Greetings from Chicago. As you can see, the name of our Section has been updated. The Executive Committee requested, and the AAP approved, the change in our name from Section of Otolaryngology-Bronchoesophagology to Otolaryngology - Head & Neck Surgery.

In this report, I will introduce a new position on the Executive Committee and review our meeting schedule, membership recruitment, our relationship with SENTAC, the work of the Surgery Advisory Panel, membership dues, the Chapter Liaison Project, and the involvement of the Section in AAP publications and statements.

The committee is elected by vote of the Section. A new position created within the Executive Committee last year is that of Chair-Elect which is held by Bruce Maddern. In my time of working with the AAP, it has become clear to me that it takes at least several years of involvement with the AAP to begin to understand how the AAP works and, more importantly, how to work within the AAP structure. Bruce has served in numerous roles for the Section including Program Director of the National Conference and Exhibition (NCE). Currently, he is in charge of our recruitment efforts. He will take over for me in two years when I step down as Chair. The other members of the Executive Committee can be found on page 8.

Membership Recruitment: The Executive Committee has worked to streamline the process of joining this section. Previously, the Section voted once a year on candidates for fellowship in AAP. We have changed this policy so that if the application is approved by the Membership Chair, currently Bruce Maddern, the candidate is approved without vote of the Executive Committee. If there are applications requiring more discussion, these will be brought to the Executive Committee on a twice a year basis.

In collaboration with the Department of Membership, we have instituted reduced fees for Post-Residency Fellows (PRTF). Specifically, the $50 PRTF fee will be paid by the Section in order to introduce them to the benefits of and value in belonging to the AAP.

We have tentative plans to host the Poster Reception at the American Society of Pediatric Otolaryngology (ASPO) Meeting over Memorial Day weekend, 2005, in Las Vegas, Nevada. This will be a breakout year for ASPO from COSM and the meeting will be held at the new Marriott Resort near Las Vegas. Our goal in hosting the reception is to raise AAP visibility and the benefits of membership among residents and fellows attending ASPO.

The Section has held two joint meetings with the Society of Ear Nose and Throat Advances in Children (SENTAC). The first was in Chicago in 2000. The second meeting was in New Orleans this past fall. The Section was approached by SENTAC to try to coordinate meetings between the Section and SENTAC in an attempt to increase visibility and interest in membership in SENTAC. The results were disappointing and therefore no further joint meetings are planned. The Section will continue to focus its NCE efforts on educating pediatricians and on providing an educational program for the Section members. The NCE in 2003 was held in New Orleans. Earl Harvey served as last year’s program chair. My thanks to Earl for his efforts in serving. (See page 4 for a recap of events.)

The 2004 NCE will be held in San Francisco from October 9th - 13th. Seth Pransky is the program chair for the meeting and has an excellent program in place (See page 2 for the program schedule.) I hope to see you there! David Darrow will be the program chair for the 2005 meeting in Washington, D.C. and is already hard at work on this program. Scott Schoem is helping to coordinate between the Section and the various AAP CME courses offered through out the year and through out the country.

As you can tell, it has been a busy time for the Section. I hope to report on a twice a year basis to you via this newsletter format.

Inside this issue:
- Guide to the 2004 NCE Page 2-3
- Membership Report Page 3
- Section News Page 4
- Chapter Section Liaisons Page 5
- Federal Affairs Report Pages 6-11
- Roster Page 12
The Section on Otolaryngology Head and Neck Surgery is proud to present an expert interdisciplinary panel on obstructive sleep disorders in children. Obstructive sleep problems in children continue to be a controversial area of pediatric medicine. Faculty from pediatric otolaryngology, pediatric pulmonology, pediatric plastic surgery, pediatric anesthesiology and pediatric gastroenterology will present a comprehensive overview of the management of these commonly encountered and often challenging patients. Included in the program will be a discussion of what defines obstructive sleep apnea in children, the various surgical and non-surgical management options available for these patients, as well as perioperative care issues. Given the physician panel of specialists from different pediatric subspecialties, the interaction promises to provide a thoughtful and stimulating discussion intended to direct the primary care physician to better understand and treat these patients. **This program is open to both Section Members and all attendees of the AAP meeting and will be held on Sunday, October 10th from 8:00 am to 12:30 pm as follows:**

**Obstructive Sleep Apnea: When Do I Worry, How Do I Assess and What Should Be Done.**
Moderator: Anna Messner, MD
8:00 – 8:05am Seth M. Pransky, MD, FAAP
Introduction

8:05 - 8:35 am Kristina Rosbe, MD, FAAP
The Pediatric Otolaryngologist and the Snoring Child

8:40 - 9:10 am Raphael Pelayo, MD
The Sleep Physician and Non-Surgical Management of the Pediatric OSA Patient

9:15 - 9:45 am Lawrence D. Hammer, MD, FAAP
Obesity Issues in the Pediatric OSA Patient

9:45 - 10:00 am Questions
10:00 - 10:20 am Coffee Break

10:20 - 10:40 am Brock Fisher, MD
Pediatric Anesthesiology: Pre-op Assessment and Post-operative Management of the Pediatric OSA Patient

10:45 - 11:15 am Fernando Burstein, MD, FAAP
Pediatric Plastic Surgery: Zone Management of Pediatric OSA

11:20 am - 11:50 am David Darrow, MD, DDS, FAAP
Pediatric Otolaryngology: The Pediatric OSA Patient with Chronic Airway Obstruction: Management Beyond T & A

11:50 am - 12:30 pm Anna Messner, MD
Panel Discussion & Questions

The Section Business meeting and luncheon will be held immediately following until 2:00 pm. Please be sure to purchase your tickets for lunch and the Section Banquet when registering for the meeting. You can register through www.aap.org or by calling 866/843-2271.

**DON’T FORGET!!**

When you register for a one-day pass, you are free to attend any programs on that day - you are not limited to attending only the Section Program. Your one-day registration also provides you access to the Exhibit Hall (located in the Convention Center). Also, don’t forget to submit your lunch ticket for reimbursement. The Section sponsors your attendance to the Section Business meeting and luncheon, so be sure to mail in your ticket stub to our AAP Manager, Chelsea Kirk (see page 12 for her address) and she will reimburse you for the cost of the ticket.

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**Attend the Section on Otolaryngology - Head and Neck Surgery Banquet**

**Baraka Restaurant**

7:30 pm to 10:30 pm

Advance Tickets Required - see your Registration Program in the June Issue of AAP News or visit www.aap.org

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We also have a variety of topics being offered for the Pediatricians:

On Saturday October 9th at 9:30 am, **Anna Messner, MD** will team up with **Kristina Rosbe, MD** to present an Audience Response Case Discussion presentation entitled “**Potpourri of Common ENT Problems that Confuse and Confound.”** On Monday, October 11th, **Linda Carlson, MS, CPNP** and **Andrew Hotaling, MD** will conduct two workshops entitled “**Otitis Media: Sharpening Your Clinical Skills.”**
Sightseeing in San Francisco

Alcatraz - Spanish for pelican, was named Isla de los Alcatraces after the birds that were the island's only inhabitants. The island served as a military fortification in the 1850s and an incarceration facility for war prisoners during the Spanish-American War. In 1934 Alcatraz became the infamous maximum-security prison for Mafia criminals and high-risk convicts. Famous island residents have included "Machine Gun" Kelly, Al Capone and Robert "Birdman" Stroud.

Bay Bridge - The San Francisco-Oakland Bay Bridge opened in 1936 and links San Francisco with Contra Costa and Alameda counties by way of an 8.5-mile suspension / cantilever structure. Views of the City's skyline are spectacular from the bridge, however no pedestrians are allowed on the structure. A $2 toll is collected westbound.

Cable cars - operate seven days a week from 6:30 am until 12:30 am. The fare is $3 (no transfers issued or accepted) or use your MUNI Passport. Purchase your ticket from the conductor on board where exact change is required. The cable car was introduced to San Francisco on August 2, 1873. Wire-cable manufacturer Andrew Hallidie conceived the idea after witnessing an accident in which a horse-drawn carriage faltered and rolled backward downhill dragging the horses behind it. The first cable car to descend down Clay Street on Nob Hill was an immediate success. Besides creating a vital link in San Francisco's public transportation system, the cable car opened the door for building on steep hills which until this time was thought to be impossible. Throughout the 1890s, eight transit companies operated 600 cars, which covered 21 cable car routes and a total of 52.8 miles. Cable cars remained the primary mode of transportation until the 1906 earthquake.

For information, visit http://www.sfcablecar.com/

The Golden Gate Bridge - (Highway 101 North) links San Francisco with Marin County. Before its completion in 1937, the bridge was considered unbuildable because of foggy weather, 60-mile-per-hour winds and strong ocean currents sweeping through a deep rugged canyon below. At a cost of $35 million, the 1.2-mile bridge took more than four years to build. Eleven men lost their lives during construction. Often shrouded in thick fog, the bridge sways 27 feet to withstand winds of up to 100 miles per hour. The color of the bridge, known as International Orange, was chosen because it blends well with the bridge's natural surroundings. The two great cables contain enough strands of steel wire (80,000 miles) to encircle the equator three times. The concrete poured into its piers and anchorages would pave a five-foot wide sidewalk from New York to San Francisco.

Membership Chairperson's Report

Bruce Maddern, MD

Our Section has continued to grow in 2004. Membership stands at 186 active Fellows. Many members have been actively involved in membership recruitment and retention. Thank you to all who have helped over the past year.

The Executive Committee has made important changes to enhance our recruiting efforts and retain existing members. Our Section sponsors dues for fellowship candidates (post residency trainees) who are entering pediatric otolaryngology fellowships. This has been coordinated through the American Society of Pediatric Otolaryngology (ASPO). By supporting these trainees, we promote awareness and ensure the continued growth of our section.

The section application process has been streamlined. Applications for fellowship status are now evaluated as they are received. In the past, application approvals were performed once per year. Section criteria for membership continue to stress the Academy's high standards and commitment to pediatric otolaryngology. A minimum of 80% pediatric surgical cases and/or fellowship training is required for section membership.

Recruiting efforts within our sister society meetings such as ASPO and SENTAC have increased awareness and added members. As always, if members know of interested pediatric otolaryngologists, please encourage them to join. Membership materials can be obtained through our Section manager, Chelsea Kirk at 847/434-7087 or via e-mail at ckirk@aap.org.

Involved members ensure our continued success. If you are interested in participating in any of our section programs or committees, please call or e-mail Chelsea at the above listed number and e-mail or e-mail me at bmaddern@bellsouth.net.

Congratulations to our newest members:

Ellis Arjmand, MD
Jeffrey Carron, MD
William Collins, MD
Charles Hughes, MD
Sanjay Parikh, MD
Kristina Rosbe, MD
Denise Sherman, MD
David White, MD
Karen Zur, MD
Take a Break and Catch up on Section News

A Note from the Surgery Advisory Panel (SAP) Representative
Andrew Hotaling, MD

Of great benefit to our members has been Section participation in the Surgery Advisory Panel (SAP). The SAP was established due to concerns that the AAP was not paying attention to the concerns of the various surgical sections in the AAP. In my opinion, SAP has been extremely beneficial for both the surgical sections and for the AAP. Typically, SAP meets twice a year with a board member of the AAP in attendance. Of note, Michael Cunningham was elected last year as Chairman of SAP and is doing a great job in leading this important group. Over 7 years of work, multiple revisions, and approval by various levels of the AAP, the SAP has produced referral guidelines and explanatory brochures for each surgical section. These have been published and are available online as well as by mail from the AAP if you wish to have them in your office for distribution. Attached are copies of the statements.

Many of the surgical sections, including Otolaryngology – Head & Neck Surgery, are concerned about the cost of membership in the AAP being prohibitive toward recruiting new members. I believe that the AAP is now listening to our concerns. There is ongoing discussion about creating a ‘cafeteria style’ benefit package in which individual members could choose to receive or not receive specific benefits of membership at reduced cost. This concept is not a reality yet, but I am hopeful. Although the membership dues are high for AAP, I feel that the benefits of belonging far outweigh the cost. The AAP is the largest group of pediatric health specialists in the world, numbering over 60,000. Although the AAP can be slow to reach a consensus, when it does, its voice carries tremendous weight, especially with state and federal legislators. The AAP employs lobbyists in Washington who work full time to promote the health care of children. The political leadership of both parties listens closely to what the AAP says. As surgeons dedicated to the care of children, I believe the AAP is the best group to represent us as Pediatric Otolaryngologists in advocating optimal children’s health care.
There is a major effort by the AAP to have the Chapters interface better with Sections. We are appointing a Section member to serve as the Chapter liaison for every Chapter. From reports of the liaison between the Georgia Chapter and the Surgical Section, it has been a win-win situation for both the Chapter and that Section.

### Section on Otolaryngology - Head & Neck Surgery Chapter Liaisons

(* Indicates alternates)

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### States Still in Need of Representation

(The number after your state indicates your district.)


Please contact Chelsea Kirk at ckirk@aap.org if you are interested in serving as a Chapter Liaison for your unrepresented state.

### Log-On for More Information

The Section on Otolaryngology - Head & Neck has its own Web page within the AAP Web site. You can find information about upcoming meetings, a roster of the Executive Committee, a pamphlet entitled "What is a Pediatric Otolaryngologist and much more!" at www.aap.org/sections/otolaryngology/

### Important 2004 NCE Reminder!!

Attend the 2004 National Conference & Exhibition (NCE) to explore the latest trends in pediatric medicine, brush up on your technical skills, interact with your peers, and see the latest in pediatric products and technologies from over 300 vendors. October will be here before you know it, so don't miss your chance to earn up to 52 hours of AMA-PRA Category 1 Credit at over 350 individual sessions. Visit the City by the Bay October 9-13. Pre-registration ends August 27, so sign up now! Sign up for the 2004 NCE at http://www.aap.org/nce or for a registration packet call 866-843-2271.
ACCESS TO HEALTH CARE


1. Every child must have health insurance.
2. Health insurance should be a right, regardless of income, for all children, pregnant women, their families, and ultimately all individuals.
3. All health insurance plans should have a comprehensive age appropriate benefits package such as that of the American Academy of Pediatrics (AAP).
4. All children should have access to primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, pediatric mental and dental professionals, and hospitals with appropriate pediatric expertise.
5. All health plans should have levels of reimbursement that promote unrestricted access to health services for children.
6. Health insurance should be fully portable and provide continuous coverage.
7. Administrative aspects should be streamlined and simplified.
8. Families should have a choice of clinicians.
9. Health plans should complement and coordinate with existing maternal and child health programs to ensure maximum health benefits to families.

Immigrant Children's Health Insurance Act (ICHIA) of 2003

On April 9, 2003, Sen. Bob Graham (D-FL) reintroduced the Immigrant Children’s Health Insurance Act (ICHIA) of 2003 (S. 845). This legislation would give states the option to provide health coverage to lawfully present children and pregnant women under Medicaid and SCHIP. This legislation remedies the five-year ban on Medicaid and SCHIP coverage for immigrants entering the country legally on or after August 22, 1996 that was set in place with the passage of the 1996 welfare reform bill. The ICHIA bill would allow states to receive federal help to provide health care to legal immigrant families, providing immediate fiscal relief to those states that are already covering legal immigrants, and in those states where coverage has not been available, allowing states to reduce their uncompensated health care burdens. The Congressional Budget Office projects that restoring Medicaid and SCHIP benefits to legal immigrants would provide coverage to 155,000 legal immigrant children and 60,000 pregnant women in fiscal year 2003 alone. The Academy has endorsed this proposal.

In June 2003, the Senate approved Medicare reform legislation (S.1) that included the ICHIA legislation. As the ICHIA language was not in the House-passed Medicare reform legislation, the Academy and coalition efforts to pass this legislation were focused on the Senate-Senate conference negotiations. Unfortunately, the ICHIA provision was stripped from the final Medicare bill in the last stage of negotiations. It is expected that the Senate will consider welfare reform reauthorization legislation, Temporary Assistance for Needy Families (TANF), as early as March 2004. The ICHIA provision is among the top democratic amendments to be offered during floor debate. The Academy is working in a coalition effort with Sen. Graham’s office to secure passage of the ICHIA amendment and its inclusion in the final TANF bill.

MediKids Health Insurance Act of 2003

On March 11, 2003, Rep. Pete Stark (D-CA-13) and Sen. John Rockefeller (D-WV) reintroduced the MediKids legislation (H.R. 1205/ S. 588). The Academy participated in a press conference with these two offices to announce the introduction of the bill. The Academy strongly supports this legislation which would create a unified health care system that would achieve the Academy’s goal of health insurance for all children regardless of family income. MediKids would make coverage automatic and promote equity, family responsibility, choice, and uniform benefits. At the end of 2003, the MediKids legislation has 7 Senate cosponsors and 57 House cosponsors.

Start Healthy, Stay Healthy Act of 2003

On May 8, 2003, Sen. Jeff Bingaman (D-NM) introduced the Start Healthy, Stay Healthy Act of 2003 (S. 1033). This bill gives states the option to further extend coverage to pregnant women through Medicaid or SCHIP (above 185% of poverty up to the full SCHIP eligibility levels) and to cover newborns through the first year of life (12 months continuous eligibility). Federal law currently limits coverage of pregnant women through SCHIP to mother’s at or under age 18. This legislation would give states the option of covering pregnant women regardless of age, without having to apply for a waiver. The Academy has endorsed this legislation.

Children’s Express Lane to Health Coverage Act of 2003

On May 20, 2003, Sens. Jeff Bingaman (D-NM) and Richard Lugar (R-IN) introduced the “Children’s Express Lane to Health Coverage Act of 2003” (S.1083). This legislation would give states the option to determine that a child is income eligible for Medicaid or SCHIP based on the fact that they have already been found eligible for a nutrition program or other comparable program that operates under similar financial guidelines. This legislation would allow states to eliminate some of the bureaucracy and barriers low-income people (children, pregnant women, and their families) have to deal with to become eligible for a variety of federal/state programs.

This legislation seeks to enroll the 70% of uninsured children who are eligible for public programs but unenrolled by simplifying enrollment procedures and streamlining the application process for federal and state programs, including Food Stamps, School Lunch, WIC, Medicaid, and SCHIP. Under this legislation states would have the option to allow an eligibility application under one program serve as proof of eligibility for any of the others. This legislation follows Academy policy and efforts to streamline enrollment and increase outreach efforts under Medicaid and SCHIP. The Academy has endorsed this legislation.
Health Coverage, Affordability, Responsibility, and Equity (CARE) Act of 2003


This legislation would allow poor and near poor families a variety of options for affordable and comprehensive health coverage, building on current public programs. This legislation would encourage enrollment of Medicaid and SCHIP eligibles by providing financial incentives to the states to enroll and retain these children. The legislation would allow those individuals with family members eligible for Medicaid or SCHIP to buy-in to either program in order to unify family coverage. Among its provisions, this legislation also would provide tax credits for the uninsured who are at or under 200% FPL, ineligible for Medicaid or SCHIP, and lack access to employer coverage that costs less than 5% of household income. The bill also includes provisions to help families of small businesses purchase health coverage through market-based health insurance pools. The Academy has endorsed this proposal.

Family Opportunity Act (S. 622/H.R. 1811)

Legislation was reintroduced in the 108th Congress to allow states to expand Medicaid coverage to children with severe disabilities. Similar legislation was considered in the 106th and 107th Congress but did not pass either body.

On September 30th, the Senate Finance Committee reported out S. 622, the Family Opportunity Act and is now waiting for a floor vote. This bill is identical to the bill reported out of Senate Finance Committee last year. It currently has 63 bi-partisan co-sponsors. In April, Representatives Pete Sessions (R-TX) and Henry Waxman (D-CA) introduced H.R. 1811 in the House and currently the bill has 99 co-sponsors.

Senators Grassley (R-IA) and Kennedy (D-MA) along with Representatives Sessions (R-TX) and Waxman (D-CA) are working to get both bills on the floor this spring. A high priority for a four members, the only obstacle is the House Leadership will not bring it to the floor. Advocates have been asked to target Majority Leader Tom Delay (R-TX) and Speaker Hastert (R-IL) and ask to send the bill to the floor.

Bill Summary
- This program is a state-option to allow families of children with severe disabilities to purchase Medicaid coverage for their children with disabilities;
- Children are defined as having not attained 18 years of age;
- Disability is defined by same criteria as the SSI for children program;
- The buy-in into Medicaid benefits is for families up to 250% of poverty;
- Families are required to apply for, enroll in and pay premiums for employer-sponsored coverage as a condition of a family's eligibility for the Medicaid buy-in (presuming such private insurance is available to the family);
- States have the option to impose income-related premiums but the total amount for premiums (the aggregate of private and public premiums) cannot exceed 5% of family income.

Background: In the 107th Congress, following months of advocacy work, the "Family Opportunity Act" (S. 321/H.R. 600) passed the Senate Finance Committee by voice vote but the full Senate took no action. S. 321/H.R. 600 expands Medicaid options by allowing states to offer Medicaid coverage to children with severe disabilities living in low-income families through a buy-in program.

Association Health Plans (AHPs)

On February 11, 2003, Rep. Ernie Fletcher (R-KY) introduced the "Small Business Health Fairness Act of 2003" that was subsequently introduced in the Senate by Sen. Olympia Snowe (R-ME) on March 6, 2003 (S.545). This legislation would allow AHPs, groups of small employers that band together and purchase health coverage, to be exempt from state regulation, oversight, and mandates and would be federally regulated by the Department of Labor.

The Blue Cross Blue Shield Association (BCBSA) asked that the Academy join a coalition, "Insure Our Future," that opposes this legislation. Academy leadership and staff met with groups on both sides of the AHP debate and the issue was considered by the Committee on Child Health Financing (COCHF), the Committee on State Government Affairs (COSGA), the Committee on Federal Government Affairs (COFGA), and its Access Subcommittee. All four of
these committees recommended to the AAP Executive Committee and Board of Directors that the Academy join this coalition and oppose this legislation. The Board agreed that this legislation would threaten the progress that has been made in ensuring that insured children have appropriate access to preventive and well-child care. The Academy is now working in this coalition to oppose this legislation.

Although this legislation passed the House in June, the work of the Academy and other members of the “Insure Our Future” coalition has prevented the advancement of this legislation to in the Senate.

**Federal Proposals for State Fiscal Relief (Medicaid/ SCHIP)**

Medicaid: The Academy has been actively involved in legislative efforts seeking fiscal relief to the states to fund their Medicaid programs. The Senate Economic Stimulus bill included state fiscal relief for Medicaid. On May 23, 2003 the House and Senate approved the conference report for the tax-cut bill (H.R. 2) that included a provision giving $20 billion to the states in fiscal relief, $10 billion of which is specifically for Medicaid. This is a big win for the states and for the efforts to maintain the Medicaid program and the State Children’s Health Insurance Program (SCHIP) - the vital child health care safety net.

As states continue to face budget deficits and important child health programs are threatened due to a lack of funding, the Academy will continue to endorse efforts to provide long-term fiscal relief to the states.

**SCHIP**

The Academy continues to work to protect funding for the State Children Health Insurance Program (SCHIP) for children.

In 2003, the Academy worked throughout the year to restore the nearly $3 Billion in unspent SCHIP dollars that were scheduled to revert back to the federal treasury by September 30, 2003. After a lengthy back-and-forth between the House and Senate in the summer of ‘03, legislation was passed (H.R. 2854) that restored the unspent SCHIP funds. The legislation also included compromise language on the formula for redistributing unspent funds amongst the states, allowing states to retain ½ of the unspent funds and give the other ½ over for redistribution to states that had already spent their allotments.

In 2004, efforts are underway to work with Congress to restore $1.2 billion in unspent SCHIP funds that are scheduled to revert back to the treasury this year. The Academy is working in a coalition to develop a strategy both for restoring these unspent funds in the next three years of the program (2004-2006), as well as a long-term strategy looking at reauthorization for the SCHIP program in 2007.

**President’s Medicaid Proposal**

In 2003, the Administration announced a proposal to reform the Medicaid program in its FY2004 Budget proposal. The proposal sought to overhaul the Medicaid and State Children’s Health Insurance (SCHIP) programs through capped funding and “ultimate flexibility” to the states. The Academy was part of a large coalition that strongly opposed this proposal.

Seeking support of their reform agenda, the Administration first sought the endorsement of the National Governor’s Association (NGA). The NGA considered the Bush proposal through the establishment of a Medicaid task force, made up of both Republican and Democratic governors. The NGA Task force was the focus of six months (February-June) of lobbying efforts by the entire Medicaid advocacy community. Fortunately, on June 10, 2003, the National Governors Association (NGA) announced that its Medicaid Reform Task Force had disbanded without coming to a consensus on the block granting - or capping - of federal Medicaid financing. Also in June, Senate Democrats wrote a letter to President Bush stating that they would not pass Medicaid reform legislation that included capped federal financing of the program. The combination of the NGA’s failure to reach consensus on the Bush Plan and the opposition in the Senate to consider a key component of the Bush proposal, stopped any efforts to move the proposal in 2003 in a legislative year that was monopolized by the Medicare drug bill debate and the War on Terrorism.

In 2004, the Bush Administration renewed its interest in reforming the Medicaid and SCHIP programs in its budget proposal (FY05); however, it altered its strategy in moving the reform agenda forward. Unlike last year when the Administration sought to move a national Medicaid reform agenda through Congress and the NGA, this year the Administration is moving forward with its reform efforts on a state-by-state basis, seeking agreements with individual governors under section 1115 waiver authority. Reports indicate that such negotiations are underway and in some states governors have already issued public statements about their willingness to consider a blockgrant of their Medicaid programs. Given that any such cap would undermine the entitlement nature of Medicaid and would also likely include “flexibility” for the states to weaken the benefits package (EPSDT) currently guaranteed by law for children, the Academy opposes these reform efforts.

Although the Administration’s state-by-state Medicaid reform strategy makes efforts to oppose it more difficult, The Academy continues to monitor the Administration’s efforts through our Chapters, and remains committed to protecting the critical guarantees of the Medicaid program for children.

The Academy is also monitoring efforts by the Administration to alter the way in which states receive federal funding for their Medicaid programs. On January 7, 2004, the Administration published a notice in the Federal Register that would require states to prospectively budget Medicaid expenses, specifically on the CMS-37 form. This means that states would be required to submit to the Centers for Medicare and Medicaid Services (CMS) advance budget information and documentation, in an effort to predetermine state Medicaid budgets. Doing so would enable CMS to identify and resolve potential funding issues prior to the budget being implemented and the expenditures being paid. The goal of this requirement is to put a stop to intergovernmental transfers (IGTs) and other financial “gaming” that allows states to draw...
The Federal Register notice gave a one-day comment period. The National Governors Association (NGA) and others complained about the lack of time given to respond, and the Administration has since rescinded the notice, in an effort to work with the governors and Medicaid directors on this issue. The Administration will submit another notice on prospective budgeting in the Federal Register in the near future, with a longer comment period so that other organizations can weigh in. As such, the effort to require prospective budgeting is not dead; it is simply on hold. The Academy will continue to monitor this effort, recognizing it could have a dramatic impact on the Medicaid program.

**MEDICAL LIABILITY**

**Medical Liability/Legislation**

The House passed comprehensive medical liability legislation known as the Help Efficient Accessible, Low-cost, Timely Health Care (HEALTH) Act (H.R. 5/S. 607) in March 2003 by a vote of 229-196. The bill, which was reintroduced in the 108th Congress by Representatives Jim Greenwood (R-PA) and John Murtha (D-PA), would among other things: (1) limit non-economic damages, such as pain and suffering awards, to no more than $250,000; (2) limit punitive damages to the greater of two times the amount of economic damages or $250,000; (3) establish new guidelines for joint and several liability so that providers could be held liable only in direct proportion to their percentage of responsibility; and (4) allow providers to request periodic payments if an award for damages exceeds $50,000. The bill also would limit the number of years a plaintiff has to file a health care liability action; in cases involving care to minors under the age of 6, claims would have to be filed within 3 years or the minor’s 8th birthday, whichever is later.

To date, efforts to pass medical liability legislation in the Senate have been less successful. In July 2003, the Senate failed to agree on moving forward to consider comprehensive liability legislation similar to H.R. 5, known as the Patients First Act (S. 11). And, in February 2004, the Senate failed to agree on moving forward to consider a bill (S. 2061) that would have provided liability relief for out-of-pocket services only.

With medical liability reform continuing to top the President’s domestic agenda, Senate Majority Leader Frist (R-TN) has indicated he will bring various medical liability bills to the Senate floor throughout the remainder of the congressional session. The next bill expected to be brought up for debate will be limited to trauma and emergency services only. The Academy will continue to work closely with others in the medical community - including the AMA, ACOG, ACP and AAFP - in support of enactment of comprehensive medical liability legislation this year.

**Medical Liability/Pediatric Rule**

One year after a lower federal court struck down federal regulations requiring pharmaceutical companies to conduct pediatric drug studies of certain drugs if they are used in pediatric populations, the Congress passed legislation (S. 650 - the Pediatric Research Equity Act) restoring those protections. President Bush signed the bill into law on

The passage and subsequent signing of S. 650 into law was the culmination of many months of intense activity by the American Academy of Pediatrics (AAP) on both the legal and legislative front. As a result of this successful advocacy effort children will no longer be therapeutic afterthoughts by the pharmaceutical industry. Pediatricians and parents can now be assured that the medications they use in infants, children and adolescents will have safety and efficacy information and appropriate formulations for the pediatric populations in which they are used.

Legal Proceedings: The American Academy of Pediatrics and the Elizabeth Glaser Pediatric AIDS Foundation filed a motion in late 2002 to ask and were granted the ability for the two organizations to appeal the lower court ruling which struck down the 1998 Pediatric Rule. The legal appeal proceeded forward throughout the entire congressional debate and proved to be a catalyst in prompting Congress to act swiftly on legislation to fully restore the requirements and protections of the Pediatric Rule. Congressional staff stated that the continuation of the lawsuit was one of several motivating factors in moving strong and unambiguous legislation through Congress.

Once the President signed S. 650 into law there was no need to continue the court appeal and the AAP and EGPAF filed a motion to dismiss the case.

Congressional Action: On July 23 the Senate unanimously passed S. 650, the Pediatric Research Equity Act (aka: Pediatric Rule legislation), as amended. AAP had been working for months to secure a legislative fix of two outstanding issues in S. 650. AAP was concerned that the enforcement provision of the legislation was ambiguous, leaving the possibility that the legislation could be challenged in court. In addition, the effective date in the legislation would have resulted in over 300 pediatric studies being lost. A third issue – a provision to time limit (“sunset”) the legislation – was added during the Senate Health, Education, Labor and Pensions Committee (HELP) markup of S. 650 back in March. AAP does not support the sunset provision.

In an amendment offered on the Senate floor by the chair of the Senate HELP Committee Senator Gregg (R-NH), the enforcement and effective date provisions were appropriately fixed however, the troubling provision to sunset the legislation in 2007 remained. AAP endorsed the Senate-passed legislation because it fully restores the protections of the pediatric rule. On balance, this legislation is a win for children’s therapeutics. AAP has vowed to fight the sunset provision when the bill is reauthorized in 2007.

The House of Representatives was slow to move on the Pediatric Rule legislation but ultimately considered and passed the Senate-passed bill S. 650 on November 19. The House Energy and Commerce Committee, which had jurisdiction over the legislation, did not consider the bill in committee; rather, the legislation was sent directly to the full House for debate and passage.

Since there was virtually no change between the Senate-passed and House-passed versions of S. 650 there was no need for a conference. The bill went directly to the President for signature.

Immunizations

Federal Legislation - VICP: Sen. Bill Frist (R-TN) introduced the Improved Vaccine Affordability and Availability Act, S.754, in the spring of 2003. Briefly summarized, under S.754, the Vaccine Injury Compensation Program (VICP) program would be required to collect data on adverse impacts associated with immunizations. The bill also revises provisions governing VICP, such as: equitable relief; third party petitions; jurisdiction to dismiss improperly brought claims; vaccine-unrelated injury; an increase in the award for pain; and suffering in the case of a vaccine-related death. It would extend the statute of limitations from three to six years for families of children injured by required vaccines to file claims under VICP, and also would increase the amount of compensation that families can receive for children’s pain and suffering from $250,000 to $350,000. In addition, the legislation would allow parents to receive compensation for their own pain and suffering.

Mark-up on this bill has been postponed numerous times. Although at the time of this writing it remains unclear when it will be considered in the second session of the 108th Congress, it is hoped that it will be prior to the adjournment of this congressional session in October 2004.

The Academy has outlined principles that any amendments to this important legislation must be measured. These are:

1. VICP must guarantee a safe and stable supply of childhood vaccines;
2. The scientific credibility of the VICP must be preserved; and
3. The VICP must stand as the first contact for all alleged vaccine-related injuries before pursing legal action.

Additional advocacy “action” information and materials are available on the members only channel of the AAP web site - www.aap.org/moc, click on Federal Affairs, then click on “Pass Remedies for Vaccine Supply and Liability” to send the email or fax directly.
Federal Legislative Update cont.

Vaccine Programs/Appropriations: As he did last year, the President's FY 2005 budget proposal includes $511 million for the section 317 immunization program. This reflects a reduction in funding pursuant to a proposed legislative recommendation that would transfer some funding for vaccine purchase and delivery to the Vaccines for Children (VFC) entitlement program. If the legislation is not passed the president's budget essentially level funds the program for FY 2005. Current funding for the section 317 program is $643.6 million. This also reflects the transfer of $7.3 million to support the National Vaccine Program Office that moved from CDC in Atlanta to Washington, DC.

During the Senate floor debate on its FY 2005 budget resolution an amendment, offered by Senator Jeff Bingaman (D-NM), to reserve funding to pursue this legislative change was adopted by voice vote. While the intent of this legislative proposal is important - to increase access to immunizations to more children through public health clinics - to tinker with an important entitlement program at this time as well as potentially having children not immunized in their medical home where other care is provided is very troubling. This proposal will also present a challenge to those states, such as North Carolina and Massachusetts, that are "universal purchase" states and therefore do not have public health clinics and would not benefit from the expanded access being proposed. Senator Bingaman will join Senator Gordon Smith (R-OR) in introducing legislation to transfer funding the week of March 22. Senate staff has indicated that it would not support a decrease in funding for the 317 immunization program to implement their VFC legislative expansion to public health clinics.

In FY 2005 the childhood and adolescent immunization community is pursuing additional funding above the current level - $643 million - for vaccine purchase ($77 million) and for vaccine prevention activities ($5 million). Additional funding is needed to address the 19 states that are not vaccinating approximately 500,000 children with the PCV7 vaccine as well as the need for funding to implement the new routine influenza recommendations, the flu vaccine stockpile and for additional surveillance, communication and public education activities.

FY 2004 Appropriations

Congress began the FY 2004 budget and appropriations process in early spring, passing the FY 2004 budget in record time and proceeding to debate the 13 appropriations bills. The House completed 11 of the 13 bills comprising the total federal government-spending package by the time they adjourned for its summer recess, although the Senate worked at a slightly slower pace. Throughout this period of time the AAP worked diligently to ensure that public health discretionary programs, such as immunizations, health services and biomedical research, children's hospital GME, health professions, EMSC to name a few, received at least modest inflationary increases or at a minimum are maintained at FY 2003 funding levels. However, although the new Fiscal Year - 2004 - officially began on October 1, 2003, it essentially was postponed because Congress was not able to complete its work on seven of the 13 freestanding appropriations bills, resulting in the signing of a sixth short-term funding bill - Continuing Resolution (CR). The CR kept the federal government running and funded at FY 2003 levels through January 31, 2004. The seven remaining bills, including Labor/HHS and Human Services/Education, were bundled into an omnibus (“catch-all”) spending bill. The omnibus spending bill includes a .59 percent across-the-board cut to provide funding for certain congressional and White House priorities including additional funding for veterans medical care. The House of Representatives voted to approve the $820 billion package before it adjourned for the year. The Senate approved the final measure on January 22 by a vote of 65-28, and sent the bill to the President's desk for his signature.

House of Representatives

The House of Representatives, by a narrow vote of 215 - 212, approved its version of the FY 2005 budget resolution on March 25. This followed debate on the rejection of three Democratic alternative budgets proposals and one alternative budget plan offered by Rep. Jeb Hensarling (R-TX) on behalf of the Republican Study Committee.

The $2.4 trillion budget includes $821 billion in discretionary spending including $2.5 billion for Project Bioshield. The budget resolution also provides $138 billion over the next nine years in tax cuts and $13 billion in cuts to mandatory spending programs including the Medicaid program. The Academy continues to vigorously oppose cuts to the Medicaid program as well as inadequate funding for public health programs such as immunizations, NIH, AHRQ, health professions training and several others.

The House budget resolution also contains two “reserve funds.” Similar to the Senate, one is a deficit-neutral reserve fund for health insurance for the uninsured - if legislation is reported out that provides health insurance for the uninsured adjustments can be made for the allocations. The second is a deficit-neutral reserve fund for the Family Opportunity Act. If a bill is reported out that provides coverage for children with special health care needs appropriate adjustments in the budget allocations could be made.

The House and Senate now must reconcile the differences in the two versions of the budget resolution and bring the revised budget resolution to the House and Senate floor for a final vote. It is anticipated that the House/Senate conference could be a difficult process because the Senate budget resolution includes a provision that restores the so-called pay-as-you-go ("paygo") rules. The Senate paygo rules require that the cost of additional tax cuts or new entitlement spending be offset with new revenues or spending cuts. In contrast the House budget resolution does not contain the paygo enforcement rules but rather it passed a separate budget enforcement bill that would cover new entitlement spending, but not tax cuts. The House opposes the Senate’s approach. Despite the possible difficult negotiations, the House Budget Committee Chair Jim Nussle (R-IA) has indicated his intent to move the process forward and complete the conference agreement with the Senate by the congressional recess scheduled to begin April 2.

The budget resolution is essentially an internal congressional document, non-binding on other committees and does not need to be signed by the President. The budget resolution however, does offer the president a blueprint and sets in motion the process in which decisions on spending and taxes must be made - appropriations and reconciliation.
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Future Meeting Dates

- 2005
  Washington, DC
  October 8-11

- 2006
  New Orleans, LA
  November 4-7

- 2007
  San Francisco, CA
  October 27-30

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