Will and Charlie Mayo in Rochester, Minnesota by Steven Matson, MD
Practical Pediatrics CME Course—Extended Early Bird  
Long Beach, CA  
The Westin Long Beach  
Oct 4—6, 2007  
Maximum 16.5 AMA PRA Category 1 Credit(s)™

Aloha Update Pediatrics 2007  
Kauai, HI  
Grand Hyatt Regency Kauai Resort  
Oct 7-11, 2007  
Maximum 22.5 AMA PRA Category 1 Credit(s)™

24th Annual Care of the Sick Child Conference  
Orlando, FL  
Arnold Palmer Children’s Hospital/Orlando Regional Healthcare  
Oct 19-21, 2007  
Maximum 17.5 AMA PRA Category 1 Credit(s)™

*To register, please call (800) 648-0450 or email shirley.ferris@orhs.org to register.  
*For a copy of the brochure, go to www.orlandoregional.org. Click on For Medical Professionals. Then click on Continuing Medical Education.

National Conference & Exhibition  
San Francisco, CA  
Westin St. Francis  
Maximum 53.0 AMA PRA Category 1 Credit(s)™

5th Annual Pediatric Brain & Spinal Cord Injury Conference  
Coconut Grove, FL  
Sonesta Hotel & Suites  
Nov 2-4, 2007  
Maximum 16.25 AMA PRA Category 1 Credit(s)™

*For more, see http://www.pedibrain.org/conference/conference.asp  
*This year’s conference features internationally recognized leaders in pediatric traumatic brain injury, pediatric spinal cord injury and less common types of brain injury in children. Topics all along the continuum of care will be covered including injury prevention, acute
Editor’s Request:
Please contribute to the Newsletter. You, the member, are a vital part of the process for helping the Newsletter become an excellent resource tool and vehicle of unification for the entire Florida Pediatric Society. Subject matter need not only be scientific. I strongly encourage you to submit articles and artwork of a personal nature. Contribute well and contribute as often as you like.

Artwork Needed!

Articles Needed!

Scanned artwork, photography, or other digital artwork are accepted in jpeg, bmp, & pdf format. Please submit all articles and artwork for the next issue of The Florida Pediatrician by November 30., 2007.

trauma, neurocritical care, neurosurgical management, basic neuroscience, acute and long-term rehabilitation, and school reentry. *Registrants may attend two of four specialized workshops: sports-related concussion in children, neuroimaging after brain injury, adolescents and TBI, and restorative therapies for SCI and paralysis. *The first day is capped with complimentary sailing and cocktails at the famous Miami Shake-A-Leg Center and Water Sports Program: http://www.shakealegmiami.org/site/c.kkLUjbMQKpH/b.2521629/k.BF03/Home.htm

1st Annual Pediatric Review Course!!!
Orlando, FL
Hawthorn Suites Orlando Airport
Nov 10-11, 2007
Maximum 17.0 AMA PRA Category 1 Credit(s)™

Practical Pediatrics CME Course– Registration Open!
Phoenix, AZ
Pointe Hilton Squak Peak Resort
Nov 15-17, 2007
Maximum 16.5 AMA PRA Category 1 Credit(s)™

Safer Health Care for Kids: Racial/Ethnic Disparities & Patient Safety — Webinar
12:00—1:00 PM EST
Nov 15, 2007
Maximum 1.0 AMA PRA Category 1 Credit(s)™

Safer Health Care for Kids: The ABP: Efforts in Patient Safety & Maintenance in Certification — Webinar
12:00—1:00 PM EST
Dec 4, 2007
Maximum 1.0 AMA PRA Category 1 Credit(s)™

Practical Pediatrics CME Course– Registration Open!
San Antonio, TX
Hyatt Regency San Antonio
Dec 14-17, 2007
Maximum 16.5 AMA PRA Category 1 Credit(s)™

For more, please visit http://www.pedialink.org/cme
Dear Fellow Pediatrician:

Thank you for the opportunity you have given me to serve as the 67th President of the Florida Pediatric Society / Florida Chapter of the American Academy of Pediatrics.

I am fortunate to have assumed stewardship of an organization that, under the leadership of our Immediate Past President Dr. David Marcus, has achieved significant progress which will serve as a starting point for our continued growth in Advocacy, Education and Service.

In revising our Constitution and Bylaws, redesigning our web page, achieving accreditation as an independent provider of CME, and securing grant and other sources of non-dues revenue, we are positioned to increase our effectiveness and fulfill our mission to the children of our great State as we increase our value to you, our members.

It is a great privilege to work with a talented Board of Directors and the elected Regional Representatives who practice in communities throughout Florida, and whom you will meet over time on the pages of this newsletter. Today, I take the opportunity to present the Executive Officers who share the responsibility of guiding our organization.

Jerry Isaac, MD, our President-Elect and Chair of the FPS/FCAAP Council on Governance is currently in solo practice in Sarasota. He is affiliated with Sarasota Memorial Hospital, has practiced for 31 years; was educated at New York University and completed his Residency at Bellevue Hospital.

John Donaldson, MD, our First Vice President, has practiced for 30 years in Illinois and Nova Scotia before moving to Florida in 1990. He graduated from College of Medicine University of Saskatchewan, interned at Royal University Hospital, and completed his residency at University of Saskatchewan. He completed his fellowship in Pediatric Otolaryngology at Children's Hospital of Pittsburgh. He is a former Head of Otolaryngology at the IWKilam Children's Hospital in Halifax and Medical Director of the Children's Hospital of Southwest Florida. He is currently the Chairman of the
Lisa M. Cosgrove, MD, our Second Vice President, has practiced for 21 years, is currently in private practice in Merritt Island and is Chair of Perinatology Committee at Cape Canaveral Hospital. Dr. Cosgrove graduated from Ross University and completed her Residency at Emory University in Atlanta. She is the FPS/FCAAP Chair of the Council on Membership and Communication and has been a Board member since 2002.

In addition to our elected officers, we are fortunate to have Louis St. Petery, MD, as Executive Vice President and lobbyist for the Society and Dawn Pollock who is Executive Director.

Louis St. Petery, MD, serves as Executive Vice President, Chairman of the Legislative Committee, and the FPS/FCAAP representative to the KidCare Coordinating Council. He has been a physician for 38 years and currently practices pediatric cardiology in Tallahassee in partnership with his wife, Julia R. St. Petery, MD, a general pediatrician. Dr. St. Petery graduated from University of Florida Medical School and served his Residency and Cardiology Fellowship at Shands.

Dawn Pollock, Executive Director (CAE), holds a Masters Degree in Organizational Communication from Florida State University. She has more than 20 years of experience with a variety of non-profit organizations and volunteer programs. She has worked with the FPS/FCAAP for 2 years and served as Executive Director for the past 14 months.

Our future success will reflect the measure to which we are able to secure today the cooperation of stakeholders who value children’s issues. Most importantly, we value and seek your input, participation, and support, as we move forward, “Dedicated to the Health of All Children”\ä.
Friends and Colleagues,

This has been a very exciting quarter for healthcare! SCHIP seems on its way in Congress. However, President’s Bush eminent veto looms over our heads. It’s astounding that the President of our wonderful country sees fit to limit healthcare for children who are underprivileged and from low-income families. All this must stem from lack of personal experience; many in political arena have not seen what we have seen. We have all undoubtedly seen the effects of lack of healthcare in the children. As a result, we don’t want anymore preventable negative consequences to occur. The AAP and our very own Dr. St. Petery have been excellent in keeping us up to date on the latest with SCHIP, Florida KidCare, and the Medicaid Lawsuit. You will find the most recent of these updates in this issue. I am so proud to be a member of these organizations whose members and staff have a genuine concern for children and aggressively act on those concerns. As we continue to fight the fight, urging Congress and our President as to the importance of children’s healthcare, we should all keep one thing in mind; we are the voice for those who do not have one.

I wish to thank all of those who are submitting articles to the Newsletter. This month, we have our first contributor to the “At Your Leisure” section; Dr. Steven Matson has submitted some wonderful person photos and a brief biography. I encourage you all to submit all photos and stories for publication in The Florida Pediatrician. You need not send a biography. You can send photos of your travels. Let us all live vicariously through your adventures!

In addition, I would like to see the artist inside of you come out into the open. Come out of the closet! Submit a photo or artwork for consideration as the cover of the Newsletter. Submit a short story, poetry, or prose for the “At Your Leisure” section. Do you have a funny photo of your kids or pets? So many of us pediatricians are naturally pet lovers; so why not share that side with us? Also, Halloween is coming up. You may have some really cool pictures of your kids, your pets, or even your private practice that you care to share. Feel free to write as little or as much as you like with any artwork you submit. Please help me with my goal for this section to be in every issue of The Florida Pediatrician.

If any of you have won special awards that you would like to share with the members of your Florida Pediatric Society, then, please submit digital pictures and a history of the award, and any other pertinent information. We have amazing members in our Florida Pediatric Society. So many of us are local and national child advocates. Let us be proud of each other’s accomplishments, thereby encouraging others to do the same.

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

Sincerely,

Nancy M. Silva, MD, FAAP

http://www.katiesstory.com/
Florida Pediatric Society Presents the 1st Annual

Pediatric Review Course

November 10-11, 2007

Hawthorn Suites Orlando Airport, Orlando, FL
7450 Augusta National Drive • Orlando, FL 32822
Phone: (407) 438-2121

REGISTRATION INFORMATION

This program is supported by a restricted medical education grant from the Ross Products Division of Abbott Laboratories, Inc.
Perhaps the most significant news for the Department of Pediatrics in Jacksonville is that for the first time the Jacksonville Regional Campus will now have a Chairman. Thomas Chiu, MD, MBA was appointed the first Chairman of the Department this academic year. Dr. Chiu has served as the Associate Chairman for the department for over 10 years. Despite the title, he was the defacto Chairman of the Department of Pediatrics in Jacksonville. Dr. Chiu is also the Regional Medical Director for the CMS Northcentral Region that includes Daytona, Gainesville, Jacksonville, and Ocala. Mobeen Rathore, MD and Mark Hudak, MD serve as Associate Chairs for the Department.

The Department of Pediatrics in Jacksonville has eighty-three (83) full time faculty members, ten (10) additional with joint appointments, and 43 with courtesy appointments (http://ufhscj.edu/peds/faculty.asp). More information about the department can be found at http://ufhscj.edu/peds/.

Our residency program led by our Program Director Dr. Jim Kirk is in collaboration with Wolfson Children’s Hospital and Nemours Children’s Clinic. The program accepts eleven (11) residents a year (http://ufhscj.edu/peds/pr/). In addition, we have two fellowship programs in Pediatric Infectious Diseases and Pediatric Endocrinology. We have successfully matched our residency slots for several years with outstanding residents. Jacksonville also has a Pediatric Emergency Medicine Fellowship.

The Department provides both primary and specialty services. Through a pediatric network in collaboration with the Duval County Health Department, our department boasts the largest general pediatric practice at 10 sites in Jacksonville. Dr. Goldhagen is the Chief of General and Community Pediatrics. In addition, our citywide neonatal program which was started by Dr. Chiu is the largest in town and serves six hospitals. Dr. Hudak is the current Chief of Neonatology. Our Cardiovascular program in collaboration with the Wolfson Children’s Hospital and UF Gainesville has grown rapidly under the leadership of Jose Ettedugi, MD and our two cardiovascular surgeons. The Division of Nephrology and Rheumatology serves both Jacksonville and Daytona. Our division of Infectious Diseases, led by Dr. Rathore, has the first accredited fellowship program in the State and is responsible for the Rainbow Center, University’s HIV program, caring for both adults.
and children and the Pediatric TB program for the Duval County Health Department. Our Division of Forensic Pediatrics under the leadership of Randy Alexander, MD provides child protection services for the region. Dr. Alexander also serves as the statewide consultant for child protection services. In our four member adolescent medicine division, we recently recruited Dr. Steve Matson as the new Division Chief and you will surely hear more about them in future writings. Our Division of Hospital Pediatrics, seven hospitalists strong, provides inpatient services at both Wolfson Children’s Hospital and Shands Jacksonville.

The Department of Pediatrics, University of Florida College of Medicine Jacksonville is a growing department. We are currently recruiting over ten (10) new faculty members. The Division of Critical Care Medicine has grown substantially over the past couple of years and we are recruiting a Division Chief in this Division. Our very successful Division of Developmental Medicine is currently recruiting for the division chief while they continue to provide the much needed services in the region.

Through collaborative efforts with Wolfson Children’s Hospital, Nemours Children’s Clinic and Duval County Health Department, the Department has established outstanding programs and services for children of our region.
Our programs for our students have entered into the next year with our new first-year students attending the initial “White Coat Ceremony.” The pediatrics special interest group has recruited over fifty (50) new members from our incoming class! We will definitely need to increase the number of postgraduate pediatric positions in the State of Florida to accommodate the entire group of interested students in four years.

Our college had record numbers of children attend our annual back to school physicals which is done in coordination with the dental college and the optometry college. The pediatric special interest group provided valuable support throughout the entire day.

Our pediatric residency at Palms West started its new intern class with an orientation and introduction to the attendings and senior residents. One of our senior residents, Brian Vaske, D.O., had a successful poster presentation on the complications of the lapse of community health care at the Future of Pediatrics conference in Orlando this past June.

The greater Central Florida area continues a trend of significant growth and development. We have experienced growth in our physical structure and in our faculty over the past year. The Winnie Palmer Hospital for Women and Babies opened in May 2006. In our first year of operation, we had 13,637 deliveries, so our
residents have ample opportunity to develop their newborn skills. In addition, the Bert Martin’s Champions for Children Emergency Department and Trauma Center (Level One) is now open at Arnold Palmer Hospital for Children. The pediatric emergency department is staffed full-time with fellowship-trained pediatric emergency medicine faculty. The pediatric emergency department includes 29 private rooms and a 4-bed resuscitation/trauma room, all in a very child-friendly, non-threatening environment. This allows for excellent training of our residents in pediatric emergency care. We have two joint emergency medicine-pediatric conferences each month to discuss topics of interest to both departments. At Arnold Palmer Hospital, the department recently moved into new educational spaces, including a state-of-the-art educational conference room and spacious resident library.

We welcomed three residency graduates back to Arnold Palmer Hospital as new pediatric subspecialty faculty this year. Dr. Joshua Yang, after completing his fellowship at UCLA, now practices with Drs. Paul Desrosiers and Richard Banks in Pediatric Endocrinology. Dr. Maricor Grio, joined Dr. Jorge Ramirez in Pediatric Nephrology. Dr. Grio completed her fellowship in pediatric nephrology and a Master’s in Clinical Research Design and Statistical Analysis at the University of Michigan. Dr. Robert Sutphin joined Dr. Vincent Giusti and Dr. Don Eslin, with M.D. Anderson Cancer Center in Orlando. Dr. Sutphin completed his pediatric hematology/ oncology fellowship at the University of Texas M.D. Anderson Cancer Center in Houston, prior to returning to Orlando.

A number of our faculty serve on the planning committee of the annual Care of the Sick Child Conference, sponsored by Orlando Regional Healthcare, Arnold Palmer Hospital for Children, the Nemours Children’s Clinic, and the Florida State University College of Medicine. The 24th Annual Conference is October 19-21, 2007 at the Walt Disney World Hilton and offers a broad range of topics, including some skill-based workshops. An alumni dinner is planned for October 19 for former residents of Orlando Regional Healthcare. Dr. Doug Short’s ever popular Vaccine Jeopardy will be featured.

For the current academic year, we have 14 interns, 14 second year residents (including one new transfer to our program), and 10 third year residents, as well as two residents who are completing their training in combined internal medicine and pediatrics. One of our 2007 graduates, Dr. Megan Fraker, is completing a one year clinical fellowship in Pediatric Sports Medicine, coordinated by Dr. Jay Albright, who is fellowship trained in Pediatric Orthopaedics and Sports Medicine. The remainder of our 2007 graduates scattered throughout the country. Pediatric hospitalist practice has been a popular career choice for our recent graduates.

Dr. Joi Lucas, PL-2, serves as our program’s representative to the Resident Section of the American Academy of Pediatrics. Through the efforts of Dr. Lucas, our program was awarded one of ten Oral Health Risk Assessment Preceptorship Programs from the AAP. With this program, Dr. Lucas hopes to improve the training of pediatric health care providers in Central Florida in assessing and maintaining optimal oral health of pediatric patients. We will be partnering with the Central Florida Pediatric Society in this endeavor. Drs. Eva Desrosiers and Odett Stanley-Brown serve as Joi’s faculty mentors on this project.

Dr. Salma Elfaki, PL-3, and Dr. Jenny Villar, PL-2, are our resident representatives to the Florida Pediatric Advocacy Network, and
Dr. Elfaki is serving a lead role in that group. Dr. Shamin Jivabhai, PL-3, and Dr. Sabrina Adams, PL-3, are our Reach Out and Read Coordinators for our residency program. We have had several successful book fairs to support Reach Out and Read, and our resident volunteers are key to the continued growth of the program.

The Florida Pediatric Program Director’s Meeting was held on September 28, 2007 at Arnold Palmer Hospital in Orlando, with a coordinator from the University of South Florida. This forum provides an opportunity for the pediatric program directors across the state to network, share similar concerns, and problem solve.

Dr. Penny Tokarski has completed her first year as the Associate Program Director for our Pediatric Residency Program and has proven to be a valuable asset to the program. Dr. Tokarski oversees the competency area of professionalism and coordinates our procedural skills training and residency retreats. Dr. Nicole Bramwell directs our Outpatient Practice and puts her M.B.A. to good use as she, along with Dr. Mark Swanson, Chief Medical Officer of Arnold Palmer Hospital, have developed a systems-based practice curriculum for our residents. Dr. Ankur Shah serves as our fourth year Chief Resident and Junior Faculty, and Dr. Timm Galey and Dr. Denise Young are our third year Co-Chiefs for this academic year.
Greetings all,

I just had another quarterly meeting with the Florida Medicaid Pharmacy and Therapeutics Committee. There are always some contentious issues discussed. We heard a lot of testimony from members of numerous Mental Health organizations asking not to make cuts in any of the mental health drugs. And to that effect, all atypical antipsychotic drugs were approved including a new one, INVEGA. So all of your patients will get to remain controlled on their Abilify, Geodone, Strattera and Focalin as well as Adderall XR.

Other agents important to pediatrics that remained on the formulary are all of the inhaled corticosteroids with the addition of Symbicort. Singulair was still on but we had a tough time trying to get Clarinex syrup on for children ages six (6) months to two (2) years. It is the only non-sedating drug in its group recommended for this age. However, the adult doctors would not let it get passed. They want the company who deals with the pharmacy companies to go back to Schering Plough and get a better price.

Celebrex was taken off the Preferred Drug List (PDL) mainly because of the new warnings for Cox-2 inhibitors and heart disease. Not that this affects pediatrics much, but it is used in children with Rheumatoid Arthritis a lot.

The nasal steroid group remained the same as last time. Veramyst, the new one, was not added due to the high cost and the fact that it would push off the other steroids already on the PDL not allowing any choice.

For eyes, you still can get most Antibiotic-corticoid combos but now we are able to use Pataday, a once a day solution for allergic conjunctivitis. If any one has specific questions, please do not hesitate to email me.
Dear Key Contacts,

As the Sept. 30 deadline to reauthorize the State Children’s Health Insurance Program (SCHIP) looms, the following is an update on congressional negotiations and a message you can send to the White House.

**CONGRESS AND SCHIP**

Congress is continuing pre-conference debates to determine the final legislation that will move to the floor of the U.S. House and Senate for a vote. Current negotiations between House and Senate leaders are focused on key differences between the House (H.R. 3162) and Senate legislation (S. 1893/H.R. 976).

The main issues include:

**Funding** – How much funding will be provided to pay for SCHIP over the next five years? The Senate approved $35 billion, the House $50 billion.

**Medicare** – How will the legislation address extensive Medicare provisions included in the House bill but not in the Senate version?

**Cigarette Tax** – The Senate bill would fund SCHIP with a 61 cents cigarette tax increase. The House bill would partially fund SCHIP with a cigarette tax increase of 45 cents, offsetting the remaining costs with cuts in other programs.

**Continuing Resolution** – If Congress is unable to pass final SCHIP legislation before the Sept. 30 deadline, they run the risk of letting SCHIP expire and adding up to 6 million more children to the ranks of the uninsured. House and Senate leaders are debating whether they will need to put in place a temporary continuing resolution to extend SCHIP in its current form, at its current funding levels, until they can pass final reauthorization legislation. For more information about the House and Senate bills, read this Sept. AAP News article.
**Grass Roots: SCHIP**

**AAP Dept. of Federal Affairs**

**THE WHITE HOUSE**

As congressional negotiations continue, the president has said he will veto both the current House or Senate versions of SCHIP legislation. His veto threats leave Congress little room to extend coverage to more uninsured children – 2/3 of whom are eligible, but not enrolled, in SCHIP or Medicaid.

*YOU CAN TELL THE PRESIDENT TO RECONSIDER*

**Take Action**

Contact President Bush, and tell him how important it is to reauthorize SCHIP for the health of America’s children.

**Tell the president:**

The clear intent of SCHIP is to provide much needed preventive care, well-child visits, immunizations, and treatment for poor children suffering childhood illnesses. When children go without needed care, their health, well-being, and development suffer. For children with chronic illnesses, the consequences can be much more dire.

Now is not the time for our country to turn its back on the problem of uninsured children. The federal government should be doing everything it can to cover uninsured children. We need you to act now in a bipartisan fashion to reauthorize and fund a SCHIP bill to keep the program strong. It would be a greater catastrophe to add more children to the rolls of America’s 9 million uninsured children.

You can call the White House at 202-456-1111, or log on to the AAP Member Center to send an e-mail to the president.

If you have any questions about SCHIP federal action, contact Bob Hall, AAP Dept. of Federal Affairs, 800-336-5475, ext. 3309, or rhall@aap.org.

**STAY TUNED!**

As Congress heads into the final weeks of September, they must reach an agreement on SCHIP legislation soon. Stay tuned for information and what you can do to keep SCHIP strong and give America’s children the health care they need and deserve.

**TAKE ACTION: Stop a SCHIP Veto!**
There has been a tremendous amount of activity recently in Region 4. The third try was the charm for the Nemours Foundation as they were granted a certificate of need for the construction of a new Children’s hospital in Orlando. Orlando Regional Healthcare Systems (ORHS) is appealing this decision as they feel that the inpatient needs of the community are already being met in part due to their affiliate Arnold Palmer Children’s Hospital and Florida Children’s Hospital. Arnold Palmer has expanded from 96 pediatric beds to 158. Florida Children’s Hospital is a “hospital within a hospital” at the Florida Hospital Orlando campus. It is currently undergoing a renovation and expansion from 144 pediatric beds to approximately 190.

Pediatric subspecialists in town have been choosing their allegiances between Nemours, ORHS, and KidsDocs. Some physicians have made multiple moves among these organizations. Nemours has opened satellite clinics in Lake Mary and Melbourne to compliment their Orlando location. KidsDocs is a professional association of private practice pediatric subspecialists committed to providing quality medical and surgical care. We primary care docs have been trying to keep tabs on the locations of our referral doctors as we wait for all of the dust to settle.

Patients in our area now have multiple options for after hours care with the growing popularity of the pediatric after hours clinics. Pediatric ER care is also available at Florida Hospital and at the new Arnold Palmer Hospital emergency department. Retail-based clinics are popping up in town at some Publix and CVS pharmacies. Despite the education efforts by the FCAAP, some parents prefer the convenience of these clinics and are unaware or unconcerned about the lack of pediatric training, expertise, and supervision of the practitioners and the lack of continuity care provided.

The University of Central Florida Medical School seems to be on track to open in 2009. Dr. Deborah German has been hired as the founding Dean. She will be speaking to the Central Florida Pediatric Society in September. Dr. Jogi Patissapu, MD, FAAP will be working with her to find physician support for a Pediatric Department. At the following meeting, Robert Chong, MD, FAAP will be introduced as the new president of the Central Florida Pediatric Society beginning in January 2008.
closely with these groups for development of similar public reporting programs on physician data and physician level hospital data.

Approved that the FMA representatives to AHCA work closely with the FMA Committee on Patient Safety and Quality Improvement and the Specialty Society Section, to ensure appropriate development of public reporting programs on physician data and physician level hospital data by the AHCA.

Council on Public Health
Approved that the FMA support the Healthy Florida Alliance to increase excise tax on cigarettes by $1.00 to approximately $1.34 per pack and use this revenue to expand health care access for low-income children, adults, and increase reimbursement rates for physicians who provide Medicaid services.

Council on Ethical and Judicial Affairs
Approved reaffirmation of 1997 policies relating to Code of Ethics and Volunteer Expert Witness; reaffirmed as amended policy relating to Negotiating Units for Physicians.

Approved sunsetting 1997 policy relating to Expert Witness List. Tabled until the October Board of Governors meeting 1997 policies relating to the Regulation of Expert Testimony and Expert Witness Committee Program.

Recommended to the House of Delegates that Resolution 06-42, FMA Members Practice Scrupulous Honesty, not be adopted.

Council on Legislation
Approved the 2008 FMA Legislative Program as follows:

Priority Issues to Oppose: scope of practice expansions; any legislation that would take away physicians ability to self-insure; foreign physician licensure without meeting the same requirements as all other applicants; more onerous physician profile issues; any increased cost of hearing interpreters; Fabre changes; and physician supervision issues.

Priority Issues to Pass: Increase reimbursement for Medicaid to Medicare level; require managed care companies to accept valid assignment of benefits, prohibit silent PPOs and changes in prompt payment law; legislation to retain the current personal injury protection (PIP) system; sovereign immunity for physicians providing mandated treatment in emergency rooms; obtain sovereign immunity for the Professionals Resource Network and IPN providing impairment services to health care licensees; seek a $1.00 increase in cigarette excise tax with revenue used for increasing Medicaid reimbursement rates to Medicare levels, funding for KidCare program and additional Medicaid services; legislation to authorize AHCA to investigate decisions by a hospital to close a particular department and to take action to ensure patients are not left without needed medical care; legislation requiring expert witnesses to become licensed in Florida and clarify that giving expert testimony is the practice of medicine.

Issues to Support: legislation that would make seat belt violations a primary offense in Florida.

Approved 1997 policies to reaffirm or sunset.

Approved the FMA work with the AMA to enact federal legislation that stops the proposed 9.9 percent Medicare physician fee cut scheduled for January 2008, and to replace the Sustainable Growth Rate with a new approach to physician payment.

Environment and Health Section
Opposed, on an environmental public health basis, any expansion of the Miami-Dade County Urban Development Boundary and that the FMA President communicate this policy to the parties involved.
Grass Roots: FMA Major Board Actions

Approved policy that the FMA urge state government to develop energy use policies, to adopt renewable energy requirements and improve efficiency standards for transportation, businesses, etc. In addition, approved that the FMA urge the Florida Congressional Delegation to support federal legislation to regulate CO2 emissions and that the Florida AMA Delegation work to further the principles of this policy.

Approved that the Florida AMA Delegation submit a Resolution to the AMA asking the Council on Science and Public Health to work with the AMA Federation to update policy on climate change so that it is consistent with current science.

Specialty Society Section
Approved that the FMA explore ways of improving the availability of vaccines in physician offices through a public education campaign and possible group purchasing of vaccines through the FMA or through a new corporation.

Approved the FMA ask AHCA to suspend its program on physician procedure volume public reporting until it can be reviewed by applicable specialty societies, FMA, and AMA; and that AHCA work with these groups for development of similar public reporting on physician data and physician level hospital data.

Approved that AHCA and FMA representatives to AHCA work closely with the FMA Committee on Patient Safety and Quality Improvement and the Specialty Society Section to ensure appropriate development of public reporting programs on physician data and physician level hospital data by the AHCA.

Florida AMA Delegation
Referred to the Committee on Bylaws with a report at the October Board of Governors meeting a recommendation to amend the Bylaws providing that the Chair of the FMA Delegation to the AMA, or the Chair’s designee, be designated as the representative on the FMA Board of Governors; and further directed the Committee on Bylaws to look at all the appointed positions on the Board of Governors.

Board Actions from the Executive Committee
Approved that the Board of Governors examine its relationship with FMA Physicians Advantage to explore opportunities for increasing synergy and ensuring a lasting relationship.

Approved instructing the FMA Treasurer to re-evaluate every expense line item during the 2008 budget preparation.

The Board of Governors approved, if necessary, an increase in the personnel budget line item to cover a merit and cost of living increase for FMA staff in accordance with 2007 budgeted amounts.

Approved changing the FMA contribution policy to “People for a Better Florida” from a bi-annual to a semi-annual contribution policy.

Approved the 2007 FMA Awards as follows:
Certificate of Merit: John O. Brown, M.D.
Heidar Heshmati, M.D.
Miguel A. Machado, M.D.
Certificate of Appreciation: Arthur E. Palamara, M.D.
Distinguished Layman’s Award: Representative Allan Bense
Harold Strasser, M.D.
Good Samaritan Award: N. Donald Diebel, Jr., M.D.
Edward Homan, Jr., M.D.
Professional Liability Award: Martin B. Unger
Approved referral of the Specialty Society Section’s White Paper on...
Emergency Room Call back to the Section for development of specific recommendations to be reported back to the Executive Committee and Board of Governors; and the Section to coordinate these recommendations with Drs. Altenburger, Dolan, Pillersdorf and Tippett.

Present to the Government Services Committee of the Taxation and Budget Reform Commission the need to increase Medicaid reimbursement to Medicare levels and the FMA to seek individual contact with the Commission members prior to submitting the information.

Approved that the FMA General Counsel review the information provided by the Chair of the Council on Legislation regarding any conflict of interest and report back to the Post-Convention Board meeting in August.

Other Board Actions
Approved that the FMA provide assistance to county medical societies that are convening Medicare reimbursement meetings in Florida this year.

That the FMA President write a letter to all the state medical societies to encourage their congressional delegations to sponsor Senator Nelson’s and Representative Meek’s legislation, “The Residency Physician Shortfall Reduction Act of 2007.”

2:00 PM - 3:30 PM
Specialty Society meeting representing the Florida Pediatric Society. Two resolutions presented to be sponsored by the Section which includes the establishment of an online data bank to record schedule 3 prescriptions from physicians and pharmacies. This will decrease the multiple filling of “drug seekers” by allowing physicians and pharmacists to see a patients’ drug history with regards to narcotics. Second resolution involves not allowing substitution of generic epilepsy medicine for brand name meds as this has caused many patients to end up in the emergency room with onset of seizures based on the half-life of generics being different.

3:30 PM - 3:45 PM
International Medical Graduates meeting: A resolution was done asking for standardization of requirements for licensure for IMG’s as compared to American graduates so that a qualified physician that passes the exam is licensed in the same way as an American graduate. Much discussion on this and will probably not pass in house as all believe it is already standardized.

3:45 PM - 5:30 PM
Meeting with Andrew Agwunobi, director of ACHA and Tom Arnold to discuss Medicare and Medicaid in the state of Florida. He is all for
SCHIP but wants to wait to see what happens nationally. HMO rollout is happening and he believes that it’s less costly than fee for service. He is personally working on Kidcare and making it easier to get into and with less documentation. He is also working to get the HMO for Medicaid in all counties in a workable model. This will be with an HMO who either gets a profit or not (non profit HMO’s). Also will be able to provide Evidenced Based care in a medical home with little administrative costs and pay for performance incentives. He is trying to get rid of fraud especially in DME.

5:30 PM - 6:30 PM
Networking with our management president, Susan Cabrera and Dr. Curran on Peds issues.

6:30 PM - 9:00 PM
Networking with the Brevard County delegation at the Southern Medical Association cocktail

**Friday**
7:00 AM - 8:00 AM
Specialty section caucus: Resolutions were discussed and assigned to various persons to speak about in reference committees. New resolution made to bring young physicians into the FMA by means of a mentoring program where costs would be paid.

8:00 AM - 10:00 AM
Reference Committee I Health Policy- Presented the FPS resolution and had to defend it against nay-sayers who think it would cost too much money to fight off chiropractors and people who want cursory sports exams for $10.00. Also rose to support the walk or ride to school resolution and the mandatory PE for middle and high schools.

11:00 AM - 12:00 PM
Medical Ethics CME where 4 principles were presented regarding ethics: Autonomy, beneficence, non-malficence and justice.

12:00 PM - 2:00 PM
Good Government lunch by FLAMPAC. Governor Mitt Romney from Massachusetts gave his view on MA healthcare reform and how it worked there and his vision for the same sort of healthcare reform if he were to become President. Very impressive!

2:00 PM - 3:30 PM
In the medical expo to see all different vendors and what they have new for physicians. Also network with the candidates.

3:30 PM - 5:30 PM
First session of the House of Delegates. Mostly ceremonial with presentation of medical school scholarships and awards of various types. Also all candidates were nominated and speeches given in their favor.

5:00 PM - 5:30 PM
FPS caucus to discuss resolutions important to us.

5:30 PM – 8:00 PM
Dinner with the Brevard County delegation to celebrate Dr. Hashmati receiving the Certificate of Merit from the FMA, the highest honor bestowed on an FMA member. Great Cuban food at Padrinos in Hallendale.

8:00 PM - 9:00 PM
Desert reception for Michael Wasylik, candidate for District C

9:00 PM - 10:00 PM
Desert reception for incoming President Karl Altenberger

**Saturday**
7:00 AM - 8:00 AM
Caucus with the Internal Medicine physicians to review changes of resolutions and garner support for the FPS resolution

8:00 AM - 12:00PM
2nd House of Delegates Resolutions were reviewed and several were sent to the Board for action including a resolution to make legislation to regulate retail based clinics. Also another resolution, maintenance of PIP, was passed and referred for immediate action.
The FPS resolution was referred to the board for study and action which will allow the FPS to speak to the members of the board and network with them regarding the importance of the 3 mandatory physical exams and try to include large counties with an acceptable amendment of getting more funding to put a nurse and social worker in each school where there already is a problem of access to care. This does not usurp the idea of a medical home but expands the concept of a medical home to mobile units and school based clinics. Other resolutions pertaining to Peds were passed without problems including adding PE requirements to secondary schools and endorsing walk/ride to school as a “get fit” way to get to school. We saw two very entertaining public announcements made by the Academy of Orthopedics that showed a “fat” Ronald McDonald and several kids getting around their “chores” which would help to keep them fit by sitting down and letting the dog walk on a treadmill, mowing the grass by remote control, or playing basketball while lying in bed and tossing balls into a door basket, or the best one—a kid on a computer calling his grandmother in another room from his cell phone to bring him some chips. All emphasize the importance of getting up and moving.

12:00 PM - 3:00 PM
Fun in the Exhibit hall where we had lunch sponsored by the vendors and a chance to win many prizes like IPODS (10). Candies provided by all of the booths.

3:00 PM - 6:30 PM
A much needed rest period to relax and regroup.

6:30 PM - 10:30 PM
Installation of new officers and dance party with Gloria and Emilio Estefan’s old band Carlos Oliva and Sobrinos de Juez. Danced until the band stopped.

Sunday
7:00 AM - 7:45 AM
Caucus with the American College of physicians where resolutions from Reference Committees 2 and 4 are done. Visited by all candidates for office where they gave their views on how the FMA should be run.

7:45 AM - 8:00 AM
Vote for candidates for office

8:00 AM - 12:00 PM
Third session of House of Delegates. Resolutions discussed: Executive Vice President hiring, additional board positions to make the number thirty (30) - (defeated), AMA delegation chair and who should represent the FMA at the AMA board, reunification of FMA and County Medical society boards, Mentorship program in the FMA for new members (Paid meeting), changing the way Board members are voted in giving each election two (2) candidates to choose from (defeated). And finally, the new Board members and officers were announced: Alan Harmon as treasurer and David McKalip as Board of Governors District C. All others were unopposed. Sandra Mortham is now leaving the FMA and a search will be on to find an EVP.

This concludes the 130th FMA meeting.
Louis B. St. Petery, Jr, MD
Executive Vice President

Dear FPS Membership:

Over a year ago, our attorneys asked the State if they would consider discussing settlement of our lawsuit. Recently, the State indicated a desire to do so. That discussion was held in Tallahassee on September 11, 2007 from 9:30 a.m. until 6 p.m. Representing the plaintiff’s were attorneys Carl Goldfarb and Damien Marshall from the Fort Lauderdale office of Boies, Schiller and Flexner, attorney Jim Eiseman from the Public Interest Law Center of Philadelphia, our legislative liaison Nancy Moreau, and me. Representing the state were Stephanie Daniel, Assistant Attorney General, Craig Smith, General Counsel for Agency for Health Care Administration, Josefina Tamayo, General Counsel for Department of Health, Thomas Koch, deputy general counsel for Department of Health, and Herschel Minnis, assistant general counsel for Department of Children and Families.

I am not permitted to discuss the details of what the State officials said except with members of the FPS executive committee since the parties agreed that discussions would be considered a confidential settlement meeting. Suffice it to say, we seem to have gotten their attention. The concerns we presented were as follows,

1. There must be a significant increase in payment to physicians and dentists. In addition, the payment must be indexed so that it changes annually.
2. There must be significant resolution of the obstacles that hinder the provision of care to Medicaid patients. There was not time for an exhaustive listing of all of our issues, but we did have a good interchange regarding switching and other eligibility concerns, transportation limitations, and our concerns about the complexities of the Medicaid application process.
3. There must be meaningful outreach for Medicaid-eligible children; there is very little at the present time.

There was concern that I have been exploring solutions to Medicaid patient-related problems with various individuals within the Department of Children and Families, the Department of Health, and the Agency for Health Care Administration, and utilizing information gained to aid our lawsuit. As a result, for the duration of the litigation, I am no longer allowed free access to staff within the Department of Children and Families, the Department of Health, and the Agency for Health Care Administration regarding the resolution of Medicaid patient-specific issues. Our attorneys were able to obtain agreement that a single individual at an administrative level within each of those state offices would be assigned as a contact person to research and resolve issues that I bring to their attention.

Finally, the FPS was notified two (2) weeks ago that our contract with the Department of Health to assist with the Immunization Registry would not be renewed, when it expires later this month. Our attorneys brought this issue to the State’s attention at yesterday’s meeting, pointing out that the timing of this announcement is suspicious, in view of our pending litigation. The attorneys for the State promised to look into that issue.

Overall, the interchange was quite positive. I will keep you informed, as I have more information than I am allowed to share.
Advocacy at UM/Jackson Memorial Hospital

Haneen Yasin, MD
UM / Jackson Memorial Hospital
Pediatrics Resident – PGY2

As you drive towards downtown Miami and wind your way through the streets that lead to the city’s largest county hospital, you will realize that you are entering a busy world of its own. Jackson Memorial Hospital (JMH), the University of Miami’s premier teaching hospital, is made up of countless buildings, including inpatient wings, research centers, outpatient clinics, and rehabilitation facilities. I can only imagine a patient’s confusion as they are entering our little world trying to find their way to a specific destination. Yet in the midst of all the activity, Holtz Children’s Hospital shines. With its columns in a bright array of colors and its walls covered with large Britto paintings, this pediatric facility attracts the eyes of child and parent alike, where hope of treatment may be found.

As pediatric residents, we have the opportunity to experience every aspect of the services provided to our patients, and as a result, we use these as platforms for advocacy and patient education. JMH provides medical care to all patients not only in Miami-Dade County, but to many of the surrounding areas and countries. With or without insurance, patients have the guarantee of being cared for with the utmost in quality. One of the areas in which we have the greatest exposure to patients and their needs is the emergency room. On average, 2,900 patients are seen in the ER every month, and approximately 12-15% of these patients are admitted for further care. In the emergency room, we rush from one patient to the next, knowing that the patient may not have access to medical attention in their local clinics, but will wait a few hours in the JMH ER to be seen and cared for. This is an excellent opportunity for advocacy and education, since many of these children do not have regular visits with pediatricians, their parents are unaware of the services available in their communities, and even though they may know that their children have a right to medical insurance, they have no idea how to access it. The ER also connects patients to a large medical center, where regular outpatient care can be arranged, and social workers are available when families need further guidance.

To help residents consider advocacy ideas and to then focus their interests into a specific project, the residency program has organized an advocacy program which is part of our rotation on development. These projects are guided by Dr. Lee Sanders, assistant professor of pediatrics, and Mr. Brian Guerdat, coordinator of the Dyson Grant and community based pediatrics programs. All residents decide on an advocacy project which may center on a particular topic or a neighborhood of need. Residents meet with various organizations in Miami to better understand the needs of the community, what is already being done, and what their role can be in promoting advocacy on both the community and policy levels. Some residents become very involved in their projects and have accomplished great tasks in local activities and research with the guidance of mentors specializing in their areas of interest.

Amarilys Murillo, MD, a 3rd year pediatrics resident, worked with Dr. Jeffrey Brosco, associate professor of clinical pediatrics, and
Dr. Ruby Natale, assistant professor of pediatric clinical psychology, on a project which focused on teaching parents about normal development and behavioral problems during a workshop given at three (3) YWCA centers in the Miami area. Pre- and post-tests on parent-pediatrician communication were given to the parents during the workshop. They found that parents felt more confident in asking their pediatricians questions in regards to their children’s behavior and developmental skills, and would write questions down before an office visit. Dr. Murillo presented the project at the annual conference of the Florida Association for Infant Mental Health in May 2006.

Yesef Antongiorgi, MD, a 2nd year resident, and Marcelo Egea, MD, a 3rd year resident, have been working with Dr. John Kuluz, associate professor of Pediatric Critical Care Medicine, on a research project in which they are analyzing the factors that influence the timing of school re-entry in children following traumatic brain injury. These factors include length of stay in both PICU and rehabilitation facilities, the development of an individualized education plan, and the cooperation of the school board in meeting with those involved. They also plan to compare traumatic brain injury to other chronic conditions that affect school re-entry.

Sandra Crespo, MD, a 3rd year Medicine-Pediatrics resident, has been a long-time advocate for children with autoimmune and joint disorders and has been working on an abstract, in which the expansion of a subset of CD8+ T cells containing Perforin/Granzyme B was found to correlate with increased disease activity in systemic lupus erythematosus and mixed connective tissue disease. These results suggest that activated CD8+ T cells may serve as a newly identified biomarker of disease activity in these disorders. This abstract will be presented in an oral presentation at the annual meeting of the American College of Rheumatology in Boston in November 2007. Also, Sandra Crespo along with Mary-Sydney Karsh, MD, a 3rd year pediatrics resident, participated in last year’s National Resident Advocacy Day in Washington, D.C.

The truth is that we are busy residents with responsibilities inside and outside of the hospital, but we must start advocating for our patients now, even while we are still in training. We need to determine the greatest needs of our patients, and start the tradition of not only educating these families in our clinics, but to also reach out on the community level and even further to create policies that will help our patients in accessing quality healthcare.
Resident Section: Resident Section 2007-8

State Co-Chairs:
Sarosh (Shawn) Percy Batlivala, MD - PGY-3
batlis@peds.ufl.edu
Salma Elfaki, MD - PGY-3
salma.elfaki@orhs.org
Salma.elfaki@yahoo.com

Assistant Coordinator for District X:
Sarosh (Shawn) Percy Batlivala, MD - PGY-3—Co-Chair
batlis@peds.ufl.edu

University of Florida - Gainesville Program:
Lorena Acosta, MD - PGY-2
lorenam@peds.ufl.edu

Stephanie Harrell, MD - PGY-3
harres@peds.ufl.edu

University of Florida - Jacksonville Program:
Carla Laos, MD - PGY-2
Carla.laos@jax.ufl.edu

Kara Driver, MD – PGY-2
Kara.driver@jax.ufl.edu

Miami Children’s Hospital Program:
Program’s Representative to the Resident Section:
Eric Eason, MD - PGY-2
Eric.eason@mch.com

Patricia Musolino, MD - PGY-2
Patricia.musolino@mch.com

Dayanand Bagdure, MD - PGY-3
Dayanand.bagdure@mch.com
Kirin Munar MD, - PGY-3
Kirin.munar@mch.com
Miriam Ricardo, MD - PGY-1
Miriam.ricardo@mch.com
Roosevelt De Los Santos, MD - PGY-1
Delossantos_r@hotmail.com

University of Miami – Jackson Memorial Medical Center Program:
Program’s Representative to the Resident Section:
Marlie Dularier, MD - PGY-3
md7757@hotmail.com
Mdularier@med.miami.edu

Haneen Yasin, MD – PGY-2
hyasin@med.miami.edu
haynesse@yahoo.com

Orlando Regional Healthcare Pediatric Residency Program:
Salma Elfaki, MD - PGY-3 Co-Chair
salma.elfaki@orhs.org
Salma_elfaki@yahoo.com

Joi Lucas, MD – PGY ????
joilucas@orhs.org

Florida State University-Sacred Heart Program - Pensacola:
Program’s Representative to the Resident Section:
Kelli Tapley, MD - PGY-3
khtapley@earthlink.net

University of South Florida Program - Tampa/St. Petersburg:
Program Representative to the Resident Section:
Roxanna Eftekhar, MD - PGY-3
reftekha@health.usf.edu

Nadia Sauer, MD — MP-3
nsauer@health.usf.edu

Grace Dougan, MD — MP-2
gdougan@health.usf.edu

Karolina Dembinski, DO - PGY-1
kdembins@health.usf.edu

Jeannine Del Pizzo, MD - PGY-1
jipizzo@health.usf.edu

Shilpy Setya, MD - PGY-1
ssetya@health.usf.edu

Nova Southeastern University College of Osteopathic Medicine Program - West Palm Beach:
Program representative to the Resident’s Section:
Erin Gerhart, DO - PGY-2
eringerhart@yahoo.com

Faculty Advisors to Resident Section:
Sharon Dabrow, MD
sdabrow@hsc.usf.edu

Cristina Pelaez-Velez, MD
cristypelaez@hotmail.com
Pediatric Research in Office Settings (PROS) Studies in the Field

Lisa A Cosgrove, MD, FAAP
Florida Pros Coordinator

Pediatric Research in Office Settings (PROS), the AAP’s practice-based research network, includes more than 1,900 practitioners who focus on projects meaningful to the practicing clinician. A PROS pediatrician in each participating AAP chapter serves as a PROS Chapter Coordinator. To join, all you and your colleagues initially need to do is to complete brief enrollment questionnaires and send them back to the PROS research staff at the Academy.

To become an active PROS practice, please follow either of the following methods; E-mail your name, address, practice name, phone number, fax number, e-mail address, and how you heard about PROS to JOINPROS@aap.org. If you do not have e-mail access, you may convey this information by calling (800)433-9016, extension 7623 or download the enrollment questionnaires at [http://www.aap.org/pros/hotojoin.htm](http://www.aap.org/pros/hotojoin.htm) on the PROS website. Then, please return them by fax or mail.

Presently, PROS is conducting two important national studies that require additional participants, Safety Check and the Reducing Immunizations Disparities Study (RIDS).

Anticipatory guidance is among the core activities that we do as pediatric providers. However, do we know if our good counsel actually works? It is a practical question. The PROS network is tackling this question with our latest project, "Safety Check.” Pediatricians will test new, brief screening and counseling tools for violence prevention and reading promotion. The specific aim is to evaluate the effectiveness of these procedures on changing parental behaviors and the stability of changes in behavior over the short term. Participating practitioners enroll 30 children between 2-11 years of age seen for well child visits. Parents complete a questionnaire prior to the visit, and, at the conclusion of the visit, both the provider and the parent complete a one-minute questionnaire. The project involves minimal paperwork and typically lasts about 4 weeks. The study’s results will lead to new recommendations on how we as pediatricians provide guidance on these and other safety and developmental issues.

Similarly, immunization is an important, routine task for pediatric providers. RIDS came out of the first PROS/National Medical Association study on immunizations in young children. Like other researchers, we found that African American (AA) children were less likely than non-AA children to have received all their recommended immunizations at 8 months of age, even after adjusting for differences in educational levels. The purpose of RIDS is to determine if practice-level interventions, when implemented in pediatric offices, will eliminate differences in observed immunization status between AA and non-AA children. Some RIDS practices will conduct a year-long implementation of five office-based interventions designed by focus groups of parents of AA
children, pediatricians, and office staff. One practitioner in all RIDS practices will measure the immunization status of 60 patients aged 3 to 18 months seen consecutively by abstracting data from vaccine administration records before and after the implementation of the interventions. Lastly, office staff will ask participating parents to complete a brief questionnaire to describe their families and their attitudes about immunization.

As in all PROS studies, the aggregate results of these studies will be shared with all members of the PROS network. Participating practitioners receive preliminary reports of research results as soon as they are available and review manuscripts before they are submitted for publication.

Participating practices are acknowledged at the end of published articles if desired. PROS is seeking interested practitioners to participate in these studies. RIDS participants must serve 25% AA patients. If you would like further information or to participate in a study, please contact your chapter coordinator or the PROS office at 800/433-9016 ext. 7623. More information about Safety Check and RIDS is available on the Internet at [http://www.aap.org/pros](http://www.aap.org/pros).

CONTINUED FROM PAGE 42 …

**Pedialink Module: Negotiating with Payors**

Upon successful completion of this online module, you will be able to:
1. Identify benefits for you and your practice from improving negotiations with payers.
2. Identify technical considerations and issues for developing a payer strategy, including elements of a model contract.
3. Recognize your negotiation style and its impact on negotiation outcomes.
4. Apply a 4-phase negotiation process (steps and elements) to negotiations with payers.
5. Link to an array of resources related to negotiating with payers.

The primary audience is general pediatricians and general pediatric residents. Secondary audiences include office managers, finance managers, coding specialists, and other employees who are involved in reimbursement for services, employment, or working with vendors.

The registration fee is $100 for AAP members. Five credit hours are earned upon completion of this activity.
Preceptorships, grants, and training material/curricula (Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals - Supported by the MCHB, HRSA, and Department of Health and Human Services - U93MC00184). The training can be found at http://www.aap.org/commpeds/dochs/oralhealth/training.cfm. The AAP recognizes the lack of adequate number of pediatric dentists nationally to meet the demands of the growing pediatric population, particularly children who are high risk and children less than 3 years of age.

The AAPD supports the AAP initiative to adequately train physicians in the provision of the oral health risk assessment and Fluoride Varnish application for children 0-3 years, as long as physicians recognize that these services do not replace the need for the establishment of a dental home by age 12 months if available.

ORAL HEALTH RISK ASSESSMENT: (Table 1.)

Children at high risk for caries include:

- Children with special health care needs
- Children from low socioeconomic and ethnocultural groups
- Children with suboptimal exposure to topical or systemic fluoride
- Children with poor dietary and feeding habits
- Children whose caregivers and/or siblings have caries
- Children with visible caries, white spots, plaque, or decay

Based on the policies of the AAPD and the AAP, most if not all children enrolled in Medicaid would fall into a high risk group. Therefore, in addition to the application of fluoride varnish, the recommended policy for these children is referral to a dentist. All preventative oral health interventions provided by physicians should always include diet counseling, oral hygiene instruction, judicious administration of systemic and topical fluoride modalities, and an attempt to refer the patient to a dentist by 12 month of age.

Consistent with these policies, the AAPD urges dentists and physicians to work collaboratively at the state and community levels to overcome barriers to access to comprehensive oral health care for all children.
<table>
<thead>
<tr>
<th></th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Conditions</strong></td>
<td>No carious teeth in past 24 months</td>
<td>Carious teeth in the past 24 months</td>
<td>Carious teeth in the past 12 months</td>
</tr>
<tr>
<td></td>
<td>No enamel demineralization (enamel caries “white spot lesions)</td>
<td>One (1) area of enamel demineralization (enamel caries “white spot lesions)</td>
<td>More than 1 area of enamel demineralization (enamel caries “white spot lesions”)</td>
</tr>
<tr>
<td></td>
<td>No visible plaque; no gingivitis</td>
<td>Gingivitis</td>
<td>Visible plaque on anterior (front) teeth</td>
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<td></td>
<td></td>
<td></td>
<td>Radiographic enamel caries</td>
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<td></td>
<td></td>
<td></td>
<td>High titers of mutans streptococci</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Wearing dental or orthodontic appliances</td>
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<td></td>
<td></td>
<td></td>
<td>Enamel hypoplasia</td>
</tr>
<tr>
<td><strong>Environmental</strong></td>
<td>Optimal systemic and topical fluoride exposure</td>
<td>Suboptimal systemic fluoride exposure with optimal topical exposure</td>
<td>Suboptimal topical fluoride exposure</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Consumption of simple sugars or foods strongly associated with caries initiation primarily at mealtimes</td>
<td>Occasional (ie, 1-2) between-meal exposures to simple sugars or foods strongly associated with caries</td>
<td>Frequent (ie, 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries</td>
</tr>
<tr>
<td></td>
<td>High caregiver socioeconomic status</td>
<td>Mid-level caregiver socioeconomic status (ie eligible for school lunch program or SCHIP)</td>
<td>Low-level caregiver socioeconomic status (ie, eligible for Medicaid)</td>
</tr>
<tr>
<td></td>
<td>Regular use of dental care in an established dental home</td>
<td>Irregular use of dental services</td>
<td>No usual source of dental care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Active caries present in the mother</td>
</tr>
<tr>
<td><strong>General Health</strong></td>
<td></td>
<td></td>
<td>Children with special health care needs</td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td></td>
<td></td>
<td>Conditions impairing saliva composition/flow</td>
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Scientific Update: Newborn Screening

August 31, 2007

To All Physicians and Health Care Providers Who Care for Newborns in Florida:

Florida Newborn Screening Program is proud to announce the screening of all newborns for Cystic Fibrosis (CF) beginning September 17th. This addition to the panel of disorders screened in Florida completes the expansion proposed in November 2004. With CF, Florida is now screening for all disorders recommended by the March of Dimes and the American College of Medical Genetics.

Cystic Fibrosis screening will be comprised of two components: 1) All infants will be tested for Immunoreactive Trypsinogen (IRT). 2) The top five percent who have high IRT levels will be tested for 43 Deoxyribonucleic Acid (DNA) CF mutations.

All infants with one or more CF mutations found and all infants with ultra-high IRT levels and no CF mutations found will be referred by the CMS Newborn Screening Follow-Up Program to the nearest CF Center for additional evaluation and testing. The CF Center will contact the family to arrange for the infant to come to the CF Center for a sweat test. A sweat test is the definitive test used to determine whether the child has CF. The CF Center will also contact the infant’s primary care physician, if known. The newborn screening lab report will report the IRT level if abnormal and the CF mutation if found. All newborn screening results that are abnormal will have appropriate follow-up actions included in the recommendations section.

Based on Florida’s expected annual birth rate and the method of testing used by the Newborn Screening Program to screen for CF, it is estimated that 815 infants will be referred to a CF Center each year because of an abnormal cystic fibrosis screening result. It is estimated that approximately 51 infants will actually be diagnosed with cystic fibrosis. Please see the attached fact sheet for more information about cystic fibrosis and save these pages for future reference.

All physicians should receive a copy of the newborn screening result from the infant’s birth hospital or can obtain a copy by accessing the new Florida Newborn Screening Results website that will be available after September 2007. If you have questions about CF screening, please contact the nearest CF Center or the Florida Newborn Screening Program.

Sincerely,

Joseph J. Chiara, M.D., FAAP
Deputy Secretary
Children’s Medical Services

JJC/lpt
Enclosures
cc: Max Salfinger, M.D.
Jean Kline, R.N., M.P.H.

4052 Bald Cypress Way
Tallahassee, FL 32399-1707

4025 Esplanade Way

Main Line (850)245-4201
FAX (850)922-5385
Toll Free (866)804-9166
(866)289-2037

www.fcaap.org
Florida Newborn Screening Fact Sheet for Cystic Fibrosis (CF)

An abnormal cystic fibrosis screening test does not mean an infant has CF. It means the infant *might* have CF. A sweat test, *is* needed to determine whether the child has CF.

The newborn-screening test for cystic fibrosis involves two steps:

1) First, the blood spot obtained through routine newborn screening is tested for trypsinogen. The test is called the Immunoreactive Trypsinogen Test or IRT. Trypsinogen is higher in infants with CF. Each day the top 5% of specimens with the highest levels of Trypsinogen will be selected for further testing.

2) If the specimen’s trypsinogen level falls in the top 5%, a second test is performed on the blood spot to detect delta F508, the most common CF gene mutation, and 42 other less common CF gene mutations.

Patients with an abnormal screening test results will be referred by the Florida Newborn Screening Follow-Up Program to the Cystic Fibrosis Center according to their county of residence for additional evaluation and testing. All infants referred to a CF Center will have a sweat test. The sweat test measures the amount of sodium and chloride in the sweat.

There are three reasons why the infant may be referred to the Cystic Fibrosis Center:

1. **The trypsinogen level is elevated and there are two CF gene mutations found.**
   - The child is presumed to have CF but a sweat test is needed to confirm the diagnosis. Genetic counseling for the parents is also recommended.
   - There will be approximately 30-50 infants born in Florida each year that will have two CF gene mutations found through newborn screening.

2. **The initial trypsinogen level is elevated and there is one CF gene mutation found.**
   - There is a 1 in 20 chance that the child has CF.
   - A single gene mutation is not sufficient for CF, but other CF gene mutations exist. The possibility exists that the child could have a second CF gene mutation not identified through the newborn screening test. A sweat test is needed to determine whether or not the child has CF. Genetic counseling for the parents is also recommended and prenatal testing results would be considered by the CF Center.
   - If a child has one CF gene mutation, then one of the parents is also a carrier of the CF gene mutation. The carrier status of the parents can only be determined by further genetic testing.
   - There will be approximately 625 infants born in Florida each year that will have at least one CF gene mutation found through newborn screening.

3. **The trypsinogen level is ultra-high but there is no CF gene mutation detected.**
   - There is a small possibility (less than 1 in 150 chance) that the child has CF.
   - Although the newborn screening test looks for 43 different CF gene mutations, there are over 1200 CF gene mutations that are not identified through newborn-screening. A small possibility exists that the child could have two of those other CF gene mutations.
   - Some possible reasons (other than the presence of CF) for elevated trypsinogen levels include a stressful or premature delivery and/or low Apgar scores.
   - There will be approximately 150 “ultra-high IRT” infants with no CF gene detected through newborn screening.

Please see the Flow Chart how the patients are going to be tested and the follow up care according to the results. Please also see the list of the Cystic Fibrosis Centers where the child will be referred for a sweat test and genetic counseling. Children’s Medical Services Area Office receives a copy of all presumptive positive abnormal results. Should the infant have CF, the child will be known to CMS who will assist in the care coordination of the child if the family is financially eligible.

Effective Date: September 2007
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<thead>
<tr>
<th>CF Center</th>
<th>Address</th>
<th>Telephone Number</th>
<th>County Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nemours Children’s Clinic – Pensacola</td>
<td>5153 North Ninth Avenue Pensacola, FL 32504</td>
<td>850 505 4785</td>
<td>Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, Washington</td>
</tr>
<tr>
<td>Nemours Children’s Clinic – Orlando</td>
<td>83 West Columbia St. Orlando, FL 32806</td>
<td>407 650 7539</td>
<td>Brevard, Indian River, Lake, Orange, Osceola, Seminole, Sumter, Volusia</td>
</tr>
<tr>
<td>All Children’s Hospital – St Petersburg</td>
<td>801 6th Street South St. Petersburg, FL 33701</td>
<td>727 767 4146</td>
<td>Citrus, Hernando, Manatee, Pasco, Pinellas, Sarasota</td>
</tr>
<tr>
<td>University of South Florida – Tampa</td>
<td>17 Davis Blvd., Suite 200 Tampa, FL 33606</td>
<td>813 396 9774</td>
<td>Charlotte, Desoto, Hardee, Highlands, Hillsborough, Lee, Polk</td>
</tr>
<tr>
<td>St Mary’s Medical Center – West Palm Beach</td>
<td>901 45th Street West Palm Beach, FL 33407</td>
<td>561 840 6065</td>
<td>Glades, Hendry, Martin, Okeechobee, Palm Beach, Saint Lucie</td>
</tr>
<tr>
<td>Joe DiMaggio Children’s Hospital – Hollywood</td>
<td>3435 Hayes Street Hollywood, FL 33021</td>
<td>954 986 6333</td>
<td>Broward, Collier</td>
</tr>
<tr>
<td>University of Miami – Miami</td>
<td>1620 NW 12th Avenue, (DA 20) Miami, FL 33136</td>
<td>305 243 6162</td>
<td>North Miami – Dade</td>
</tr>
<tr>
<td>Miami Children’s Hospital – Miami</td>
<td>3100 SW 62nd Avenue Miami, FL 33155</td>
<td>305 666 6511 ext 4540</td>
<td>South Miami – Dade, Monroe</td>
</tr>
</tbody>
</table>

Effective Date:  September 2007
Breastfeeding Report Card (BRC) - United States, 2007

One of CDC’s key health promotion goals is to improve maternal and child health by protecting, promoting, and supporting breastfeeding. The Breastfeeding Report Card (BRC) - United States, 2007 is an important tool for improving breastfeeding nationwide because it provides state and local community members with needed information on the current status of breastfeeding protection, promotion, and support within a given state, while also allowing for direct comparisons across states. (All references to ‘states’ in the BRC include the District of Columbia as well.) Over time, data from the BRC will allow advocates to examine change and growth in their communities relative to progress across the nation and in peer states.

The BRC is made up of eight process indicators and five outcome indicators. The 8 process indicators represent the different spheres of influence on breastfeeding protection, promotion, and support that can be compared across all states. These indicators are elements of breastfeeding-friendly communities. They include measures of hospital support, professional support, mother-to-mother support, legislation and infrastructure. The outcome indicators are the five Healthy People 2010 breastfeeding goals, (initiation, 6 and 12 month duration of any breastfeeding, and 3 and 6 month duration of exclusive breastfeeding).

PROCESS INDICATORS
Hospital Support
* Percent of live births occurring at BFHI-designated facilities

The wide range in size and births of BFHI facilities means that the public health impact of BFHI is more accurately assessed via a measure of the proportion of births in a given state occurring at BFHI-designated facilities than by counting the raw number of facilities in a given state. More than any other indicator in the BRC, this indicator demonstrates clearly that practice change at one major facility can have dramatic health impact statewide.

Professional Support
* Number of International Board Certified Lactation Consultants (IBCLCs) per 1,000 live births

Because of the individual nature of much of IBCLCs’ work, a ratio of their availability per live births provides a gross estimate of their availability to provide these many different kinds of professional support within a state.
Mother-to-Mother Support
* Number of La Leche League
  Groups per 1000 live births
The number of La Leche League groups per 1,000 live births provides a broad estimate of the availability of assistance with breastfeeding for new mothers in any given community.

Legislation
* Breastfeeding in public
* Breastfeeding women who return to work
Both of these elements are important for community members to be able to meet their breastfeeding and economic goals.

Infrastructure
* State Full Time Equivalents (FTEs) responsible for breastfeeding
* State Breastfeeding Coalition
State agencies responsible for public health and welfare including health departments, WIC, early intervention, and others all play a pivotal role in ensuring that breastfeeding is included across all public programs and interventions affecting women and infants.

The reach, function, and work of state breastfeeding coalitions vary widely across states. However, regardless of this variation, the presence of a state-wide coalition dedicated to breastfeeding represents a basic level of community support for breastfeeding.

OUTCOME INDICATORS
Healthy People 2010 Breastfeeding Goals - State Rates
* Increase breastfeeding in the early postpartum period to 75%
* Increase breastfeeding at 6 months to 50%
* Increase breastfeeding at 12 months to 25%
* Increase exclusive breastfeeding at 3 months to 60%
* Increase exclusive breastfeeding at 6 months to 25%

Healthy People 2010 outlines the nation's health priorities. The importance of breastfeeding as a national health goal is demonstrated by the five breastfeeding goals that are included in this important document. Each state's progress on these goals is measured via the CDC National Immunization Survey breastfeeding items. States can use these data in combination with the other indicators in the BRC to help tell the story of breastfeeding locally, to cheer and celebrate state successes, and to identify prime opportunities for growth and improvement in breastfeeding protection.

These two indicators together highlight the synergistic need for people to do the work of creating communities that support breastfeeding and sufficient state level recognition of their role in that work.
August 28, 2007

Dear Director of Nursing Services or Newborn Hearing Screening Contact:

The July 2007 summary of the hearing screening data reported to the state is posted on the CMS Program web site at: http://www.doh.state.fl.us/Cms/nbscreen-hearing.html. Contact Ann Filloon at Ann_Filloon@doh.state.fl.us or (850) 245-4673 for a report showing the detail of the babies reported monthly at your facility. You can receive this update in advance of the aggregate statistics web posting. Your hospital will have 7 days to review the reports and submit corrections to the Department. Take advantage of this opportunity.

Remember to submit the last valid hearing screen results prior to discharge on either the metabolic specimen card or the DOH Hearing 002 form. Please do not mark both ABR and OAE for each ear. Instead select only one method for each ear. Also when babies return to your facility for a rescreen, the results are to be submitted on DOH Hearing 002 form.

3.77% of the babies born in July 2007 did not have hearing screen results reported and 2.59% were not screened because the babies were in the NICU, transferred, missed or their parents refused. Please note that the number of babies on the report may be overstated due to repeat metabolic specimen cards submitted that are not linked with previously submitted specimen cards. This happens if the key fields used to link babies do not match. This may also result in a higher number of babies categorized as having unreported hearing screens since the repeat specimen often omits the hearing screen data. Please encourage staff to accurately and legibly complete the specimen cards.

The intent of Universal Newborn Hearing Screening is to identify infants with hearing loss as early as possible so that appropriate intervention can be initiated. To date, 132 babies have been identified with hearing loss in 2007.

The Department’s Hospital Hearing Educator can visit your hospital and share suggestions to help lower your refer rates. Contact Laura Olson at (407) 592-8415 to schedule an appointment.

Sincerely,

Lois Taylor, Unit Director Newborn Screening Unit Children’s Medical Services (850) 245-4670 Lois_Taylor@doh.state.fl.us
Ann Filloon, Lead Follow-up Coordinator Newborn Screening Unit Children’s Medical Services (850) 245-4673 Ann_Filloon@doh.state.fl.us
Drowning Prevention Awareness Study

Deborah Ann Mulligan, MD, FAAP, FACEP

We are pleased to provide you with an attached copy of the Drowning Prevention Awareness Study commissioned by the former FL DOH Secretary Dr Francois, Deputy Secretary Humbert and funded jointly in March 2007 by the Broward and Miami-Dade County Health Departments.

Florida has the highest drowning death rate in the nation for children ages 1 to 4. This pilot study sought to evaluate the critical role of public health advocacy in translating research into policy, practice and assess public opinion. Both English and Spanish surveys were mailed to 2000 households with registered pools in pre-selected zip code areas of Broward and Miami-Dade County. Selection of these communities was based on highest incidence of drowning and nonfatal submersion, as well as the highest numbers of pools coupled with the second highest percentage of children under the age of five among all the zip codes areas. Analyses were performed on qualified surveys collected (N=420) and surveys were grouped by different stratification factors, such as county, household type and demographic variables. Overall, there are few differences on awareness of drowning risk factors or perceptions and knowledge towards drowning prevention among families with a residential pool in selected communities. However, when household type and pool safety practices are considered, there are differences between county and differences by households with or without children. Overall, households with children are better at practicing household measures and are more likely to have a pool safety fence installed. In addition, a higher percentage of Broward County pool owners utilize more than one pool safety measure. The county differences may be due, in part, to the fact that a higher percentage of pools in Miami-Dade were built prior to 2000, the year residential pool safety barrier legislation was enacted. Through this study, it can be concluded that pool owners are well aware of the drowning risk factors and are advocates of legislating pool safety devices. Nevertheless, there are still differences in practicing pool safety measures among subgroups within our community.

The Florida Chapter of the American Academy of Pediatrics and Florida Medical Association Public Health Council plan to post the report on their respective websites. It is our hope that the findings from this study will prove useful in guiding our collective efforts to reach Ms. Humbert’s dream for Florida’s children ages 1 – 4” of a summer with “zero drowning.”

Wishing you well,
Dr Mulligan

Editor’s Note:
The full study is available on their website. On the following pages, I have provided the Executive Summary and other important findings and recommendations.
EXECUTIVE SUMMARY

To investigate the drowning prevention and awareness among families with residential pools in our communities, surveys were mailed out to households with registered pools in pre-selected zip code areas within Broward and Miami-Dade Counties. These zip code areas have high percentages of young children under the age of 5 in the household as well as other factors that fit best for this study. Analyses were performed on all qualified surveys collected, as well as on surveys grouped by different stratification factors, such as by county, household type and demographic variables. Overall, there are not many differences concerning awareness of drowning risk factors or perceptions and knowledge towards drowning prevention among families with a residential pool in our selected communities within Broward and Miami-Dade Counties. The same holds true when analyses were performed on families with children and without children. However, when house safety and pool safety practices are considered, there are differences between county and differences by household type with or without children.

Though, little research has been completed to examine the impact on childhood drowning in Florida subsequent to enactment of Year 2000 state legislation mandating residential pool barriers, the findings from this study indicate that in general households with children are better in practicing common household safety practices as well as safety fencing around pools. A higher percentage of pool owners in Broward County utilize more safety devices on their pools. The difference between Broward County and Miami-Dade County may be partially due to the fact that a higher percent of pools in Miami-Dade County were built before year 2000—prior to the mandatory pool safety barrier becoming law. Further investigation, involving more communities and larger sample size in our local area, will help to further understand the reasons for pool safety practice behaviors. Through this pilot study, we conclude that pool owners in our study are well aware of the drowning risk factors and strong advocates of legislating pool safety devices. But there are still differences in practicing pool safety measures between subgroups in our community. Three critical dimensions (attention, proximity and continuity) of caregiver supervisory behaviors are identified as important areas for measurement. Targeted interventions are needed to reduce the incidence of residential swimming pool drownings across racial/ethnic groups, particularly adult supervision.
The majority of residential pool safety measures practiced among our survey participants consists of having child-resistant locks on doors and/or windows leading to the pool, having fencing that surrounds the pool on all sides and having fencing that has a self-closing, self-latching gate. In addition, about sixty-nine percent (69%) of the survey participants reported using two or more residential pool safety measures. When comparing residential pool safety measures practiced in households with children and households without children, we found that households with children have a higher percentage of fencing that surrounds the pool on all sides compared to households without children. When comparing differences at the county level, Broward County participants have a higher percentage that placed child-resistant locks on doors and/or windows leading to the pool, installed fencing that has self-closing, self-latching gates and had an audible pool alarm compared to Miami-Dade County participants. Thus, compared with pool owners in Miami-Dade County, overall Broward County pool owners have a higher overall percentage of utilizing more safety devices on their pools. Interestingly, eighty-five (85) survey participants have fencing that surrounds the pool on all sides with self-closing, self-latching gate. This is equivalent to twenty percent (20%) of all survey participants. This is the recommended safety device that works effectively in preventing drowning or near-drowning occurrences.

In addition the researchers sought to identify survey participants who currently have children under the age of 5 who do not have a child-resistant fence separating the pool from the house and explore some of the reasons why they haven’t taken this safety precaution. Also, further exploration was sought on the types of residential pool safety measures participants may consider installing. Responses to these particular questions were low; some reasons may be that the majority of the participants have some type of residential pool safety measures currently installed at their homes. Another reason may be that the participants who do not have a residential pool safety measure may not want to expose themselves to questions as they may have thought they would be perceived as behaving in a way that is socially undesirable.

The AAP recommends that if a home has a residential swimming pool it should be surrounded by a fence at least 5 feet high that prevents direct access to the pool from the house (AAP, 2003). Gauging residential pool safety measures practiced in households where children under the age of 5 often spend time was also measured. The majority of the residential pool safety measures practiced in households where children under the age of 5 spend most time consist of having child-resistant locks on doors and/or windows leading to the pool, having fencing that surrounds the pool on all sides and having a screened-in
pool. In addition, almost half of the participants reported that those households, where there are children under the age of 5 spending time, use three or more residential pool safety measures. Again, responses are low in number for this question due to the fact that a very low percentage of households we surveyed have children under the age of 5. Further study is necessary to confirm the answers and percentages regarding safety practices in other houses where young children often spend time.

The American Academy of Pediatrics recommends that parents, caregivers, and pool owners should learn cardiopulmonary resuscitation (CPR) (AAP, 2003). Most survey participants (70%) reported knowing how to perform CPR on their children. More than half of the participants (58%) reported that their spouse/partner knows how to perform CPR, and one third (33%) reported that their caregiver (to the children) knows how to do so.

When comparison was performed between households with children in Broward County and in Miami-Dade County, there are no significant differences in proportions between counties.

When comparison was performed across gender of survey participants, there are no significant differences in percentages between female participants and male participants.

However, when comparisons were performed across ethnicities, there are significant differences. About three quarters (76%) of non-Hispanic participants answered they knew how to perform CPR, while only more than half (56%) of Hispanic participants answered the same. Forty-one percent (41%) of non-Hispanic participants answered that the caregivers to their children know how to perform CPR, while only twenty-three percent (23%) of Hispanic participants answered the same for their caregivers.
Pedialink Module: Negotiating with Payors
Edward N. Zissman, MD, FAAP
Subject Matter Expert

This article reprinted with author’s permission from SOAPM (Section on Administration and Practice Management).

“I would encourage any pediatrician with interest in successful practice management to join SOAPM and subscribe to its very active listserv”. – Edward N. Zissman, MD, FAAP

The AAP has published its first Practice Management Pedialink online education module entitled: “Negotiating with Payers”. Two years in development, the program was introduced at the AAP ALF in March 2007. This five credit program presents techniques and processes to confidently conduct successful negotiations. Key topics include technical considerations, model contracts, negotiation styles, and a four phase negotiation process model: 1. Preparing and Planning to enter the process of contract negotiation with third party payers; 2. utilizing proven strategies to successfully Negotiate the best contract terms; 3. making Decisions concerning the contract terms; and finally, 4. Reviewing the contract and Monitoring Compliance with the contract terms. There are five overarching elements to consider throughout all phases of negotiation: Information; leverage; time; power; and analyze. The program teaches the multiple steps of each phase using an interactive case history and an interactive “negotiations coach.”

Phase one is Prepare and Plan: **Step 1.** Look first at the top 10 CPT codes for which you bill. Define priority contract issues, including provisions/what services are important to you. **Step 2.** Identify your goals, desired outcomes, needs, and wants – and reason (s) why you want the outcome. **Step 3.** Collect and analyze data about your practice performance. Document the quality of care you offer. Assess the market, different payment models, physician numbers, geography, patient volume, largest area employers, and other areas that relate to your practice. **Step 4.** Identify your strengths (niche). **Step 5.** Determine who it is that you will be talking to in each step of the negotiation process. Identify the decision-maker representing the payer on your contract. **Step 6.** Research payer interests, needs, and wants, including ascertaining what you perceive to be their interests and desired outcomes. **Step 7.** Know federal and state antitrust law, as it applies. **Step 8.** Plan your strategy and create your agenda… then prepare to work it. Plan your strategy and approach to implement your agenda. **Step 9.** Rehearse important parts of your agenda and negotiating position. **Step 10.** Set your target based on your goals and identify your options, alternatives, and compromise level.

Phase 2 is Negotiate: **Step 1.** Orient yourself toward a successful negotiation. Implement your planned strategy and approach. **Step 2.** Establish rapport in phone and face-to-face meetings. **Step 3.** Take an active listening stance and skills into every meeting. Focus on understanding … and on being understood. **Step 4.** Reassess your pre-determined negotiation style based on what you observe and perceive early in the meeting(s). Adapt your style, if necessary. **Step 5.** Assert your needs clearly. Align your responses and overall path.
forward with your expectations, goals, outcomes, needs, and wants. **Step 6.** Acknowledge the payer’s representative as a person and recognize the payer’s point of view. **Step 7.** Reframe. **Step 8.** Ask problem-solving, open-ended questions to gain deeper understanding and encourage dialog. Why? Why not? What if? **Step 9.** Review and refine options. Brainstorm possibilities and ideas for solutions. **Step 10.** Focus on needs, interests, and concerns. Deal effectively with objections and dishonest tactics. Manage impasses with patience and respect. Clarify issues and feelings. Counter offers, using persuasive and bargaining skills.

Phase 3 is **Make Decisions:** **Step 1.** Identify signals that could indicate it is time to begin closing the discussion. **Step 2.** Restate and evaluate options. Pick a solution (or solutions) from the options, adjust, and work to agree on preliminary outcomes. Build consensus. **Step 3.** Decide when to close for agreement, defer/delay, or walk away. If you decided to defer or delay negotiations at this or some other point, evaluate when or if it is reasonable to return to the bargaining table at a later time with new options or explore other payer options. **Step 4.** Close for agreement. **Step 5.** Recap/summarize to ensure that all parties are clear on agreed upon points. **Step 6.** Secure commitment. **Step 7.** End the meeting with a mutual commitment to implement determined plans. Build an opportunity to check back with each other to evaluate progress on implementation.

Phase 4 is **Review Contract and Monitor Compliance:** **Step 1.** Review/evaluate the contract. **Step 2.** Conduct a legal review to ensure that the contract is legally binding. **Step 3.** Have both parties sign the contract. **Step 4.** Evaluate the negotiation process and results. **Step 5.** Implement the contract. Ensure that all pediatricians and staff in your practice are fully informed as to all provisions of the new contract. **Step 6.** Monitor compliance by the payer and enforce contract provisions. **Step 7.** Establish a formal review process to evaluate the overall impact of the contract on your business, patients, practice, and staff. **Step 8.** Renew, replace, or terminate the contract. Make your decision based on the payer’s performance and the value the relationship brings to your practice.

The module discusses key aspects of communication including nonverbal communication. It also addresses negotiations concerning vaccines – both the product and the administration services. After discussion of the five overarching elements with definitions and explanations, the module finishes with a very comprehensive checklist of contract issues. This checklist is adapted from: A Pediatrician’s Guide to Managed Care – 2nd Edition, American Academy of Pediatrics, 2001 by Dr. Richard P. Nelson and Dr Maria E. Minon. All registrants will receive a complimentary copy of this valuable resource. The learners are also taught to access AAP materials including appeal letter templates and other resources which can be accessed through the educational activity.

To register for Contracting with Payers, go to AAP.org. On the bottom right of the home page is Pedialink.org. This takes you to the Pedialink learning center. The center column of this page lists CME. Click on “view all online CME”. This takes you to CME finder. Scroll towards the bottom and click on “Contract Negotiations with Payers” – details.

CONTINUED ON PAGE 27 ...
Dr. Louis St. Petery, (left) and Dr. Jorge Del Toro (right) welcome Dr. Lisa A. Cosgrove as 2nd VP (center)

Drs. Del Toro, Jerome Isaac, John Curran and Xavier Sevilla (left to right) with Dawn Pollock (center) at District 1 & 10 Meetings in Vermont this past quarter

Drs. St. Petery and Del Toro extend their thanks to Dr. David Marcus (center) for his excellent service as immediate past President of FPS.

Drs. Nancy M. Silva and Sarosh (Shawn) Percy Batilvala at the 17th Annual AAP Legislative Conference in June 2007

Dr. & Mrs. Bernard and Elaine Feldman, on a recent trip to Lysoen Island, Norway. Dr. Feldman would like to send a special hello to Dr. David Childers. They practiced together in the Navy at Pensacola Naval Air Station from 1963-1965.

Bernard H. Feldman, MD, MPH, FAAP
Professor and Chair Emeritus, Pediatrics, University of Nevada School of Medicine, 455 Cove Towers Drive, Suite 1203 Naples FL 34110-6525
Phone: 239-596-8246
bhfeldman@comcast.net
Greetings to all FPS Members,

I just wanted to introduce myself as a new Floridian. My name is Steve Matson, and I am the new Chief of the Division of Adolescent Medicine in the Department of Pediatrics at the University of Florida College of Medicine-Jacksonville. I grew up in Minnesota where we walked to school in blizzards and did a lot of ice fishing. I obtained a BS in Microbiology from the University of Minnesota and my medical degree from the Mayo Clinic in Rochester Minnesota.

I did my pediatric residency at the University of Iowa Hospitals and Clinics, and in 1987 finished my Adolescent Medicine Fellowship in Cincinnati, Ohio. I spent 18 years in Milwaukee building the Adolescent Medicine program at the Medical College of Wisconsin. One of my favorite clinics was out Teen-Tot Clinic, where we care for teen mothers and their children during the same visit.

After Milwaukee, I spent almost 2 years in Little Rock, doing Adolescent Medicine at The University of Arkansas for Medical Sciences. They take their Razorbacks very seriously in Arkansas.

I moved to Jacksonville and have fallen in love with the South. I am
pretty sure I will be a damn Yankee which we all know is one that won’t leave!!!! Our Adolescent Program right now includes a clinic on the medical complex campus, a mobile care van that serves all the Jacksonville Schools, work at a community center providing reproductive health services and an outreach clinic at the local GLBT center. I like to fish, play tennis, read, and am learning golf at fifty (50) and love to cook.

I have two great kids Daniel who is in his first year of a MD/PhD program at the University of Virginia, and Sandra who is finishing a degree in International Business in Wisconsin. I work several shifts at the Volunteers in Medicine clinic here in Jacksonville and am amazed at all the providers that donate their time to provide such important services.

If there is anything our division can do to assist you please email steven.matson@jax.ufl.edu or call me at (904) 244-8344.
Florida Improvement Network for Kids

Lloyd N. Werk, MD, MPH, FAAP

Over a year and a half ago, Nemours, University of South Florida and the Florida Pediatric Society partnered to create the Florida Improvement Network for Kids (FINK). FINK is a practice based network designed to fight childhood diseases throughout the state and improve care for children at the primary care level.

This collaboration emerged out of a 2005 project called the Partnership for Quality that focused on improvements in the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children. This initial project sponsored by the Florida Pediatric Society lasted for approximately six months. As a consequence of the Partnership for Quality, we discovered a desire among primary care physicians to collaborate across the state and share their collective knowledge.

After this successful program fulfilled its goals, the partnership grew into the Florida Improvement Network for Kids that is now one of few, if not the only pediatric health care quality improvement networks available to clinicians in the state.

The FINK program strives to share best practices, new techniques and tools with primary care providers in Florida. It provides a forum for participants to discuss ways to improve the care they deliver to children. The program draws its leadership from Dr. Lloyd N. Werk of Nemours, Drs. Sharon Dabrow and Denise Edwards of the University of South Florida, and Dr. David Wood of the Duvall County Health Department.

As the group began to take shape in late 2006, FINK chose childhood obesity as its initial area of focus in order to combat the growing epidemic in this country.

Childhood obesity can lead to significant health problems and cause life long health effects.

The number of children and adolescents in this country that are overweight has more than doubled since the 1970s. Kids today are spending less time exercising and more time watching television and using other electronic devices than ever before. Childhood obesity is an epidemic that affects 17% of children six (6) – nineteen (19) years old and is associated with a higher body mass in adulthood that can compound health problems. Approximately 15% of this population is at risk of becoming overweight. It is necessary to recognize obesity problems and intervene early in a child’s development in order to prevent long-term health problems such as diabetes. Primary care doctors, under new guidelines due to be published in November 2007, will soon be charged with taking an aggressive role in identifying and caring for children with these conditions.

Since the FINK obesity initiative began in January 2007, 43 clinicians in 28 practices have used the
network’s patient educational materials, obesity tools or shared experiences with each other online and via monthly teleconferences. Each participant chooses to participate at his or her own level of interest. The most involved members attended a workshop, collaborate on conference calls, and use an online Web site that was specifically created to help physicians calculate obesity and provide resources to aide in decision-making. The Web site provides a centralized location for historical trends, guidance on diagnosis and patient education materials. Primary care physicians from around the state have used the web site to create over 300 patients records that can then be tracked over time to see patient progress.

The network has already begun to see successes. Seven Duvall County Health Department Clinics in the Jacksonville area joined the Florida Kid Network early in the year. As a result of the obesity program and the awareness that it has generated, over 30 children have been referred to nutritionists that would otherwise not usually receive this type of consultation.

The FINK initiative is funded through a grant from the Blue Foundation for a Healthy Florida, a philanthropic organization that supports community-based health care initiatives, that was awarded to the University of South Florida in 2006. The grant began in January 2007 and will last for approximately two years. The obesity program will continue until the end of the year. In 2008, we plan to begin an entirely new children’s health initiative.

We believe that part of our commitment to our community requires investing in the capacity of local doctors to improve the care they deliver and create new programs. FINK is part of our investment and we invite new members to participate in this unique experience geared towards helping clinicians improve children’s lives.

For more information on how to become a member of the Florida Improvement Network for Kids, please contact Dr. Lloyd N. Werk at (407) 650-7177 or via e-mail at lwerk@nemours.org.

For more information, please go to www.floridakidnetwork.org.

Lloyd N. Werk, MD, MPH, FAAP Nemours Clinical Management 4901 Vineland Road; Suite 300 Orlando, FL 32811

(407) 650 - 7177  (Voice Mail)  
(407) 650 - 7169  (Administrative Assistant - Linda Minnick)  
(407) 650 - 7083  (Facsimile)
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