THE FLORIDA PEDIATRICIAN

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THE PRESIDENT'S PAGE

Salutations. I hope this finds you well and vigorous in the battle for the best interests of kids (not to mention their physicians and advocates). I would like to fill you in on some of the issues, ideas, and thoughts that came up during September's Annual Retreat and Annual Meeting at Amelia Island.

The Annual Meeting agenda covered a wide range of academic topics from breast-feeding to submolecular genetics, and I believe was well received by the attendees. As added entertainment, Governor Lawton Chiles and his daughter Rhea visited the Business Meeting to discuss the Chiles Center for Healthy Mothers and Babies, introduced by the Center's Director, Dr. Charles Mahan, and Dr. Phil Adler of Tampa.

We were also graced by the presence of Steve Edwards, Chairman of AAP District IV, and Charles Linder, Alternate District Chairman of District IV, as well as Sam Flint, AAP Executive Vice President, all of whom were most interested in Florida's approach to several of the following issues.

* * * * *

"..Governor Lawton Chiles visited to discuss the Chiles Center for Healthy Mothers and Babies..."

* * * * *

One of the most pressing issues affecting children for the future has to do, naturally, with money. Title XXI of the federal Balanced Budget Act, as well as expected funds from Florida's tobacco lawsuit settlements, have the potential through appropriate legislative efforts to provide funding sufficient to greatly augment health coverage for Florida's low income or under served children. A good deal of rather intense effort was expended during the session to try to rough out a program which might serve as a comprehensive system for provision of care to the medically under served kids, hopefully as a seamless single program which might incorporate a number of existing entities as well as newly devised ones. You will be hearing more about this in the very near future.

Additional issues for legislative consideration included appropriate compensation for children's mental health including ADD and prohibition of arbitrary denials for such services provided by pediatricians; uniform and timely adoption of CPT and ICD-9 codes and EOB forms; prohibition of retrospective denials of payment for verified eligible patients; coverage for rehabilitative services for children with congenital anomalies; and a variety of others.

One of the forums considered promotion of the pediatrician, according to the concept that pediatricians ARE the medical specialists for infants, children, and adolescents. A number of suggestions surfaced, which I believe will result in additional services and value from the Society, ranging from marketing efforts to additional electronic communication networking and expansion of Web Page functions. A survey will be forthcoming with a needs assessment to get your feedback on these issues.

In the Pediatric Interest Group forum, several issues surfaced involving strategies for enhanced interaction of community pediatricians with students and pediatricians in training; there is an increasing need for involvement of office physicians in the formal education of future practitioners and a fairly immediate need for academic institutions and practitioners to explore the

*(see **President**, page 25 ▸)*

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Where are we, and Where are we going?

We are living and practicing in strange times, operating in uncharted waters. Can we survive? There are many pressures on us. Can we resist them, or should we "roll over" and just give in? Let's look at some of these pressures.

One of the phenomena at present is that of hospitals buying pediatric practices. Assuredly, this helps the hospital, by producing a more captive audience for admissions; and since admissions have fallen off, this may be a way to increase revenues in the form of the differential between fees collected and salaries paid. BUT, is this tenuous ground? Can the point be made that the hospital is practicing medicine sans benefit of medical school or license? Shades of the conflict years ago, involving the pathologists and radiologists! Many tax-exempt hospitals have formed profit-making subsidiaries, but this solves only a part of the problem.

> "...hospitals buying pediatric practices"

For the pediatrician, there appears to be relief from some of the burdens of medical economics: billing, hiring of personnel, etc. And what happens if the hospital cuts loose later on? The pediatrician is left to his own devices, but he at least has his patient roster and can pick up the pieces.

A major problem at present is the HMOs. Their rapid, almost phenomenal growth has been spurred on by government support early on, and by the image of reducing costs of health care. On the one hand, there appears to be increasing evidence that the money saved by the insured (or his employer) is less important than the "bottom line" of the HMO. On the other hand, the "pick your own physician" choice becomes "from our exciting list". The power to document findings or to refer to a specialist or subspecialist is surrendered to clerks with a whim or a "rule book". The length of stay for something as elemental as a normal delivery becomes a charade synonymous with "drive-through delivery", and the need to pass preventive legislation. Any attempt to alter the established parameters is met with the threat that any such change will push premiums up so high for the employer that he will stop providing health insurance. (Has everyone forgotten that the insurance premium paid, if it is, by the employer is really part of the real wages of the employee, and he is never asked?)

> "...a major problem ...the HMOs..."

And the pediatrician? He is faced with the threatening possibility that he/she may be closed out of a plan at its inception, and left with a practice too small (if at all) to be financially supporting. It is not comforting to be told that a group of doctors is being brought into the community to fill your shoes! Thus, many pediatricians hasten to join one or more or many or all plans, usually accepting reduced fees (in return for a "guaranteed" list of patients) as well as restrictions on activity and referrals. The guarantee? There is none. The HMO can refuse to renew the contract of an individual or a group, even then bringing in new physicians. And what then is left to the pediatrician? No practice! Or rebuilding with those patients who do not abide the change.

A disconcerting bit of recent news is the item that the government is considering paying hospitals *not* to educate residents. Is this like the farming subsidies, to prevent crops, or tobacco subsidies, to support prices? Do we really have too many doctors, like the "excess" we had some twenty or thirty years ago, which turned out to *(See **Editorial**, page 21 ▸)*

THE REGIONAL REPRESENTATIVES REPORT

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

Region III reports:

Region III of the Florida Pediatric Society has a new Regional Representative. Sue Griffis, who has served as the Alternate Representative, replaces Richard L. Bucciarelli as Rick moves to the position of Secretary of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics. The new Dean of the University of Florida College of Medicine is Dr. Ken Berns, a pedatrician. Plans are underway for renovation of the Gerold L. Schiebler Children's Medical Services Center and the building of a new state-of-the-art Ambulatory Care Facility for Pediatrics. The Region has welcomed several new pediatricians and is attempting to entice them to join the Chapter. Gerry and Audrey Schiebler were honored as the 1997 recipients of the Sharon Solomon Child Advocate of Valor Award. This award is just one of a long list of honors Audrey and Gerry have received. All of us in Region III and in the FPS/FCAAP are truly honored to have known and worked with Audrey and Gerry. As advocates for children, they are the perfect role models for all of us.☐

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

Region VII reports:

Region VII has had a relatively quiet period. In May, 1997, the Palm Beach County Pediatric Society held a brunch and invited Ellen Wald, M.D. to speak. This was well attended by physicians in the area.

There will be another meeting on October 29, 1997, when Theresa Rattey, M.D. and Bert Baynham, M.D. will speak on Pediatric Orthopedics.

At this time, the North Broward Hospital District and the BCMA are working on a Pedivan project for Broward County. This van will hopefully be fully operational in the Spring of 1998, and will service indigent and homeless patients. It will also do on site visits at schools and be available for emergency relief efforts.

The Broward County School Board has accepted a proposal from the

*(See **Region VII**, page 15 ▸)*

Sam Flint, Ph.D., Associate Executive Director, American Academy of Pediatrics, addresses the Executive Committee Retreat, September 1997

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Report of the Commitee on Bioethics

Donald V. Eitzman, M.D.
Chairman

NEONATES WITH ANENCEPHALY AS ORGAN DONORS

BACKGROUND: The intention of the following statement is to provide guidance to Pediatric practitioners in their interaction with parents and to provide guidance to professional and legal stakeholders on the position of the Florida Pediatric Society regarding this matter of both practice and policy.

An infant with anencephaly is born without a forebrain and a cerebrum, but is able to survive for a short time (hours or days) with a brain stem that supports breathing, sucking, and other autonomic functions. However, anencephaly is uniformly fatal.

At the time of the drafting of this statement, under Florida law, parents of infants with anencephaly, diagnosed prenatally or perinatally, are without the option to offer their child's organs for transplantation prior to the time of the legal (whole brain or cardiopulmonary death of the child. Parents who might choose to donate their child's organs may not do so until a time when the organs may no longer be useful for transplantation. A decision to donate the organs of one's anencephalic newborn is a personal decision arrived at through a search of deeply conflicted emotions. Many parents would want good for another family to come from their own disappointment. The trauma to the parent of an anencephalic newborn is appropriately met with grief as in any personal loss, but neonatal transplantation now makes possible a partial gain out of what has in the past been a total loss. Many parents might desire, and should be permitted, the satisfaction of knowing that they have perpetuated the gift of their child's existence by saving the lives of other ill infants.

Anencephaly has an estimated incidence of 0.3 per 1000 live births. This is frequent enough to be seen by most pediatricians and often enough that we all know about it. The diagnosis is usually made before birth with the frequent use of prenatal ultrasound. There is general agreement that the diagnosis is possible with very little error on a prenatal basis and conclusively after birth.[1] The most commonly accepted criteria for diagnosis are: (i) a large portion of the skull is absent, (ii) the scalp, which extends to the margin of the bone, is absent over the skull defect, (iii) hemorrhagic, flbrotic tissue is exposed because of defects in the skull and scalp, (iv) recognizable cerebral hemispheres are absent. 0utcome of thes unique group of deformed babies is also generally accepted to be death within 2 months, with the majority dying within a few days of birth.[1] Only with the provision of extraordinary measures has life been extended.[2] Within these defined parameters we have a condition which can be diagnosed without confusion and which will uniformly result in death. It seems reasonable to propose that these hopelessly doomed infants could be organ donors that might save the life of another infant should the parents so desire.

With the advent of transplantation as an acceptable option for situations where death or severe handicap was the only previous option, the donor pool becomes a critical factor. This varies with the organ involved, but is especially evident in the area of heart transplant in the newborn age group. Currently about one-half of the listed possible recipients die before a suitable donor is identified. Previous experience with organ donation from anencephalic infants has not gone well primarily because they were not initiated until after legal death of the donor. In all of the situations where legal death has occurred, the incidence of successful transplantation has been small, ranging from 0 to 30%. This has included a variety of attempts to maintain the viability of the target organs using drugs and ventilation. The other alternative has been to allow donation while there are still some signs of brain stem function remaining. This was advocated by the AMA Council on Ethical and Judicial Affairs.[3] The result was a lot of emotional debate and several requests for the Council to reconsider its opinion. The final result was a reversal of the original decision. At the time of drafting of this document we don't know of any comparable group that has advocated the use of organs from anencephalic infants that still have signs of brain stem activity. Another proposal has been to change either the law about the determination of death in the case of anencephalic infants or the law that regulates donation of organs. Both introduction of legislation to change the law and appeals to the court system have been unsuccessful. An example of a court decision is the recent case from South Florida illustrating one family's attempt to make the gift of organ donation possible through their newly born anencephalic infant.[4] With a great deal of persistence they got involved with the court system. They made a request to expand the common law definition of death to equate anencephaly with death. Their petition was denied by several courts, including the Florida Supreme Court.

CONCLUSION AND RECOMMENDATION: There is a real need for organs for transplantation that would extend the life of infants with organ failure. In the case of newborns this is true primarily for certain congenital malformations of the heart, liver and kidneys. Utilization of organs from anencephalic infants would significantly improve the chances for life for such infants. Diagnosis and counseling should be offered to parents of an anenecephalic fetus at the earliest possible time during the pregnancy. Pediatricians should act as advocates for parents requesting organ donation from anencephalic neonates. It should be possible for parents to have such a request honored. Consequently, pediatricians should advocate for changes in organ donor laws relating to anencephalic newborns, to honor parents' wishes to allow the perpetuation of the gift of their child's existence to save the lives of other infants.

BIBLIOGRAPHY

1. The infant with anencephaly. The Medical Task Force on Anencephaly. NEJM, 1990; 322:669-673
2. Anencephalic Newborns: Legal and Ethical Comments Regarding the Matter of Baby "K". Neonatal Intensive Care, Sept, 1994: 36-39.
3. The Use of Anencephalic Neonates as Organ Donors: Council on Ethical and Judicial Affairs, American Medical Association. JAMA 1995; 273:1614-1618.
4. In re T.A.C.P., a Supreme Court of Florida decision, fount at 609 So.2d 588 (Fla. 1992.)

Committee on Bioethics, 1996
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The Legislative Report: 1997

Submitted by:
Nancy Moreau, Legislataive Liaison
Tallahassee, FL

(Our excellent legislative group, including Nancy Moreau, our legislative laiason, was very active during the Legislative Session. This is part 2 of the legislative report for 1997. Again, our thanks to all for their hard work.)

CS/CS/SB 496 (CH. 97-284) - Regulation of Orthotists / Prosthetists / Pedorthotists

This legislation creates the Board of Orthotists and Prothetists, and establishes education and experience requirements for five licensure categories. The bill establishes a five-member task force within the Department of Health to assist the board in developing the proper education requirements and minimum professional knowledge, competencies, and skills necessary for licensure. Certain exemptions are provided from the educational requirements and the bill prohibits the use of protected professional titles.

Effective Date: July 1, 1997

B 48 S6 (CH. 97-47) - Assistive Technology Devices

Creates the Assistive Technology Device Warranty Act requiring manufacturers of assistive technology devices to provide a one year express warranty for devices which are defective. Within the warranty period the act provides for the repair, refund, or replacement of the non-conforming device. This act applies to manual and motorized wheelchairs, optical scanners, talking software and braille printers.

Effective Date: July 1, 1997

CS/SB 508 (CH. 97-290) - Medicaid Provider Agreements

This legislation requires a Department of Law Enforcement and a Federal Bureau of Investigation background check as part of the investigation by the Agency for Health Care Administration (AHCA) of an applicant seeking to be a Medicaid provider. A full set of fingerprints is to be filed with AHCA which will submit them for the background checks. The cost of the criminal history checks is to be paid by the applicant. Penalties are increased for knowingly submitting false or misleading information or statements to the Medicaid Program for the purpose of being accepted as a program provider.

Effective Date: July 1, 1997.

HB 1853 (CH. 97-168) - Medicaid / School Match Program

This bill enables the Agency for Health Care Administration to amend Florida's Medicaid State Plan to allow school districts to claim federal reimbursement for services they deliver to Medicaid eligible students. Reimbursement will go directly from the federal government to the school district. If approved by the federal government the Agency may reimburse school districts for services provided in 1995-96 and 1996-97. The legislation authorizes the Agency to conduct a pre-enrollment review of a school district. It is further required that a student's managed-care plan or MediPass provider must receive information about the school services a student receives.

Effective Date: July 1, 1997

HB 1465 (CH. 97-243) - Medicaid Reimbursement / Licensed Midwives

This bill authorizes Medicaid to provide reimbursement to non-nurse licensed midwives for home deliveries. As part of this authorization, the Agency is required to adopt rules for appropriate malpractice insurance coverage for such midwives.

Effective Date: July 1, 1997

SB 244 (CH. 97-171) - Dermatologists Direct Access

The exclusive provider organization and health maintenance organization laws are amended to require, if they offer dermatological services, to provide direct access for their policyholders for office visits and minor procedures and testing to a dermatologist under contract with the organization. These organizations are required to develop criteria by July 1, 1997 for compliance with this law. The criteria may include a maximum of five office visits for a dermatologic problem within a 12-month period.

Effective Date: May 30, 1997

CS/SB's 530 & 848 (CH. 97-48) - Breast Cancer Treatment

This law tracks similar legislation which prohibits insurers and HMO's from forcing persons who have mastectomies to leave the hospital prior to the time determined to be medically necessary by the treating physician. The law also requires that policies cover prosthetic devices and breast reconstructive surgery incident to a mastectomy.

Routine follow-up care to determine the presence of breast cancer must not be considered medical advice, diagnosis, care, or treatment for purposes of determining a preexisting condition unless evidence of breast cancer is found during, or as a result of the follow-up care. Further, insurers and HMO's may not deny or cancel a policy or exclude benefits solely due to breast cancer, if the insured has been free from breast cancer for more than 2 years before the applicant's request for health insurance coverage.

Effective Date: October 1, 1997; application is for policies and contracts issued or renewed after this date.

*(see **Legislation,** page 23 ▸)*

Drs. Janet Silverstein and Jay Goldsmith answer questions at the Scientific Session of the Annual Meeting, September 20, 1997 at Amelia Island Plantation.

Note:

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

Outline for a Concept Paper
Florida Pediatric Society/Florida Chapter American Academy of Pediatrics
September 17, 1997

John S. Curran, M.D.
Immediate Past President

Recent legislation passed by Congress as part of the Budget Reconciliation Act provides a unique opportunity for Florida to provide health care coverage through several vehicles to Florida's 600,000+ uninsured children. The ability to leverage tobacco settlement dollars as part of the required federal match as well as unique provisions that recognize the national leadership by Florida in school based health insurance enrollment in the Healthy Kids Program combine to make Florida unique in its opportunity to lead the nation in the implementation of the options provided under this legislation.

Although Subtitle J-State Children's Health Insurance Program and Title XXI provide a funding vehicle for an innovative state financing system for children's health benefits, it must be recognized that there is a responsibility for ensuring the existence of a system of care that promotes access and provides a wide range of children's benefits to enhance preventive and therapeutic services for all children including those with special health care needs.

Florida has a long tradition of public private partnership in the delivery of health services to children with special health care needs through the Division of Children's Medical Services in the Department of Health. On the other hand, the access and provision of services to underserved children is provided through multiple programs at diverse sites without program integration, such as but not limited to, publicly supported clinics, health departments, volunteer programs, federally qualified health centers both rural and urban, private practitioners, academic practitioners and training programs using funding vehicles such as Medicaid, Medipass, Medicaid HMO's, local funding, and volunteer donations. In general, the Florida Pediatric Society goal of a "medical home" for every child has not been achieved.

Florida's unique opportunity must relate to the creation of a new program using multiple funding vehicles that is uniquely identified as Florida's Child Health Insurance Program. It is essential to recognize that Florida's Healthy Kids Program has achieved in part that unique identifiability whereas Medicaid carries the stigma of welfare, dependency, and entitlement and has not achieved effective outreach to some underserved populations. Whether a new market identifier must be created for a single state administered program remains to be determined by discussion with appropriate legislative and administrative leadership.

The Florida Pediatric Society met recently (Sept. 17-20, 1997) to discuss the unique opportunity that we have to advocate for all uninsured children in Florida and presents this preliminary draft with many of our preliminary discussions and recommendations. The unique contributions of the Children's Medical Services Primary Care Networks delivered via a foundation model as well as the public sector throughout the state have been noted for cost savings for the 30,525 children currently enrolled and may be a model worthy of evaluation and continued propagation as one component of a system that will be heavily dependent on public-private partnership. Florida Healthy Kids is much better known throughout the state in the 17 counties where imple-mented (39,323 enrollees 8/1/97, 62,128 estimated at end of FY). Complementary expansion may be desirable; the CMS program has the unique feature of providing care to children with special health care needs and their siblings within a public private partnership.

The Florida Pediatric Society supports a two phase developmental approach which emphasizes the necessity of a carefully considered and crafted plan for full implementation. Nevertheless, in order to provide immediate access for children we provide the following suggestions:

- **Phase I - Immediate Expansion of Eligibility - October 1, 1997 to June 30,1998**
  - Expand maximum eligibility to the 0-1 population to 235% of Federal Poverty Level (FPL) - This is time limited, achieves maximum eligibility for the most vulnerable population using the Medicaid vehicle available *(currently 185% FPL)*
  - Expand eligibility for the 1-5 population to 200% FPL using the Medicaid vehicle currently available *(currently 133% FPL)*
  - Expand eligibility for the 6-13 age population to 200% FPL in those areas with Healthy Kids Program implemented or in process of implementation based on school enrollment with adjustments to the copay cost of premium *(currently 100% FPL)*
  - Expand eligibility for the 14-18 age population to 200% FPL in those areas with Healthy Kids Program implemented or in process of implementation based on school enrollment with adjustments to the copay cost of premium *(currently 28% FPL)*
  - Implement presumptive eligibility for children under age 19 and adopt 12 months of continuous eligibilty likewise
  - Develop and draft substantive legislation with legislative and administrative leadership to create and implement a new Florida Child Health Insurance Program that provides a comprehensive benefit plan, assures seamless application, eligibility, and enrollment; provides parental choice; assures access to services for children with special health care needs through the CMS Network and Primary Care, and assures a statewide provider participation network and an effective quality review and payment system.
- **Phase 2 - The Florida Childrens Network - July 1, 1998 and after**
  - **Assure a "medical home" for every child**
  - **A simplified application process, ideally a one page form which is common to all children's applications**

(See **Concept Paper**, page 22 ▸)

THE MANAGEMENT OF BREASTFEEDING

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Nemours Children's Clinic
Orlando, FL

The United States Public Health Service, in the Healthy People 2000 Goals, has determined that the percentage of women who initiate breastfeeding in the U.S. should be increased to 75%, from a current average of 60%, and that the percentage of women who continue to breastfeed at 6 months, should be increased to 50%, from a current average of 20%. To meet these goals, pediatricians and other health care providers caring for children must take an active role in supporting breastfeeding.

Breastfeeding benefits both parties of the mother/infant dyad, helps to decrease health care costs, and has a positive environmental impact. Breast milk is species specific for the human infant, has a composition which is dynamic and specifically suited for the infant's gestational age, enhances development of the infant's brain and central nervous system, and is nutritionally superior to artificial infant formula. The breastfed infant has decreased incidence and severity of otitis media, gastroenteritis, lower respiratory infection, bacterial meningitis, and urinary tract infection during infancy. Long term benefits include decreased risk of sudden infant death syndrome, Type I diabetes mellitus, inflammatory bowel disease, lymphoma, allergies, and dental and orthodontic problems. Breastfed babies have been shown to require less health care utilization and decreased costs in a managed care setting.

The mother who breastfeeds her infant has a reduced risk of postpartum hemorrhage, ovarian cancer, and premenopausal breast cancer. A lactating mother will return to her prepregnancy weight more quickly by utilization of fat stores accumulated during pregnancy for milk production. After cessation of breastfeeding, the mother experiences enhanced bone mineralization. Breastfeeding is convenient, more cost effective than formula feeding, and produces less waste in the environment. Exclusive breastfeeding is associated with improved child spacing in the first six months postpartum. There is less absenteeism related to illness of the infant, for the employed parents of a breastfed infant.

Ready availability of artificial infant formula, marketing practices of formula companies, lack of education of health care professionals, including physicians and nurses, lack of societal or familial role models, and early hospital discharges are some of the factors which have contributed to a decline in breastfeeding rates in the 1900s. Hospital policies, such as, mother and infant separation, routine use of pacifiers and infant formula, and discharge packs which contain formula or advertisements or coupons for formula, can subvert a mother's intent to breastfeed. Hospital personnel must be knowledgeable and supportive of breastfeeding. The Baby Friendly Hospital Initiative has put forth criteria which a hospital should meet to support fully the breastfeeding mother/infant dyad.

Preparation for breastfeeding should begin with education during pregnancy and with a careful breast exam as part of prenatal care. History of previous breast surgery or biopsies and previous breastfeeding experience should be obtained. Mothers with inverted nipples or nipples which retract with pressure or stimulation should be identified. The use of a nipple shell worn inside the bra during the latter stages of pregnancy and early days postpartum may be considered, although this has not been proven to be effective. The use of a pump, to help draw out the nipple, just prior to placing the infant to the breast may be helpful.

Preferably, the first breastfeeding should take place in the delivery room, within thirty minutes of birth. During this critical period of attachment, the infant is usually awake and alert, the rooting and sucking reflex can be elicited, and the infant can suckle at the breast to obtain his/her first colostrum. Colostrum is a concentrated substance, high in protein, and particularly high in immunoglobulins, especially, secretory IgA, which lines the infant's immature gastrointestinal tract with antibodies which help to prevent infection. During this first contact, the infant skin begins to become colonized with the maternal skin flora, and the infant's gut becomes colonized with bacteria which prevent the growth of pathogenic organisms. A first time breastfeeding mother often perceives that she does not have enough milk in the first days postpartum, but should be reassured that the colostrum provides all of the fluid and nutrition that her infant requires in the first days after delivery and that as the infant's need for fluid increases, milk production also increases.

The infant should be placed to the breast at least eight to twelve times per day in the early days. Frequent nursing and nipple stimulation increase maternal prolactin levels, which are crucial to maintaining good milk supply. The infant learns to nurse at the human breast, instead of attaching to a latex nipple or pacifier. Infant nursing should be observed in the hospital and appropriate technique of latch-on and positioning assured prior to discharge of the mother and infant from the hospital. When properly positioned, the infant's head should be in-line with the body, the infant should be abdomen-to-abdomen with the mother, the infant should have a generous amount of areola in the mouth, and the lips should be everted in a "fish lip" position. The infant should have audible swallowing with feeding and a good nutritive sucking motion. The infant should remain on one breast until the infant detaches or falls asleep, and then an attempt can be made to nurse on the opposite breast. Allowing unrestricted nursing time is important to allow the infant to obtain the higher fat content in the hindmilk. There is no rationale in limiting duration of breastfeeding to prevent nipple soreness. Nipple trauma and cracking results from improper positioning at the breast, not from length of feeding. The mother may feel a tugging sensation as the infant first begins to feed, but should not feel pain or discomfort throughout the feeding. Discomfort is a signal that the breastfeeding latch-on and positioning needs correction.

When the breastfed infant is discharged from the hospital at less than forty-eight hours of life, a follow-up visit within twenty-four to forty-eight hours is critical to assess hydration, determine weight and change from birth weight, evaluate after lactogenesis, or the time that mother's milk production changes from colostrum to transitional milk, commonly referred to as "mother's milk coming in." Once weight gain begins, the infant should gain at least fifteen to thirty grams per day. After lactogenesis, the infant should be expected to have six to eight pale or colorless urine voids per day and at least four to five loose, yellow, seedy stools per day, often having a stool after each feeding. The mother should report that the breasts soften after feeding,

*(See **Breastfeeding**, page 17 ▸)*

THE LAWTON AND RHEA CHILES CENTER FOR HEALTHY MOTHERS AND BABIES

Charles S. Mahan, M.D.
Professor and Dean, College of Public Health
University of South Florida
Tampa, Florida

The Lawton and Rhea Chiles Center for Healthy Mothers and Babies was established as a Type IV Center by the Florida Board of Regents in the Spring of 1996. It is affiliated with Florida's only College of Public Health, located at the University of South Florida in Tampa. It is part of the College's Department of Community and Family Health.

The mission of the Center is to promote and/or perform unique service delivery and research focused on the reduction of maternal and infant mortality and morbidity to the irreducible minimum. The Center brings together faculty from Florida universities with other state, national and international experts in maternal and infant health service delivery, program design and evaluation, and advocacy to build upon and expand the accomplishments of Governor and Mrs. Chiles in giving babies a healthy start in life. The Center will coordinate resources within the College of Public Health and across the University of South Florida to accomplish its objectives.

Objectives:

- Design, implement, and evaluate unique maternal and infant health service delivery programs and policies to determine their effects on outcomes for pregnant women and infants.
- Promote the implementation of maternal and infant health service delivery programs, strategies and policies which have been determined through research to positively influence outcomes for mothers and infants.
- Provide interdisciplinary educational programs for students and professionals involved in maternal and infant health service delivery and advocacy.
- Develop the resources necessary to accomplish the Chiles Center's mission.

Research, Program and Policy Activities

- Define "irreducible minimum" infant mortality.
- Design and evaluate strategies for preventing unintended pregnancies.
- Evaluate and enhance Florida's Healthy Start Program.
- Assess the impact of Fetal and Infant Mortality Review (FIMR) by Florida Healthy Start Coalitions.
- Design and evaluate low birth weight prevention stategies.
- Assess patient and provider satisfaction with public and private maternity care.
- Measure outcomes of private managed care and public systems of care for low income women.
- Develop more sensitive screens for drug and alcohol abuse in pregnancy (laboratory and historical).

Guidance in the establishment of the Center's priorities for program development, research and policy analysis and promotion is obtained from two advisory groups:

- An internal, within-college faculty advisory group, and
- An external advisory group of faculty and experts from outside
- the college, other Florida universities, other states and countries.

Florida is the primary geographic focus for the Chiles Center's initial activities. The Center's vision is expanded to the nation and the world. Because of Florida's unique physical location, the Caribbean Basin, Central America and South America are areas of likely initial expansion.

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Lawton Chiles, Governor of the State of Florida, introduces the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, at the Annual Meeting of the Chapter, September 20, 1997

SPECIAL ARTICLE

"THE CRISIS OF COMMUNITY"

Reed Bell, Sr., M.D.
Physicians Advisory Council
Florida Family Policy Council

Over the past 30 years, the revolutionary changes in sexual behavior have led to twin epidemics of STDs (Sexually Transmitted Diseases) and non-marital births. Most significant is the social impact of non-marital reproduction (illegitimacy), along with marital separation and divorce upon the lives of our children generating a "Crisis of the Kids" and, consequently, a "Crisis of the Community".

I suggest that we have had three decades of selfish rationalization where indulgent pleasure has been placed before the well-being of children and society; career and self-actualization before caring; "rights" before responsibilities. These years of self inflicted, harmful behavior have demonstrated that sexual license is not simply a private matter or an individual choice, but a profound burden to the self, other individuals and society. Unwed pregnancy, STD's and HIV are problems caused by behaviors that are creating social disorder!

There is no historical precedent to guide us away from the pending disaster. We have evolved a unique Culture of Divorce and Unwed Births while rejecting a Marriage Culture. The result? Our children are disproportionately neglected, sad and angry! Character and competence have been sacrificed. Some would venture to say that we are committing social suicide.

The public investment in myriad social programs has proved ineffective and inadequate in providing valid answers. Therefore, we must shift the debate from "symptoms and problems" to "causes and solutions". Emphasis must be on the unique importance of the civil and religious institution of marriage and the ideal of a two-parent family. This should not be viewed as an attack on single parents or their children. Nor does it mean a re-assertion of male authority or a reduction in the rights of women. However, the weakness of the family is at the heart of our children's problems and responsible for growing social decay. The impact that family fragmentation has on children's lives is a community crisis placing unmanageable stress on schools, courts, prisons, welfare and health-care.

The root of our social problems is rampant premature and promiscuous sexual behavior creating epidemic STDs/HIV-AIDS, and, even more significant, one-third (1/3) of all births are non-marital. The consequence? A huge and growing class of dependent women, fatherless children and alienated men. This sexual/social "Crisis of Community" pleads for individual sexual expression in the social context of marriage and family. The role of men as responsible husbands and fathers is essential for a civil, ordered society.☐

Note: *Visit our society's permanent website at:*
www.flmed.net/fps *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. Look for Membership Services, then Chapters.

THE WOMEN'S SECTION

WOMEN'S BREAKFAST

Sharon Dabrow, M.D.
Tampa, FL

About 20 female pediatricians attended the Society's first-ever women's breakfast, held during the Florida AAP meeting at Amelia Island. The meeting was chaired by Susan Griffis, M.D. and a variety of topics was discussed. Most of the hour was spent discussing the overall mission of the section and trying to delineate specific goals, objectives and issues on which the section should focus. Issues such as flexibility in work schedules seemed to be one of importance to many in the group.

A small working group led by Shakra Junejo, M.D., M.P.H. was created. Since the group is just beginning to formalize itself, we strongly desire input from women throughout our state. Please send us your thoughts and ideas regarding issues you would like to see addressed. You can reach one of us by e-mail or phone.

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Reed Bell, M.D., at the Annual Meeting of the Chapter, September 1997. Amelia Island Plantation

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.

THE FUTURE OF PEDIATRIC EDUCATION II (FOPE II) Project looks at Future of CME

Lawrence Nazarian, MD
Carden Johnston MD

In May of 1996, the pediatric community launched a three-year initiative, THE FUTURE OF PEDIATRIC EDUCATION II Project, to address the future supply and training of pediatricians and the provision of pediatric care well into the next millennium. One of the five Workgroups of THE FUTURE OF PEDIATRIC EDUCATION II PROJECT is the Education of the Pediatrician Workgroup. The members of this Workgroup are looking at all aspects of pediatric education, including faculty development and the education of nonpediatrician providers of pediatric care (eg. physicians in other specialties and allied health professionals). Because the Task Force wants the pediatrician to speak to the lifelong learning process of the pediatrician, this workgroup is devoting substantive time to exploring the issues, content, and methodologies of continuing medical education (CME.) The Workgroup is also looking at the importance of evaluating the educational process and encouraging needs assessment, feedback, improvement, and adaptation.

The Education of the Pediatrician Workgroup developed questions to obtain information and suggestions for innovations in the delivery of continuing medical education (CME). Information, insights, suggestions, and perspectives that you can provide will facilitate the deliberations of the Workgroup. The following questions are open-ended, and you are urged to take the time to complete these in order to share with the Workgroup your ideas about the future of pediatric continuing medical education (CME).

In addition, we encourage you to utilize mechanisms already in place in order to provide additional input (eg. Project e-mail address: futpededII@aap.org). If you are willing to assist the Project by completing a more detailed questionnaire on CME issues, please contact Mary Ruth Back at 800/433-9016, ext. 7914 or via e-mail at futpededII@aap.org.

1. Describe (name by title and location - eg, AAP Annual Meeting) one or more CME experiences (ongoing or one-time) that have been particularly influential in the way you practice. Please comment on the format.
2. Which aspects of the present system for teaching CME (teaching methods, formats, technology, logistics, etc.) should be retained or expanded, and which should be abandoned or drastically revised?
3. What steps could be taken to make CME more accessible?
4. Please identify innovative, effective evaluation methods for CME programs. Please describe any you are aware of and provide contact names and addresses for additional information.

Please submit ideas you may have in writing via US mail (mail responses to Mary Ruth Back, THE FUTURE OF PEDIATRIC ED UCATION II Project, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927) or via the Prqiect e-mail address: futpededII@.aap.org☐

SCHEDULE OF MEETINGS OF THE AAP

Spring Session:
Atlanta, Georgia
April 4-7, 1998

Annual Meeting:
San Francisco, CA
October 17-21, 1998

1998 LEGISLATIVE CONFERENCE: LEARN HOW TO MAKE A DIFFERENCE

If you want to get involved in legislative issues and just don't know how, or if you need new ideas to add to your advocacy repertoire, now's your chance. By attending the 11th Annual AAP Legislative Conference on April 26-28, in Washington, D.C., you can learn new skills and practical techniques to become better advocates for children.

Sponsored by the AAP Council on Government Affairs and the Committee on State Government Affairs, the conference permits development of advocacy skills, a better understanding of the state and federal legislative process, and learning of successful media strategies.

Seminar topics include: meeting with your member of Congress, learning how to testify successfully, gearing up the Chapter for state legislative action, and discovering how to work with the media. Workshops will focus on key pediatric issues currently receiving attention at the state and federal level such as children's health insurance. Capping it all off is a visit on Capitol Hill to meet with members of Congress and their staff.

The conference features prominent speakers to add to your D.C. experience. Last year's line up included three members of Congress, a state speaker and White House Correspondent Helen Thomas.

Attendance at the conference is limited to the first 100 to allow for more interactive activities. **Funding may be available through your state chapter, so check with your chapter president.** Limited scholarship support may be awarded after review of written requests submitted to the AAP Washington Office.

Registration fees for Academy members are $275 if submitted by Jan. 15 or $325 after Jan. 15. For non-members, fees are $450 due Jan. 15 or $525 after the deadline.

To get a registration form or for more information, contact the Washington Office at 800/336-5475.☐

NEWS FOR THE SENIOR SECTION OF AAP

From: Allen D. Harlor, Jr., M.D.,
Chair of Council on Government Affairs

Plans are underway [see above] for the Academy's 1998 Legislative Conference, in Washington, D.C. With the Academy's renewed commitment to assure access to quality health care as the next step in incremental health care reform, 1998 promises to be a year filled with challenge, opportunity, and growth. The conference prepares child advocates for the political process by offering the advocacy training necessary to advance child health and physician issues through legislation and regulation on both the state and federal level.

As a member of the Senior Section, the legislative conference would be a great opportlunity to further develop your advocacy training as a child advocate. The conference is a valuable experience for you to show your support and leadership among other advocates for children.

The AAP Council on Government Affairs, the Committee on State Government Affairs, and the Academy Staff are putting together a full agenda which is designed to be educational, informative and enlightening to both the novice and the experienced. Over the last decade, more than 1000 pediatricians have attended this conference and have remained active voices for children and adolescents. It is vital that we sustain this momentum and continue to build up this federal and state-wide network of experienced advocates.☐

The following is an excerpt from

A Report from the Committee on Pediatric Emergency Medicine
EMERGENCY MEDICAL SERVICES FOR CHILDREN AND MANAGED CARE

Deborah Mulligan-Smith, M.D., F.A.A.P., F.A.C.E.P.
Co-Chair, Pediatric Critical Care/Emergency Medicine Committee

Comprehensive EMSC coverage extends far beyond having the ability and/or authorization to stitch a child's forehead in the late-night hours, at the local emergency department. It means ensuring the availability of necessary resources to evaluate and treat any acute pediatric illness or injury. EMSC is a continuum of care which begins with recognition of the illness or injury and includes prehospital, emergency department, hospital and rehabilitative care. Essential EMSC resources include ground and air ambulance services, emergency departments, critical care units, inpatient services, surgical services, rehabilitation services, and disease/injury prevention. These resources should be appropriate for infants, children, and adolescents and should be provided by pediatric-trained personnel, including pediatric medical subspecialists and pediatric surgical specialists. The rapid growth of managed care plans has emerged as a potential barrier to emergency care access.

The importance of pediatric practitioners securing appropriate EMSC coverage for their patients cannot be overstated. Each year more than 14 million children in the United States, ages 1 - 19 years, seek treatment in emergency departments. An increasing number of these children are covered by managed care contracts. Currently, more than 66 percent of U.S. families that have health care insurance are enrolled in some type of managed care program. This shift toward managed care shows no signs of slowing. Today, more than 50 million Americans participate in managed care plans, and the Congressional Budget Office estimates that number could reach as high as 120 million by the start of the 21st century, as families are encouraged or required to join HM0s.

While it is clear that there are significant improvements to be made in the way emergency medical services are provided within the current managed care system, there is every reason to believe that with the help of pediatricians these needed changes can be made.

The best solution may lie not in universally rejecting those plans that do not contain desired services, but in working with the collective pediatric community, local emergency departments and managed care companies to forge a mutual understanding of what services are need and how they can best be provided.

Primary care pediatricians play a critical role in making needed improvements a reality, by educating themselves about emergency care provisions in managed care plans and educating parents to do the same, collaborating with emergency care providers and working at the state level to develop appropriate Medicaid managed care plans.

With more and more Americans, and especially children, moving into the managed care arena, it is clear that the pediatric community must join forces with emergency care departments and child health advocates to shape a managed care delivery system that is more responsive to children's emergency care needs.

While the needs of children may not always rank as the highest priority for these varied providers, there is no escaping the harsh reality that children do suffer serious injury and illness, including life-threatening conditions. More than ever, pediatricians can play a vital role in assuring that appropriate emergency care is available.

Requests for copies of the original article should be directed to the American Academy of Pediatrics, Ms. Tellez, 1-800-433-9016 ext. 7395.☐

In Memoriam

Peter Mamunes, M.D., of Parkland, Florida, died in June 1997 at the age of 61. Dr. Mamunes had been in Florida since 1991. Prior to this, he had had an outstanding career as a geneticist and clinician, and was loved by patients, students, and colleagues. He chaired the Department of Pediatrics at Albert Einstein College of Medicine in Philadelphia, and then at Virginia Commonwealth College of Medicine in Richmond. In 1991, he became Medical Director of Pediatrics for the North Broward Hospital District. In 1993, a full service genetics center for Broward County became a reality when Dr. Mamunes joined with Alfigen Inc. to establish the Alfigen Genetics Center of South Florida.

The circumstances surrounding his death illustrate the depth of his dedication to children and to his work. He was on his way to a class reunion in Ithaca, New York and stopped for an airport meeting with a family in need of genetic counseling. Following this, he suffered cardiac arrest before the reunion could begin.

Dr. Deborah Mulligan-Smith, who provided the information for this memorial notice, tells us that he was cherished by his pediatric staff, and that Pediatric Grand Rounds at the Broward General Medical Center have been named for him.

The heart-felt sympathy of the Florida Chapter is extended to Dr. Mamunes' family.☐

Region VII

(◂ continued from page 3)

Florida Chapter of the American Academy of Pediatrics and the American Lung Association to host an essay contest in honor of child health month. The topic of the contest is: "How to Create a Smoke-free Future for the Class of 2000", and it will be aimed at all tenth graders in the county, called the Smoke-Free Class of 2000. Financial awards for the top three essays are being funded by the Florida Pediatric Society.

David Marcus, M.D.
Regional Representative☐

First "Annual" Florida C.A.T.C.H. Meeting

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

Our first statewide Florida C.A.T.C.H. meeting consisted of an intimate gathering of approximately fifteen interested pediatricians from across the state. The panel of speakers gave phenomenal presentations! These discussions were not only interesting but also quite practical for the typical practicing pediatrician.

Dr. Thomas Tonniges, Director of the A.A.P. Community Pediatric Department, gave a thorough overview of the origins of C.A.T.C.H., The Medical Home Project, and The Healthy Child Care America campaign. He challenged Florida pediatricians to apply for C.A.T.C.H. Planning Grants as well as Healthy Tomorrow Grants. Dr. 0. Marion Burton graced us with his presence from South Carolina. He is our Regional C.A.T.C.H. facilitator. He shared the South Carolina C.A.T.C.H. experience, where they have been very successful in establishing myriad private-public partnerships throughout the state which are proving quite effective in improving child health access.

The last four speakers were Florida "CATCHERS". Dr. Louis St. Petery, Jr. presented the Tallahassee Foundation project which is an exemplary program requiring the cooperative efforts of essentially all the practicing pediatrician in Tallahassee in conjunction with the State via the Children's Medical Services. This model program stresses the important concept of a medical home for each and every child. Dr. David Cimino presented the successful school-based clinic at Norteast High School, which has improved health care access for many adolescents in Pinellas County. Dr. Sharon Dabrow gave an update on her flourishing “Reach Out and Read of Tampa” program, which is getting both local recognition and financial support. “Reach Out and Read” is an early literacy intervention program which is based in the pediatrician's office. Last, but not least, Dr. Claude Dharamraj discussed the need for public-private partnerships in order to bridge the gaps in the child health care arena.

As you can see, there are countless Florida pediatricians who are making a difference in their communities. One pediatrician can make a difference! Please make plans to attend the next Florida C.A.T.C.H. meeting. Join us! Become part of the solution.☐

Visiting Professorships/CATCH Planning Grants

The time has come for pediatric academic institutions to begin formulating plans for applications for the visiting professorship program. Be sure to give both Florida Chapter President, Dr. Edward Williams, and me sufficient time to write letters of endorsement for your proposals. Wyeth-Lederle CATCH planning funds should be available for the next grant cycle in the fall. Please begin working on these projects now. Also, remember that these funds are not to be utilized for implementation purposes. For more information about these funds, please contact:

Patricia J. Blanco, M.D.
Florida CATCH Facilitator
3675 W. Waters Avenue
Tampa, FL 33614☐

Child Health Month

Child Health Month was established by the American Academy of Pediatrics several years ago. As he has done each year, Governor Lawton Chiles declared October, 1997 to be **Child Health Month in Florida**.

Child Health Month has just concluded for 1997. It is hoped that each one of us has had some part in making this a successful month of awareness of the problems still facing the children of this nation and this state. The Editor would like to make the efforts of individuals known to the membership as a whole. It will be very helpful, for the next issue, if everyone who has had any accomplishment will let us know exactly what you have done.

The focus for 1997-1999 will be substance abuse prevention, with the emphasis for 1997-8 on tobacco use.

It is hoped that each member will continue to make an imprint throughout the year.☐

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.☐

Breastfeeding

(◂ continued from page 9)

that she has milk leaking from the opposite breast while the infant nurses and, often, that she feels a drowsy, contented sensation while feeding, secondary to hormonal stimulation. The milk ejection reflex, or "let down" may not become well developed until the second week of lactation, but the mother often reports uterine contractions with breastfeeding secondary to the oxytocin effect.

Red flags for inadequate lactation include an infant who loses more than eight per cent of birth weight, fails to regain birth weight by fourteen days of life, or spends time sucking on the hands or fists after or between feedings. In these cases, the infant should be evaluated carefully for normal health, good neuromuscular tone, adequate root, suck, and swallow. The infant should be observed nursing at the breast. Efforts to correct latch-on, positioning, frequency and duration of breastfeeding should be undertaken. Maternal pumping after or between breastfeedings will help to stimulate increased milk production.

Engorgement of the breasts should be prevented or minimized by frequent breastfeeding, application of cold packs or cabbage leaves, and judicious use of a breast pump or hand expression of just enough milk to relieve discomfort. A warm shower or the local application of heat just prior to feeding or pumping will encourage good milk flow. Breasts which remain engorged are at risk for development of plugged ducts, mastitis, abscess, and decreased milk production via inhibitory peptides in the milk. Maternal analgesia may be required for engorgement or if mother experiences excessive uterine cramping during nursing. Antibiotics which cover *Staphylococcus* and *streptococcus* are required if the mother develops mastitis, and the mother should be encouraged to complete the entire course of antibiotics to prevent worsening of infection.

The breastfeeding mother should continue her prenatal vitamins and eat a reasonably good diet, judiciously restricting intake of caffeine and alcohol. Her diet does not have to be perfect to produce good milk quality or volume, and concern about her diet should not prevent the mother who wishes to do so from breastfeeding. Extreme restriction of calories, as seen in starvation, affects volume of milk, but not quality or composition. Maternal fat intake affects the fatty acid composition of the breastmilk, but has minimal effect on total fat content of the milk. The mother should drink to thirst, but not force fluids. The mother should be advised that the infant will receive good quality milk regardless of the mother's diet, but the mother's nutrient stores and overall health are more likely to suffer if her diet is chronically inadequate.

Jaundice may be observed in the breastfeeding infant. Early onset jaundice associated with breastfeeding may reflect inadequate caloric intake and infrequent stooling. Management should be directed at increasing adequacy of breastfeeding, by improving positioning and milk transfer, and increasing frequency and duration of breastfeeding. Supplementation should be reserved for the infant with overt dehydration, and expressed breast milk is the fluid of choice if supplementation is required. Administration of water via the enteral or parenteral route does not affect the elimination of bilirubin and decreases the stimulus for the infant to breastfeed. Interruption of breastfeeding is not indicated and clearly sends the wrong message to the breastfeeding mother, both figuratively and physiologically.

Candidiasis may be encountered in the breastfeeding mother/infant dyad, particularly if one or both have been treated with antibiotics. If either infant oral candidiasis, associated with typical white plaques on the buccal mucosa, or maternal nipple candidiasis, associated with burning, itching, erythema, or irritation, is detected, both the mother and infant must be treated. The infant may be treated with oral nystatin, while the mother's nipples can be treated with nystatin or clotrimazole cream. Alternatively, both the mother and infant can be treated with oral fluconazole. To prevent reinfection, both mother and infant must be treated even if only one is symptomatic.

Mothers who plan to return to employment outside of the home may be concerned about introduction of bottles. Most infants will take a bottle if it is introduced by the fourth week after birth and given to them by someone other than the mother, whom the infant associates with breastfeeding by sight and smell. The preferred feeding in the bottle is his mother's expressed breast milk. Early introduction of bottles, latex nipples, and pacifiers may result in nipple confusion in some infants and cause the infant to have difficulty suckling at the breast. Mothers should be encouraged to continue breastfeeding after they return to work. A hospital grade electric breast pump with a double-pump set-up, which may be rented or purchased, allows pumping of both breasts at the same time, produces the greatest rise in prolactin levels, and the most time efficient pumping during breaks from the job. The expressed milk should be refrigerated and transported to the home or child care giver in a cooler. Frequent nursing when the mother can be with the infant should be encouraged. Some employed mothers choose to increase the frequency of night-time feedings to help maintain the breast milk supply.

There are few absolute contraindications to breastfeeding in the United States. A mother who is known to be HIV positive should not breastfeed her infant due to the risk of transmission of the HIV virus via the breast milk, and due to the fact that breast milk substitutes, a safe water supply, and ability to wash bottles and nipples, are available. HTLV-1 and 2 are also considered to be contraindications to breastfeeding. It is the position of the CDC that maternal infection with Hepatitis C is not a contraindication to breastfeeding, unless the mother is also HIV positive. The Hepatitis C virus may be detected in breast milk, but the viral particles are not necessarily infectious, and a number of studies have shown no increase in viral transmission when breastfed infants were compared with artificially fed infants. Maternal infection with Hepatitis B is also compatible with breastfeeding, although the infant should received Hepatitis B Immune Globulin and begin the Hepatitis B vaccine series at birth.

Most medications taken by the breastfeeding mother are compatible with breastfeeding, however, the risks must be weighed with the benefits. The lowest dose to achieve the desired effect should be used. Short acting drugs are preferred over long acting or sustained release. The medication should be administered during or just after nursing to allow peak serum levels and maximum clearance of the drug prior to the next feeding. Drugs which should be avoided are illicit drugs or drugs of abuse, chemotherapeutic agents, radioactive compounds, bromocriptine, and ergotamines. Radioactive compounds require temporary cessation of breastfeeding based on the half-life of the compound. Any time breastfeeding is interrupted, the mother should be encouraged to pump frequently to maintain milk supply.

Most infant conditions are compatible with breastfeeding. Mother's breast milk, whether obtained by nursing or by expressing and gavage feeding of the milk, is the preferred feeding for the premature

(Continued next page▸)

(◂continued from previous page)

infant. In these infants, feeding of breast milk is associated with lower incidence of necrotizing enterocolitis, enhanced function of the immune system by provision of immunoglobulins and other factors in breast milk, and a feeding specifically suited to the particular gestational age of the infant. Infants with inborn errors of metabolism, such as, phenylketonuria or amino acidurias, may be partially breastfed with close follow-up by the nutritionist and physician of the metabolic status of the child. Breast milk is the preferred feeding for the infant with cystic fibrosis. Breast milk contains lipase which contributes to fat digestion, and enzymatic supplementation may or may not be needed in infancy if the infant is solely breastfed.

Current knowledge of the benefits and advantages of breast milk over artificial milk substitutes is in a state of infancy, and is a subject of much research. Artificial human milk substitutes are higher quality than ever, based in large part upon research on the chemical composition of breast milk and on nutritional deficiencies which have been detected clinically over the years in infants being artificially fed. The canned substitute, however, will never duplicate the unique composition of the breast milk with its intact cells and a composition which changes with gestational age, throughout the course of the day, and during the course of a feeding. Likewise, for the suckling infant, the latex nipple and plastic bottle will never duplicate the human breast. Pediatricians must take an active role in educating mothers, other health professionals, and health administrators, so that their youngest, most vulnerable patients, receive the gold standard in infant nutrition.

REFERENCES:

1. American Academy of Pediatrics, American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, 3rd Ed., 1992.
2. American Academy of Pediatrics, Committee on Drugs: The transfer of drugs and other chemicals into human milk. *Pediatrics* 72:137, 1994.
3. American Academy of Pediatrics, Committee on Nutrition, Barness, LA (ed.), *Pediatric Nutrition Handbook,* 3rd Ed., 1993, 1-42, 64-89, 144-153.
4. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine: Pediatrician's Responsibility for Infant Nutrition. *Pediatrics*, 1997;99:749-750
5. American Academy of Pediatrics, Committee on Pediatric AIDS. Human Milk, Breastfeeding, and Transmission of Human Immunodeficiency Virus in the United States. *Pediatrics* 96:977-979, 1995.
6. Amir LH, Hoover K, Mulford C*: Candidiasis & Breastfeeding* (Unit 18). Lactation Consultant Series, Garden City, NY, Avery Publishing Group, 1995.
7. Anderson PO: Alcohol and Breastfeeding. *J Hum Lact* 11(4):321, 1995.
8. Bailey B, Ito S: Breast-feeding and maternal drug use. *Pediatric Clinics of North America* 44(1):41, 1997.
9. Barros, FC, Victora CG, et al, Use of Pacifiers is Associated with Decreased Breast-Feeding Duration, *Pediatrics*, 1995;95:497-499.
10. Biggs GG, Freeman RK, Yaffe SJ. *Drugs in Pregnancy and Lactation*. Baltimore, Williams and Wilkins, 1994.
11. Braveman P, Egerter S, Pearl M, March K, Miller C. Problems associated with early discharge of newborn infants. Early discharge of newborns and mothers: a critical review of the literature. *Pediatrics* 96:716-726, 1995.
12. Breitzka RL, et al: Principles of Drug Transfer into Breast Milk and Drug Disposition in the Nursing Infant. *J Hum Lact* 13(2):155, 1997.
13. Daly S, Hartmann P: Infant demand and milk supply. Parts I and II. *J Hum Lact* 11:21-37, 1995.
14. deCarvalho M, et al. Effect of frequent breastfeeding on early milk production and infant weight gain. *Pediatrics*. 1983;2:307-311.

15. Desmarais, L, and Browne, S: *Inadequate weight gain in breastfeeding infants: assessments and resolutions* (Unit 8), Lactation Consultant Series, Garden City, NY, Avery Publishing Group, Inc., 1990.
16. Demarzo S, Seacat J, Neifert M: Initial weight loss and return to birth weight criteria for breast-fed infants: Challenging the "rules of thumb." *AJDC* 145:402, 1991.
17. Freed GL, Clark SJ: Breastfeeding and maternal illness. *Contemp Pediatr* 13(4): 49, 1996.
18. Freed GL, Clark SJ: Educating ourselves about breast-feeding. *Focus & Opinion: Pediatrics* 2(3):196, 1996.
19. Freed GL, Landers SC, Schenler RJ: A practical guide to successful breastfeeding management. *Am J Dis Child* 145:917, 1991.
20. Gartner, L. Neonatal Jaundice. *Pediatrics in Review.* 1994;15:422-432
21. Goldman AS: The immune system of human milk: antimicrobial, antiinflammatory, and immunomodulating properties. *Pediatr Infect Dis J* 12:664, 1993.
22. Hale T. *Medications and Mothers' Milk 1997*. Amarillo, TX, Pharmasoft Medical Publishing, 1997.
23. Kurinij, N, Shiono, PH, Early Artificial baby milk Supplementation of Breast-feeding, *Pediatrics,* 1991;88:745-750.
24. Lang S, Lawrence CJ, Orme RL. Cup feeding: an alternative method of infant feeding. *Arch Dis Child* 71:365-369, 1994.
25. Lawrence PB: Breast Milk: Best source of nutrition for term and preterm infants. *P Clinics North America* 41:925-941, 1994.
26. Lawrence, RA. *Breastfeeding A Guide for the Medical Profession,* 4th Ed. Mosby, 1994.
27. Lawrence R. Drugs in breast milk. In *Breastfeeding: a guide for the medical profession.* St. Louis, Mosby-Year Book, Inc, 1994, 323.
28. Lin HH, et al. Abscence of infection in breast-fed infants born to hepatitis C virus-infected mothers. *J Pediatr* 126:589-591, 1995.
29. Lin HH, et al. Mother-to-infant transmission of hepatitis C virus and breastfeeding. *J Pediatr* 127:671, 1995.
30. Martinez JC, Maisel MJ, Otheguy L, et al: Hyperbilirubinemia in the breast-fed newborn: A controlled trial of four interventions. *Pediatrics* 91:470, 1993.
31. Meier P, Engstrom J, Crichton C, et al: A new scale for in-home test-weighing for mothers of preterm and high risk infants. *J Hum Lact* 10:163-68, 1994.
32. Neifert M: Failure to thrive in breastfed infants. *J of Pediatrics* 23(2):1-4, 1989.
33. Neifert M: Early assessment of the breastfeeding infant. *Contemporary Pediatrics*. 1996; 13(10):142-166.
34. Powers NG, Slusser W: Breastfeeding Update 2: Clinical Lactation Management. *Pediatrics in Review* 18(5):147-161, 1997.
35. Ryan AS: The Resurgence of Breastfeeding in the United States. *Pediatrics*. 99(4):electronic pages12, 1997.
36. Ruff AJ. Breastmilk, breastfeeding, and transmission of viruses to the neonate. *Semin Perinatol.* 18:510, 1994.
38. Slusser W, Powers NG: Breastfeeding Update 1: Immunology, Nutrition, and Advocacy. *Pediatrics in Review* 18(4):111-121, 1997.
39. Tobin DL: A breastfeeding evaluation and education tool. *J Hum Lact* 12:47-49, 1996.
40. Wilton, JM: Sore nipples and slow weight gain related to a short frenulum, *J Hum Lact* 6:122-123, 1990. □

A new feature is proposed:

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!

MORE FROM THE A.A.P.

PRELIMINARY FINDINGS
Managed Care and Children with Special Health Care Needs

September, 1997

Beth Yudkowsky
Director, Division of Health Policy Research

This report summarizes preliminary findings from the survey "Managed Care and Children with Special Health Care Needs".

- 129 Managed Care Organizations (MCOs) responded to the survey, representing 225 organizational structures.
- The total number of enrollees (covered lives) represented by the MCOs that responded to the survey is 12.6 million; 3.7 million under age 22, 8.1 million age 22 and older, and 800,000 whose age was not reported.
- Almost half (49%) of respondents were from HMOs; 26% from PPOs; and 22% from POS plans.
- The age distribution of the enrollees is as follows:

Birth to 1	4.3%
1 - 5	8.6%
6 - 11	12.2%
12-21	13.9%
Over 21 years	3.0%

- The majority of members enroll through group/employer contracts (81%); 10% enroll through Medicaid contracts; and 5% enroll through individual contracts.
- The majority of MCOs do not estimate the number of children with special health care needs. Among those that do, however, 22% use national prevalence data; 63% use diagnostic/utilization data; and 15% use some other method to estimate the number of children with special health care needs.
- MCOs estimate the average proportion of children/adolescents who have special health care needs at 8.5%.
- Most plans use the Maternal and Child Health Bureau definition when identifying children with special health care needs (83%).
- 40% of MCOs work with Title V agencies; 28% do not; and 32% are not sure. Among those MCOs that do work with Title V agencies, the three most common services used include 1) case management, 2) allied health services such as physical therapy and speech therapy, and 3) assistance in acquiring durable medical equipment.
- Care coordination activities are typically assumed by 1) general pediatricians, 2) pediatric subspecialists, and 3) the family.
- 80% of MCOs contract with at least one children's hospital
- Among MCOs in rural areas, the majority of plans have a mechanism in place to assure that children with special health care needs have access to needed services (74%). Contracts with tertiary care centers, using visiting nurses, and transportation services are the three most commonly used mechanisms.
- Nearly all plans explain their referral process and appeals process to new members at the time of enrollment through benefit summaries/booklets, brochures, and employers' educational meetings.
- Only 5 plans allow parents of children with special health care needs to sit on the Board of Directors of their managed care plans. However, approximately 50% of the plans indicated that some other mechanism exists to solicit feedback from those parents.
- Pediatricians and Pediatric Subspecialists are reimbursed differently in managed care organizations. The top three reimbursement methods for pediatricians are 1) full capitation and capitation plus withholds, 2) negotiated fee schedules, 3) fee for service. Twice as many pediatricians than pediatric subspecialists are salaried.
- 18% of MCOs employ some form of risk adjustment to compensate pediatricians who provide care for children with special health care needs. Among those that use risk-adjustments, 19 plans adjust by age, 16 plans adjust by sex, and 8 plans adjust by health status.
- 78% of MCOs use physician profiling mechanisms; 40% of those plans take into consideration the number of children with special health care needs that are in a physician's practice.
- Most plans (94%) do not encourage their physicians to treat children with special health care needs by offering financial incentives such as withholds, bonuses, or productivity incentives.
- 18% of MCOs have "carve-outs" for children with special health care needs.
- Disease State Management programs are used by a number of plans for certain pediatric conditions such as Asthma (57%), Diabetes (46%), and AIDS (17%). Among those plans that have such programs, 80% of Asthma programs, 86% of Diabetes programs, and 82% of AIDS programs are provided in-house.☐

Editorial

(◂continued from page 2)

be poor distribution? Is the aging of the "baby boomer" (horrible expression) about to take its toll in retirements, so that there may again be a real shortage? Is this a less than subtle attempt to pressure the medical schools to reduce registration, or perhaps in some cases shut down, to reduce the federal dollars spent in support of the schools?

What are we to do? Our patients are becoming more aware and more outspoken about choice, about referrals, and about the quality of care they want for themselves and their children. We need to express our concerns and beliefs, in as professional and dignified way as possible, backed up with facts. And we need to do this in as many theaters as possible, be they as local as a social evening, as general as our legislature, as global as the press. And above all, we need to practice pediatrics at the highest level of excellence, to maintain our position as the best caregivers for children.☐

The Editor

Concept Paper

(◂continued from page 7)

- Unlink the process from economic services,

welfare, and entitlement
        - Health Departments
        - Schools
        - Providers such as hospitals, physicians, clinics
        - Other local sites, existing agencies/programs with eligibility such as Headstart, WIC, Child Care
    - Single application form
    - Regional or central processing
    - Application forwarded centrally for eligibility/enrollment
    - Preferably a single page
    - No "means" test but ensure a mechanism to verify income and meet Medicaid eligibility requirements
    - Presumptive eligibility similar to that extended to pregnant women
- Eligibility Determination
    - Timely with rapid determination (Neither lengthy or cumbersome for family)
    - Assignment to funding pool
        - Medicaid $
        - Healthy Kids
        - Vouchers for Employer or Plan linked with Employer to sustain coverage and prevent "crowd out"
        - Local match $
        - Primary Care Challenge Grant
- Enrollment
    - Uniform Identification Card regardless of funding pool – ID of fund source?
    - Identification of Copay if any for population >150% FPL
    - Identification of Copay if any for population <150% FPL
    - No Coinsurance for participants
    - Copays nominal
    - Parental choice counseling and choice of plans/providers
    - ? Copay on supplemental benefits
    - Income based optional buy-in for children's premium for families over 200% FPL
    - Must permit children in same family to be enrolled in different plans and yet maintain seamless approach for the customer and provider
- Scope of Benefits
    - As defined in legislation - choice of:
        - Federal Employee Health Benefit Plan - BC/BS PPO option, or
        - State Employee's benefit package, or
        - HMO with highest enrollment in Florida, or
        - Florida Healthy Kids benefit package (grandfathered - has some limitations that should be adddressed), or
        - Actuarially equivalent benefit package
    - American Academy of Pediatrics Scope of Benefits statement due out in October 1997
    - Must provide access to comprehensive services for children with special health care needs either in public or private sector, must assure supplemental services
    - Must consider mental health benefits for children as well as restorative therapies
    - Consider development of a program whereby families with income >200% FPL could buy in to premium at a percent such as 3-4% of family income.
- **Marketing**
    - Develop a new image for Florida's Plan
    - ? Florida KidCare or Florida Healthy Kids and Healthy Kids + or "Gold", Florida MediKid, etc.
    - Review social marketing and issues of Medicaid under-enrollment, outreach and effective choice counseling
    - Assure development of networks of providers.

- **Administrative Home for Program Contracting**
    - Department of Health preferred in cooperation with DOI
    - Fully meet provisions of Florida Child Health Insurance Act
    - Contracting Section to develop bid insurance package on a regional basis with choice of options, PPO, HMO, point of service etc.
    - Coordination with WAGES
    - Consider an advisory board to make recommendations to Secretary with membership such as but not limited to:
        - Secretary of Health
        - Insurance Commissioner
        - Director of Agency for Health Care Administration
        - Representatives of:
        - Florida Hospital Association
        - A Children's Hospital
        - A Statutory Teaching Hospital
        - An Academic Health Science Center
        - Florida Medical Association
        - Florida Pediatric Society
        - A Childrens Health Foundation
        - A Commercial Insurer
        - An HMO representative
- **Billing and Claims Processing**
    - Central filing
    - Central Payment/TPA
- **Evaluation and Outcome**
    - Assure the implementation of a qualified program for evaluation of process and outcome related to children's health through development of an RFP and selection of a nationally qualified contractor.
    - Assure evaluation of family satisfaction as well as HEDIS (version ?) measures as a minimum.

One of the major challenges will be the development of a vision to ensure not only the financing but also the system development necessary to provide optimal access and care for children with the delivery of early and periodic screening and preventive services through a vehicle that will appear seamless to the customer and provider even though diverse agencies may or must participate in the funding streams necessary for the provision of those services through a combination of federal, state, and local funds. Special attention must be provided for the continued definition of Health Start/Healthy Child preventive services that are supportive and preventive at primary, secondary, and tertiary

(Continued on page 25 ▸)

Legislation

(◂ continued from page 6)

CS/CS/SB 286 (CH. 97-92) - State Employee Health Insurance

Structural and internal policy changes are made regarding how the state employee health insurance programs are managed. A nine-member State Group Insurance Council is created to advise the state agency charged with insurance responsibility on cost, quality, performance and accountability issues. Specific provisions are enacted to provide for the oversight of contractor performance by the Council. This bill centralized authority for purchasing and oversight within the Division of State Group Insurance, Department of Management Services. The Agency for Health Care Administration is removed from its joint participatory role in contract formulation.

Effective Date: May 24, 1997

CS/HB 1965 (CH. 97-263) - Health Care

The "Primary Care for Children and Families Challenge Grant Act" is created to stimulate the development of coordinated primary health care delivery systems for low-income children and families. Persons with incomes up to 150 per cent of the federal poverty level are eligible and must meet copayment requirements. State and federally financed health care program eligibility must be exhausted prior to receiving services through the challenge grant. Counties will have broad latitude to design their benefit packages, except that primary care and preventive serives, as well as inpatient services, must be included. Successful applicants for the grant will have to contribute a local match of in-kind or cash contributions. Implementation is subject to funds appropriated in the General Appropriations Act.

This bill directs the Agency for Health Care Administration, in conjunction with the Department of Health, to evaluate the cost benefits, program effectiveness, and quality outcomes associated with a service delivery model versus and insurance coverage model. This evaluation must include, but not be limited to, Medicaid, the Challenge Grant program established by this act, the Children's Medical Services Alternative Service Network, and the Florida Healthy Kids Corporation program. The report is to be completed by January 1, 1999.

This legislation also saves from repeal the voluntary health care provider program.

Changes to the Medicaid program are made to: extend family planning services to women in families with incomes at or below 185 per cent of the federal poverty level for a period of up to 24 months following a Medicaid covered pregnancy, this is subject to specific federal authorization; pregnancy prevention counseling is to be covered as part of Medicaid family planning services; and, directs creation of a program to identify low-income, uninsured children and to refer such children for Medicaid eligibility determination and provide parent with information about possible sources of care.

Effective Date: May 30, 1997

CS/SB 238 (CH. 97-270) - Certificates of Need

Certificate of Need regulation is revised to deregulate review of certain capital expenditures, except those that are incidental to projects or services subject to review; deregulates the acquisition of major medical equipment; increases the threshold for cost overruns; and exempts the delicensure of beds, the termination of a health service and adult inpatient diagnostic cardiac catheterization from review. Quality standards are established for adult inpatient diagnostic cardiac catheterization. Other process changes are made regarding letters of intent, effectiveness dates and applicability of certain statutory provisions pending administrative or judicial actions.

Effective Date: July 1, 1997

HB 259 (CH. 97-195) - Alcohol, Drug Abuse, and Mental Health Services

This legislation establishes funding thresholds for alcohol, drug abuse, and mental health services in each service district. Additional funds beyond the 1996-97 fiscal year base will be based on epidemiological estimates and a pro rata share to ensure that districts below the statewide average receive funding necessary to achieve equity.

Beginning July 1, 1998, all additional funding for substance abuse and mental health services must be performance based.

Effective Date: July 1, 1997

CHILD WELFARE, SAFETY AND EDUCATION

CS/CS/SB's 566 & 626 (CH. 97-173) - WAGES (Welfare Re- form)

This legislation is a refinement of the "Work and Gain Economic Self-sufficiency (WAGES) Act" enacted last year. The following are among the revisions to the act:

- Raises from 12 years to 16 years of age the maximum age of a child who may receive, through a protective payee, continuing assistance under the WAGES Program where a family member is in noncompliance with work requirements of the program.
- Allows WAGES applicants to participate in work activity requirements and receive associated support services or child care assistance.
- Removes from good cause exemptions for unexcused school absences in the Learnfare program, a teen with a child under 6 months of age.
- Requires the Agency for Health Care Administration to make probable cause determinations for overpayments to Medicaid providers and authorizes the Agency to recover overpayments as well as to withhold payments.
- Authorizes the Department of Children and Family Services to participate in the Federal Income Tax Refund Offset program to recover food stamp benefits or WAGES cash benefits that are owed to the state.
- Requires the department to establish a special needs allowance for families with unusually high out-of-pocket expenses related to the disability of a family member when those expenses exceed 125% of the maximum supplemental security income grant for an individual. The number of families eligible for this allowance will be limited.
- Authorizes the Department of Children and Family Services to establish minimum standards for family day care homes that must be licensed under county ordinance or voluntarily choose to be licensed.

Effective Date: May 30, 1997

CS/HB 55 (CH. 97-155) - Domestic Violence

The law providing for protective injunctions is amended to allow courts to grant any relief the court deems necessary to protect any minor child of a victim of domestic violence, and limits to $50 the amount which may be charged to issue an injunction for protection. The bill also allows evidence that a parent has been convicted of a felony of the third degree or higher involving domestic violence to be a rebuttable presumption of detriment of a child in custody cases. Evidence of domestic violence or child abuse and evidence that any party knowingly provided false information to the curt regarding a domestic violence proceeding must be considered by the court in child custody determinations. A new section is added to this law to implement the federal law requiring states to grant full faith and credit to the protection orders of toehr states or of Indian tribes. Upon the motion of any party, the court is prohibited from referring the case to mediation if it finds that there is a history of domestic violence that would compromise the mediation process.

Effective Date: October 1, 1997

CS/HB 1111 (CH. 97-226) - Termination of Parental Rights

This legislation adds to the grounds for termination of parental rights of incarcerated parents when: The period of time for which the parent is expected to be incarcerated constitutes a substantial portion of the period of time before the child will attain the age of 18 years; The parent has been determined to be a violent career criminal, a habitual violent felony offender, a habitual felony offender or a sexual predator; and the court determines by clear and convincing evidence that continuing the parental relationship with the incarcerated parent would be harmful to the child. The bill also expands the court's options for custody of the child and specifies that the termination of parental rights does not affect the rights of the grandparents. The bill applies to persons who are incarcerated after October 1, 1997.

Effective Date: October 1, 1997

CS/SB 1760 (CH. 97-276) - Child Abuse / Custody

The process for identifying and giving notice to adult relatives when a child is taken into custody of the Department of Children and Family Services as a result of allegations of abuse, neglect, or abandonment is modified by this legislation. At the time the child is taken into custody a request is to be made for identification of all known parents and next of kin. The court, at the shelter hearing, must require for the court's record disclosure of all known parents and next of kin of the child. "Next of kin" is defined as an adult relative who is the child's brother, sister, grandparent, aunt, uncle or first cousin. The legislation requires the department to conduct a search for such next of kin to be considered

(Continued next page ▸)

Legislation
(◂ continued from previous page)
as appropriate for placement of the child. If the child remains in the custody of the department, notification is required to specified persons when adoption is considered or to report on the status of the child in custody of the department.
Effective Date: July 1, 1998

HB 1421 (CH. 97-242) - Relocation of Child and Rotating Custody

This legislation amends the law regarding child custody to provide that no presumption in favor or against any request of a residential parent to relocate a child until the court considers specified factors. Those factors include: Whether the move will improve the quality of life for both the residential parent and the child; The extent to which visitation rights have been allowed and exercised; Whether the substitute visitation will be adequate to foster a continuing meaningful relationship between the child and the nonresidential parent; Whether transportation costs are affordable for one or both parents; and, Whether the move is in the best interests of the child. The court may order rotating custody if it is found to be in the best interest of the child.
Effective Date: July 1, 1997

CS/HB's 845 & 1255 (CH. 97-162) - Tobacco Products / Minors

This legislation makes it unlawful for a person under the age of 18 to purchase, possess, or misrepresent his or her age or military status in order to acquire any tobacco product. A civil citation process is established with penalties up to a $25 fine, 16 hours of community service and attendance at an anti-tobacco educational program. Upon a third violation or failure to comply with the civil penalty suspension, revocation or withholding the issuance of a driver's license is required by the act. The legislation requires all tobacco products to be sold within the direct control of a dealer or using vending machines equipped with lockout devices. Licensed premises which prohibit persons under 18 years of age are exempt from the requirements. Eighty percent of the fines collected are to be used to design programs to reduce and prevent the use of tobacco products by minors.
Effective Date: October 1, 1997

CS/SB 630 (CH. 97-63) - Child Care Facilities

The Department of Children and Family Services is directed to develop minimum standards to provide for reasonable, affordable, and safe evening and weekend child care. Additionally, the department is provided specific authority to adopt rules establishing minimum standards for family day care homes.
Effective Date: July 1, 1997

SB 198 (CH. 97-27) - Stalking

This law makes it a third degree felony for a person to willfully, maliciously, and repeatedly follow or harass a minor under the age of 16 years, without regard to whether that person makes a credible threat with the intent to place the victim in reasonable fear of death or bodily injury.
Effective Date: October 1, 1997

HB 1529 (CH. 97-165) - Alcoholic Beverages / RAVES

This legislation provides that no licensed vendor who principal business is the sale of alcoholic beverages may rent, lease or otherwise use the licensed premises during the hours in which the sale of alcoholic beverages if prohibited. These provisions are intended to address "rave" parties that have proliferated throughout the state in the last few years. "Raves" are parties conducted in warehouses, fields and most recently in premises licensed to sell alcoholic beverages where persons under the age of 21 gather during the early morning hours (normally between 2:00 am and 9:00 am).
Effective Date: May 29, 1997

CS/SB 778 (CH. 97-10) - Passing School Buses

This law increases the penalty to $200 for passing a school bus on the side that children enter and exit when the bus is displaying a stop signal, and provides that the violator be subjected to a mandatory hearing. School buses are required to display warning lights and stop signals before discharging or loading passengers. These provisions apply to both private and public school buses.
Effective Date: October 1, 1997

CS/SB 148 (CH. 97-) - Domestic Violence

Among the provisions of this bill is an allowance for a discretionary multiplier of 1.5 to be used in calculating the sentencing for a domestic violence crime when it is committed in the presence of a child who is related by blood or marriage to the victim or perpetrator and the child is 16 years of age or younger.

CS/HB 411 (CH. 97-34) - Automatic External Defibrillators

This law authorizes the use of an automatic external defibrillator (AED) by any person who has had appropriate training. Appropriate training requires successful completion of a course in cardiopulmonary resuscitation or basic first aid that includes cardiopulmonary resuscitation and demonstration of proficiency in the use of an AED. Persons so qualified are encouraged to register with the local emergency medical services medical director and any person who uses an AED is required to activate the emergency medical services system as soon as possible upon the use of the AED.

The "Good Samaritan Act" is also amended by this law to extend immunity from civil damages as a result of the use of an AED, without objection of the victim, if the person meets the reasonably prudent person standard.
Effective Date: April 30, 1997

CS/HB 991 (CH. 97-53) - Florida High School Activities Association (FHSAA)

This law designates the Florida High School Activities Association (FHSAA) as the nonprofit organization established for governing high school athletics in Florida public schools. High School is defined as grades 6 - 12. The FHSAA must adopt bylaws that establish eligibility requirements for all students. The executive authority for the organization will be vested in a board of directors which will be charged with establishing guidelines, regulations, policies, and procedures. The legislative authority of the organization will be vested in a representative assembly, which must meet annually, and is charged with the sole function of considering, adopting or rejecting any proposed amendments to the organization's bylaws. The organization must establish, sustain, and fund a public liaison advisory committee,the purpose of which is to act as a conduit through which the general public may have input into the decision-making process. The committee will annually evaluate the organization and submit a report to the board of directors, the Commissioner of Education and to the Florida Senate and House of Representatives. The bylaws must require member schools to adopt rules for sports which have been established by a nationally recognized sanctioning body, unless waived by at least two-thirds vote of the board of directors.
Effective Date May 7, 1997

CS/HB's 1309, etc. (CH.97-234) - Student Discipline and School Safety

This legislation provides for the following:

- Provides procedures for the Department of Highway Safety and Motor Vehicles to withhold issuance of or suspend the driver's license or learner's driver's license of any minor who fails to satisfy school attendance requirements.
- School districts are prohibited from permitting schools to exempt students from academic performance requirements as part of a policy designed to improve attendance.
- Requires school districts to conduct a policy of zero tolerance for crime and substance abuse.
- Expands the definition of weapons that cannot be possessed or exhibited on school property, a school bus, or a bus stop to include a razor blade, box cutter, or knife.
- Requires disclosure to classroom teachers of students who have been placed in a community control or commitment program for a felony offense.

Effective Date: July 1, 1997

CS/HB 137 (CH. 97-190) - State and Local Education Governance

This bill deregulates local governance of public schools by giving broad policy guidelines and deleting many state level policies. This bill makes the Commissioner of Education, rather than the State Board of Education, the head of the Department of Education. Authorization is provided for instruction and programs in character development and law education; the objective study of the Bible and religion; traffic education; free enterprise and consumer education; patriotism; drug abuse resistance education; comprehensive health education; care of nursing home patients; instruction in acquired immune deficiency syndrome; voting instruction; and before and after school programs.
Effective Date: July 1, 1997

Congratulations.....

.....are in order

Our Executive Vice President and our Chapter Administrator have announced the results of the recent election in selected Regions of the Chapter. All changes in status will be effective on February 22, 1998.

<u>*Region II*</u>:

Frank Genuardi, M.D., (Jacksonville), has been elected *Alternate Regional Representative*, succeeding Barbara O'Reilly.

Barbara O'Reilly, M.D. (Jacksonville Beach) advances to the position of *Regional Representative*.

<u>*Region III*</u>:

John Nackasi, M.D. (Gainesville) has been elected *Alternate Regional Representative*, succeeding Susan Griffis, M.D.

Susan Griffis, M.D. (DeLand) advances to the position of ***Regional Representative***.

<u>*Region IV*</u>:

Brenda Lewis, M.D. (DeBary) has been elected *Alternate Regional Representative*, succeeding Brenda Holson, M.D.

Brenda Holson, M.D. (Maitland) advances to the position of *Regional Representative*.

<u>*Region VI*</u>:

Edwin Guttery, M.D. (Ft. Myers) has been elected *Alternate Regional Representative*, succeeding John Bartlett, M.D.

John Bartlett, M.D. (Ft. Myers) advances to the position of *Regional Representative*.

We acknowledge and offer our thanks for a job well done, to the following Regional Representatives, who have completed their "tour of duty" in that position!

Region II: Lucien K. DeNicola, M.D. (Jacksonville)
Region III: Richard L. Bucciarelli, M.D. (Gainesville)
Region IV: Robert B. Eanett, M.D. (Lakeland)
Region VI: Jerome H. Isaac, M.D. (Sarasota)

[Please note that, for purposes of continuity, only half of the regions held elections this year; the other four will do so next year]☐

President

(◂continued from page 1)

philosophy and process involved.

There is also need for involvement of our membership in all of the above. Regarding especially legislative efforts, if our hopes and aspirations for success in funding, taming third party transgressions, and other efforts in Tallahassee are to materialize, the society leadership need all the help we can get. Suggestions:

1) Join PEDIPAC
2) Support, meet, and educate your legislators, especially those you know or whose children (or those of their staff) you care for.
3) Support your Society's Legislative Committee if you are asked for help. Better yet, volunteer. (Yeah, I know what they said in the Army, but here it is your tail on the line of you DON'T help)

Best wishes for a healthy Thanksgiving.

Edward T. Williams III, M.D.
President☐

Concept Paper

(◂ continued from page 23)

levels of intervention. Similarly, the opportunities that may be used through the funding vehicles with decreased state match for federal dollars must be effectively explored to maximize the support of primary care challenge grants relative to support of families and children.☐

Did You Know?

Pediatrics now has *Pediatrics electronic pages*, available through the Internet. Each month, there are 6 - 10 new peer-reviewed articles. Abstracts will be included on green pages in the regular issue of *Pediatrics*. However, the complete articles will be available only on the electronic pages. *Pediatrics electronic pages* may be accessed via an internet connection and a World Wide Web Browser. The site is located at **http://www.pediatrics.org.**☐

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?
Please send an update to the Executive office to assure receiving mailings. Thanks!

Add a 'pearl' ...from Chuck Weiss

Acetaminophen Update

An article in the previous issue of this publication discussed the potential of acetaminophen (Tylenol®) toxicity. Upon my inquiry, the Florida Poison Information Center - Jacksonvillel manually tabulated the 1996 and prior data bases for this issue. Presently implemented collectgion systems will record this information and such factually accurate reports will be available later this year.

Outcome of Tylenol Ingestion in Florida

Outcome	*# cases*	*Per cent*
No effect	601	28.3
Minor effect	235	11.09
Mod effect	131	6.18
Major effect	21	0.99
Death	2	0.09

Minor effect = GI upset without systemic or lab changes
Moderate effect = GI upset with lab changes (i.e., LFTs w/wo presence of other systemic effects
Major effect = above plus major systemic effects including documented organ failure

Age (yrs)	*# cases*	*Per cent*
Unknown	15	0.71
<6	902	42.57
6 to 12	135	6.37
12 to 19	364	17.18
>19	703	33.18
Grand Total	**2119**	

Exposure	*# cases*	*Per cent*
Non-toxic	30	14.3
No follow-up	231	10.9
Unrelated effect	33	1.56
Confirmed non-exposure	20	0.94

Acetaminophen/Tylenol® makers, for the first time are informing parents through revised labels and advertising that too much Tylenol® can harm their childlren. Relatively small overdoses (2x the proper dose) have been associated with liver damage and even deaths in children in the United States. The American Association of Poison Control Centers figures for 1996 show 31,511 childlren under 6 suffered inappropriate exposure to pediatric acetaminophen products. While most needed no treatment, there were minor effects in 631 children, moderate (requiring some treatment) in 63, and life-threatening or permanent effects in six.

According to their data, there were no fatalities last year. However, since these figures were released, the death of a 5 year old Florida/Louisiana winning baton twirler and the nationally publicized case of a pre-schooler in whom liver transplantation was required became known.

The FDA now requests manufacturers to explalin correct dosages for children under 2 years instead of the current language that directs parents to consult their doctors.

Many thanks to Dr. Jay Schauben and his staff at the Jacksonville Florida Poison Information Center for this manually tabulated data.

[In his usual manner, Chuck Weiss has once again kept us up to date on pharmacologic dangers to our children. It is kind of strange that this

again be surfacing! -Ed.]☐

Kudos

Former FMA President Gerold L. Schiebler, M.D., and his wife Audrey, were presented with the Sharon Solomon Child Advocate of Valor Award on October 24, by the Florida Center for Children and Youth. The Schieblers were chosen as recipients because of their compassionate commitment to the health, safety, and well-being of children. According to the program brochure "Their efforts bridge the disciplines of medicine, law,

for children provides inspiration to all who seek to save lives and enhance the quality of those lives."☐

FYI

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

Bob Grayson is editor of the Senior Bulletin. His article, reprinted here, is a masterpiece of the history of clinical medicine and pediatrics, and is so well written that it is reproduced here to bring it to those who have not yet reached senior status

As I Remember It

Robert Grayson, M.D.
Surfside, FL

It might be said that the study of history opens the window to the future. It was my good fortune to be in the right place at the right time and to have participated in the New York City epidemic of smallpox in 1947. These were the last cases of smallpox seen in the United States, and may have initiated the world wide vaccination program which finally eliminated smallpox (variola) from our planet. The story of the introduction of small pox into New York City, the difficulty in diagnosis, the mode of its spread, and the unfortunate complications of massive vaccination program are worthy of recounting.

In February 1947, an American business man (ELB) left Mexico City on February 24th, traveling cross country on a Greyhound bus which made many stops en route. Somewhere midway, on about February 28th, he became ill with fever, and malaise. He arrived in New York City with increasing fever and malaise, and stayed at a midtown hotel from March 1 to March 5. During this period, he developed a rash, presented himself to Bellevue Hospital, and was admitted to the Dermatology Ward with a diagnosis of Kaposi varicelliform eruption. Wards at Bellevue at this time were open rooms with perhaps 15 to 20 beds in one large space. After several days of observation and deliberation, ELB was transferred to Willard Parker Hospital (the infectious disease institution in NYC), and was placed in a private room with isolation technique. He succumbed there on March 10. By this time smallpox was strongly suspected, and chick egg embryo culture confirmed this impression at about the time of his demise. ELB is said to have been previously vaccinated.

Now the epidemiological detective process began. As much as possible guests at the hotel at the time of ELB's stay were traced, and vaccinated, as were contacts on the long bus trip. Obviously many contacts could never be found, but to the best of our information, none of these people developed the disease. However, hospital contacts were not so fortunate. All told, there were 11 more cases of smallpox through April 1947, all of which could be traced to ELB. There were four secondary cases from contact with ELB at Willard Parker Hospital in spite of supposed isolation technique, and awareness of the problem [including nurses! -Ed] It is believed that the spread occurred through airborne infected crust particles or mucous droplets, which were carried through several floors. One of the Willard Parker contacts (IA) who had been hospitalized at Willard Parker for a different illness at the time ELB was present, developed fever, malaise and a rash at home after discharge. He presented to Bellevue, was again briefly hospitalized on the Dermatology Ward, was transferred to Willard Parker where the diagnosis of smallpox was confirmed. There were four contacts who developed smallpox from IA. These were IA's pregnant wife who died, and three other individuals who were on the Dermatology Ward with IA.

One of the original contacts to ELB, who had been hospitalized at Willard Parker for scarlet fever, and had been discharged to a convalescent home, developed smallpox at the convalescent facility, and transmitted the disease to three other individuals at that facility.

In this outbreak, there were 12 cases in total, all hospital contacts, with 2 deaths, a mortality of 17%. At this time, a major campaign of vaccination was instituted in the New York area. Over 6.5 million individuals were vaccinated in four weeks. Unfortunately, there were a significant number of complications from this program. Forty-five individuals were diagnosed with encephalitis, 4 of whom died, but none of these showed changes at post mortem characteristic of post-vaccination encephalitis. Forty-one survived, 38 of whom made a complete recovery. Of the 6.5 million vaccinated, 45 or more developed generalized vaccinia, 38 of whom had a preexisting dermatitis, and 28 of whom were accidentally vaccinated by contact with another person's vaccination rather than directly by the vaccination procedure itself. Of the 15 cases of secondary vaccinia seen at Willard Parker, 2 died, 13 recovered.

What did I (we) learn from this unusual experience? In the first place, one has to think of a particular condition, even though rare and unexpected, when confronted with a difficult differential diagnosis. Second, that infections can spread even in an "isolation" hospital erected to prevent such spread (Tuberculosis is another example). Large open wards are unacceptable. Viral illness can spread more easily than bacterial. Since this experience, I have always hesitated to hospitalize a child unless absolutely necessary. Treatment of the child with diarrhea with oral rehydration at home is preferable to IV hospital therapy. It is only recently that hospital admissions have gone down, not for the reason stated above, but for economic considerations. Avoidance of hospital cross-infections is desirable and possible. We may have let down our guard in recent years because of false reliance on the long series of new antibiotics.

Lastly, I am impressed by the tremendous protection that vaccination gave to the general public against smallpox, and how much progress has been made in prevention of infectious disease by the use of the many vaccines now available. The story of the elimination of smallpox throughout the world is another fascinating tale, and perhaps we can pursue this in a subsequent bulletin.

[Your Editor is particularly sensitive to this historical depiction since he too was involved in the outbreak, single-handedly vaccinating about 5000 residents in the area in which he was a pediatric resident at the time. Many of these were older folks, vaccinated long before, and therefore no longer well protected. These were some of the people who developed tremendous vaccination reactions and complications following the vaccination. Well-done, Bob!]☐

Seniors to the Rescue

It is important to note a specific service initiated by the Senior Section at the suggestion of, and by the continuing effort of David Annunziato, a member of the Executive Committee and past District II Chair. David has arranged for emergency medical care for attendees at the Spring and Fall meetings of the AAP through pediatricians in the city of the meeting and their colleagues in other specialties.

An Academy staff member carries a beeper at all times, whose number is posted in the Meeting Newspaper during all the days of the meeting. If an attendee were to have a medical proble, a call to the beeper would provide a contact with a local pediatrician and adult specialist as needed. The service has been of help at each meeting since its inception four years ago.☐

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 20-22, 2997
Place: Royal Plaza Hotel, Orlando, FL
Credit: 13 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Florida Association of Pediatric Tumor Programs
Inquiries: Susan Easter, PO Box 17757, Tampa, FL 33682 (813)632-1309

Program: Practical Pediatrics
Dates: December 12-14, 1997
Place: San Antonio, TX
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

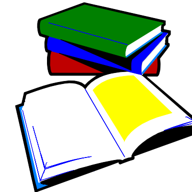
Program: 25th Annual Seminar in Pediatric Nephrology: Kidney Disorders in Children: A 25 Year Overview
Dates: January 31-February 4, 1998
Place: Fontainebleu Hilton Resort and Spa, Miami Beach, FL
Credit: 20.5 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Department of Pediatrics, University of Miami School of Medicine
Inquiries: Jose Strauss, M.D., Program Chairman, (305)585-6726, fax (305)547-1709, e-mail jstrauss@mednet.med.miami.edu

Program: 21st Annual Gold Coast Conference: Pediatrics into the Milennium
Dates: February 8-10, 1998
Place: The Breakers, Palm Beach, Florida
Credit: 13 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Intracoastal Health Systems Children's Hospital at St. Mary's, Good Samaritan Medical Center, West Palm Beach, FL
Inquiries: Director of Continuing Medical Education, (561)650-6236

Program: Gulf Coast Pediatric Conference
Dates: February 27-28, 1998
Place: Holiday Inn Select, Ft. Myers, FL
Credit: 10 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine, Dept. of Pediatrics
Inquiries: Ms. Rebecca Scott (813)272-2744 or FAX (813)272-2749

Program: 1998 Legislative Conference
Dates: April 25-28, 1998
Place: Washington, DC
Credit: 9 hours for Category 2 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics Washington Office
Inquiries: AAP, call 1-800-336-5475 or (202)347-8600

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



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