby: Patients' Rights Bill Is Bad News

NEW YORK (Reuters Health) - Some 6.5 million Americans would lose employer-sponsored health coverage under a patients' rights measure to be considered by members of the House of Representatives, the nation's insurance lobby said Wednesday.

That grim outlook is based on the Health Insurance Association of America's (HIAA) actuarial analysis of patient protection legislation sponsored by John Dingell (D-MI), Greg Ganske (R-IA) and Charlie Norwood (R-GA).

According to the analysis, the number of employers offering health coverage in 2003 would likely drop 5% compared with estimates for 2002. In some cases, employees would stop offering health benefits. In other instances, employees would decline coverage because of their inability or unwillingness to pay higher out-of-pocket costs passed on by employers faced with higher premiums.

That would leave 3.7 million people uninsured and another 2.8 million scrambling to enroll in existing government programs, such as Medicaid or the Children's Health Insurance Program--thereby driving up the cost of those programs.

Nearly half (46%) of employees with incomes below 200% of the federal poverty level who work for employers who drop coverage would become uninsured, HIAA predicted. Only 7% would retain private coverage.

Thirty-seven percent of those with incomes greater than 200% of poverty who work for companies that drop coverage would lose their insurance.

"These findings are significant because supporters of the Dingell-Ganske-Norwood 'patient protection' bill constantly downplay how this ill-conceived legislation would increase the number of uninsured Americans," according to HIAA Interim President Dr. Donald A. Young. "These so-called 'protections' would mean nothing to those who will lose their health insurance or the 42 million Americans who have no health insurance."

But Ron Pollack, executive director of Families USA, told Reuters Health that HIAA's numbers are a "wild exaggeration" of the truth.

"What is extraordinary is that when it comes to the double-digit increases in premiums that occurred last year, the insurance industry is stone cold silent about what the impacts of those cost increases are on the uninsured. But when a much smaller increase occurs to support patients' rights, they act as if the sky is falling about the uninsured," he said.

Insurers raised premiums an average of 10.5% last year, 2.5 times as much as the added cost of patients' rights legislation, Pollack noted. That should have caused 16 million people to lose health insurance, by the same logic HIAA is using, he charged.

The consumer advocacy group is urging Americans to tell their congressmen to vote for the Dingell-Ganske-Norwood bill.☐

Add a 'pearl' ...from Chuck Weiss

Mercury has been discussed in terms of office and home dangers in the past year on the list server and during the annual Committee Report on Environmental Health, Drugs and Toxicology. Studies of source of child exposure are being expanded. Federal, state and city health investigators plan a comprehensive study to see whether New York City children are being poisoned by mercury used in religious rituals by some immigrants from the West Indies and Latin America.

The study, reported by Carol Rubin, of the Centers for Disease Control Prevention, plans to test an undetermined number of children. While health officials do not think there is a crisis, they want to follow up on the research done at Montefiore Medical Center in the Bronx. A 1995 Montefiore survey, of 41 Bronx botanicas, found nearly 93 percent of the shops sold mercury capsules for use in Latino and Afro-Caribbean religions such as Santeria. Botanicas sell herbs and other items used for Afro-Caribbean religions. A more recent Montefiore study of 100 Bronx children found five had elevated levels of mercury in their urine. Those who believe in the magic of the mercury use the silvery substance to attract love or good luck. Because of its slippery nature, many believe it prevents sickness and evil spirits from sticking to a person. Some use a few drops to clean their floors, sprinkle in their bath water, or carry around their necks in amulets.

News of this CDC investigation comes as medical and environmental officials are increasingly concerned about mercury exposure. The U.S. Environmental Protection Agency has formed a mercury task force that will recommend ways to reduce exposure to the toxic substance. And *this month, the American Academy of Pediatrics called on doctors and parents to stop using mercury thermometers.*

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$1,500 are included in the law and the requirement for review of each claim by a medical advisory panel is repealed.

- Changes are made to the statute governing palliative care provided to persons suffering from "end stage conditions." The definition of "end stage condition" is changed to mean an irreversible, progressively severe and permanent deterioration of a condition for which to a reasonable degree of medical probability, rather than certainty, treatment would be ineffective. Providers are required to comply with requests for pain management or palliative care from the patient and absent the patient's intent, the surrogate, proxy, guardian or other representative permitted to make health care decisions.
- Allows the Agency for Health Care Administration to restrict or prohibit payment for mandatory or optional Medicaid services provided in mobile units.
- Creates an Organ Transplant Task Force within the Agency for Health Care Administration to study and make recommendations regarding the supply of organs, the number of existing transplant programs and the necessity of the current certificate of need requirements for proposed programs. A report to the Legislature is due by January 15, 2002.
- Creates requirements for the registration of medical clinics that charge for medical services. Such clinics will be required to employ or contract with a medical director who is a Florida-licensed physician. Clinics which are otherwise required to be registered or licensed under other statutes or which are wholly owned by licensed health care practitioners are exempt.
- Amends HMO law to require adverse determinations regarding services to be made only by a Florida-licensed physician with an active, unencumbered license.
- Directs the Department of Health to conduct a study of specialty certification and the ability of the boards to regulate speech which targets an identifiable harm regarding such certification.
- Directs the Office of Program Policy Analysis and Government Accountability (OPPAGA) to study the feasibility of maintaining the entire Medical Quality Assurance function, including enforcement, within one agency. Study due date is November 30, 2001.
- The formulary of drugs physician assistants may prescribe has been changed to a "negative" formulary which must prohibit the prescription of controlled substances, antipsychotics, anesthetics, radiographic contrast materials and all parenteral preparations except insulin and epinephrine. The formulary will be periodically reviewed for additions and deletions. All drugs not on the list will be available for prescription by a physician assistant per delegation by the supervising physician.
- New language is added to chapter 383 to require all infant postnatal tests and screenings to be performed by the State Public Health Laboratory in coordination with Children's Medical Services.
- Requires the completion of a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process for health practitioners.
- Provides a 6 year limitation for filing administrative complaints against health practitioners unless certain concealment occurred or certain offenses are involved in which case an absolute limitation of 12 years prevails.
- Requires the Department of Heath and the Agency for Health Care Administration to conduct a review of all statutorily imposed reporting requirements for health care practitioners and health facilities. A report to the Legislature is due by November 1, 2001 with recommendations and suggested statutory changes to streamline reporting requirements to avoid duplicative, overlapping and unnecessary reports or data elements.
- Effective Date. July 1, 2001

CS/SB 1568 — HMO Adverse Determinations (Ch. 2001-173)

This law was a stand alone bill to require HMO's and Prepaid Health Clinics to only allow adverse determinations regarding the rendering of health services to be made by a Florida licensed physician with an active unencumbered license.

Effective Date. January 1, 2002

CS/SB 836 — Health Insurance, HMO Contracts (Ch. 2001-107)

This law prohibits health insurers and health maintenance organizations from requiring contracted health care practitioners to accept participation in other "products" as a condition of continuation or renewal of their contract for services. This prohibition does not apply when a physician is initially entering into a new contract with an HMO or health insurer. The law applies to Medicare and Medicaid practitioner contracts as well as preferred provider (PPO), and exclusive provider (EPO) contracts. Practitioners in a group practice who must accept the terms of a contract negotiated for the practitioner by the group are an exception to these provisions. The provisions of the law apply to contracts entered into or renewed on or after the effective date.

Effective Date. July 1, 2001

CS/CS/SB 792 — Medicaid (Ch. 2001-104)

Substantive provisions of the Appropriations Act are implemented in this law which include:

- Establishes "children's provider networks" to provide care coordination and management, primary care, authorization of specialist care and other urgent care through organized providers designed to serve Medicaid patients under 18 years of age. The networks must provide after hours operation to diminish utilization of hospital emergency departments for non-emergency care.
- Requires the Agency to disproportionately assign Medicaid eligible children whose families do not select a provider, HMO or Medipass to a children's network until the children's networks have sufficient numbers to be economically operated.
- Requires the Agency to expand the use of counterfeit proof prescription pads to all prescribers who write prescriptions for Medicaid patients, regardless of their Medicaid participation status.

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- Authorizes the Agency to implement reimbursement and management reforms for community mental health services including prior authorization of treatment, service plans, and services, enhanced use of review programs for highly used services and limits on services for patients determined to be abusing their benefit coverage.
- Authorizes payment for assistive care services for patients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes or residential treatment facilities.
- Requires competitive bidding for home health services, medical supplies and appliances, and independent laboratory services. Additionally, authorization is provided to competitively procure transportation services or make changes to permit federal financing of transportation services at the service matching rate rather than the administrative matching rate.
- Changes the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to specify development of a preferred drug list which is to be adopted by the agency for the Medicaid program. The list is to be reviewed at least every 12 months for additions and deletions from the list.
- Requires the prescriber to seek prior authorization for an exception to the brand name drug restriction (4/month). Such an exception is for 12 months and does not require monthly reauthorization.
- Amends requirements for the Nursing Student Loan Forgiveness Program to include family practice teaching hospitals and specialty children's hospitals as employing institutions.
- Effective Date. July 1, 2001

CS/HB 563 — Lawton Chiles Endowment (Ch. 2001-73)

This law restructures the current allocation of funds distributed from the Lawton Chiles Endowment Fund for health and human services initiatives for children and elders and biomedical research. Dedicated line item categories for the agencies receiving funds and funds distributed from the endowment may not be used to supplant existing revenues. The 15 member Lawton Chiles Endowment Fund Advisory Council, of which the Florida Pediatric Society is a designated member, is continued to evaluate funding priorities. The Biomedical Research Advisory Council is required to report annually as to the progress made in the prevention and diagnosis of diseases related to tobacco use.

Effective Date. July 1, 2001

CS/CS/SB 1258 — Behavioral Health Services (Ch. 2001-191)

This law requires the development of two behavioral health service delivery strategies, the implementation of children's behavioral crisis unit demonstration models, the establishment of a Behavioral Health Services Integration Workgroup and the acceptance by the state of certain accreditation standards in lieu of onsite licensure reviews and administrative and monitoring requirements.

The Department of Children and Family Services and the Agency for Health Care Administration are required to develop two service delivery strategies and to contract with a single managing entity in each of two geographic areas for all publicly funded diagnostic services, acute care services, rehabilitative services, support services and continuing care services. One strategy will be a contract with a Medicaid prepaid mental health plan and the second strategy will be a competitive procurement of a contract for the management of behavioral health services.

The Department of Children and Family Services is authorized to implement children's behavioral crisis unit demonstration models beginning July 1, 2001 in Collier, Lee, and Sarasota counties to provide integrated emergency mental health and substance abuse services to patients under 18 years. The facilities used must be licensed as Children's Crisis Stabilization Units.

A Behavioral Health Services Integration Workgroup is established to assess barriers to the effective and efficient integration of mental health and substance abuse services across various systems and to propose solutions. The Workgroup must submit a report to the Governor and the Legislature by January 1, 2002.

The Department of Children and Family Services and the Agency for Health Care Administration are required to report to the Legislature by January 1, 2003 regarding the viability of mandating that all organizations that are under contract with the department or licensed by the agency to provide behavioral health services be accredited.

Effective Date. June 8, 2001

CS/CS/SB 1346 -- Behavioral Health Services (Ch. 2001-171)

This law contains the same provisions as CS/CS/SB 1258 detailed above regarding children's behavioral crisis unit demonstration models and evaluation of accreditation standards in lieu of state regulation.

Effective Date. June 6, 2001

CS/SB 224 — Medically Essential Electric Service (Ch. 2001-49)

The law provides procedures to identify and assist persons whose use of electricity is essential for the operation of medical equipment needed to avoid the loss of life or immediate hospitalization by themselves of someone residing in their homes. The law requires forms to be completed by a licensed physician which state in medical and non-medical terms why the electric service is medically essential. Customers continue to be liable for the cost of electricity consumed and for making satisfactory arrangements with the utility company to ensure payment for services.

Effective Date. May 29, 2001

CS/HB 215 — Parental Rights/Child's Records (Ch. 2001-2)

Reinforces existing law giving both parents, regardless of who is the primary custodial parent, an equal right to access their child's medical, dental or educational records and other pertinent information. However, this right may be limited by a court order or conditions of an injunction for domestic violence.

Effective Date. July 1, 2001

(Continued in next issue)

Upcoming Continuing Medical Education Events

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

Program: Practical Pediatrics
Dates: August 31-September 2, 2001
Place: Westin, Providence RI
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Update on Pediatric Sleep Disorders
Dates: September 15-16, 2001
Place: Wyndham Westshore Hotel, Tampa, FL
Credit: Maximum 10.5 hours for Category 1 for AMA Physician Recognition Award
Sponsor: University of South Florida
Inquiries: Office of CPE, (813)974-3217 or on line at www.cme.hsc.usf.edu

Program: Practical Pediatrics
Dates: October 4-6, 2001
Place: Four Seasons Hotel, Vancouver BC, Canada
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: November 1-4, 2001
Place: Southampton Princess, Hamilton, Bermuda
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: November 10-11, 2001
Place: Grand Hyatt Hotel, New York City
Credit: Maximum 12 hours for Category 1 for AMA Physician Recognition Award
Sponsor: Childrens Hospital of New York, Columbia University College of Physicians and Surgeons
Inquiries: Center for Continuing Education (212)305-3334, Fax (212) 781-6047 or http://ColumbiaCME.org

Program: Practical Pediatrics
Dates: December 7-9, 2001
Place: Hyatt Regency, San Antonio, TX
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: January 17-20, 2002
Place: Keystone Resort and Conference Center, Keystone CO
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: May 16-18, 2002
Place: Eldorado Hotel/Sweeney Convention Ctr, Santa Fe NM
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016 ext 6796 or 7657

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Program: Pediatrics in Review: Update for the New Millennium