Bulletin

Editor: Ellen Sayet, M.D.
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LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

LEE COUNTY MEDICAL SOCIETY INC.

Bulletin

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The Lee County Medical Society Bulletin is published monthly with the June and August editions omitted.

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Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and endorsement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.
All LCMS Board of Governors and Committee meetings minutes are available for all members to review.

Table of Contents

Cover Photo:
Full moon over Matlacha Pass

Calendar of Events

rsvp online at www.lcmsfl.org or call 239-936-1645

April 27, 2017 - Women Physician Spring Fling & Wine Tasting Event
6 p.m. - 8 p.m.
City Pier Building
1300 Hendry Street
Fort Myers, FL 33901

Save the Date

May 12, 2017 - Cocktail Hour at Cru
6 p.m. - 7:30 p.m.
RSVP at www.lcmsfl.org

Bell Tower Shops
13499 S. Cleveland Ave, Ste 241
Fort Myers, FL 33907

LCMS Cocktail Hour
will be every 2nd Friday of each month

May 18, 2017 - Membership Meeting
6:30 pm -Social - 7:00 pm - Dinner
City Pier Building

Need help with life's difficulties?
Please visit our website at:
www.lcmsfl.org/pwp

MEMBERSHIP NEWS

Moved from area:
Ronica Kluge, MD

Relocated
George Kalemeris, MD
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Fort Myers, FL 33916
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Resigned
Omar Benitez, MD

Reactivation
Stephen Woodring, DO
Barrett Ginsberg, MD

NEW APPLICANTS

Kembuken Amadi, MD – Dr. Amadi received her medical degree from The Medical University of the Americas, Nevis, West Indies in 2011. She completed an internship and residency at the University of Mississippi from 2012- 2015. Dr. Amadi is in practice with LPG Hospitalists, 13681 Doctor's Way, Ste 18028, Fort Myers, FL 33912 Tel: 239-343-2052.
Board Certified: Family Medicine.

Andrew Jones, MD – Dr. Jones received his medical degree from Indiana University School of Medicine, Indianapolis, IN in 1978. He completed an internship at University of Minnesota, Minneapolis, MN from 1979-1981 and an Orthopedic Surgery residency at University of North Carolina, Chapel Hill, NC from 1981-1984. Dr. Jones is in practice with Gardner Orthopedics, 3033 Winkler Ave., Fort Myers, FL 33919 Tel: 239-277-7070. Board Certified: Orthopedic Surgery and Orthopedic Sports Medicine

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It's Pictorial Directory Time!

Please find enclosed a form for you or your office Manager to fill out and return with current practice information that you would like published in the directory. The deadline to return membership update forms will be April 30th. LCMS will publish the information from the last directory if we do not have any reported changes. We encourage you to include your website address and update your photos.

Advertising forms are also included in the Bulletin. Please contact Valerie for more information at 239-936-1645 or email: valerie@lcmsfl.org .

Advertising deadline is April 30, 2017.

President's Message

By Jon Burdzy, D.O.

It's legislative time again. Soon, the Florida House and Senate will begin their session and as usual there are medical bills on the docket. The Conference of Florida Medical Society Executives (CFMSE), in coordination with our legislative committees, developed position state-ments on five key bills coming up. I'll present their recommendations (all quotes are from these position statements) and then my comments on the bills.

The one's we support:

Direct Primary Care – Less Paperwork, More Care – SB 240 (Lee) and HB 161 (Burgess). "A growing number of primary care physicians nationwide are adopting this innovative model because they are frustrated by the excessive paperwork and regulatory burdens imposed by insurance companies. They are attracted to direct primary care because of their desire to spend more time with patients." In this model, PCPs charge patients a flat monthly fee for comprehensive primary care services. These fees are far less than those charged by concierge physicians, and often more affordable than traditional insurance.

Unfortunately these agreements between doctor and patient are sometimes judged by the government-powers-that-be as health plans and should be regulated as such. Which defeats the whole purpose of this model. This bill seeks to define DPC as medical agreements outside the scope of insurance regulations. FYI - One of our local physicians, Lee Adkins ran into trouble with this model a few years ago. It was covered by the local press. [http://abc7.com/archive/7321578/]

My comments: *A common sense bill that should be supported and passed. It would provide access to many patients who cannot now afford it.*

Right Medicine, Right Time – SB 530 (Steube) This bill deals with a concept that is a little more complex. It seeks to "ensure that appropriate prescriptive treatments are based on a physician's recommendation. Each year, thousands of Floridians are subjected to 'fail first' protocols, whereby insurance companies impose their own treatment decisions ahead of treating physicians' medical judgment. This causes delays in care that can lead to unnecessary hospitalizations and sometimes devastating consequences for patients." Most of us have experienced this; to get drug C, the patient must have first tried and failed drugs A and B. Not only does this often lead to delays in treatment and patient harm, it imposes a tremendous administrative burden on the physician. "A recent report from the Annals of Internal Medicine found that, for every hour a physician spent seeing patients, another two hours were spent on paperwork."

My comments: *Anything that gets patients needed treatment and reduces our administrative burden is worthy. The only caveat is that at times physicians chose an inappropriate and expensive newer drug when the old standby would work as well or better. e.g. for uncomplicated type 2 diabetes, in a patient without significant kidney disease, there is little evidence to support prescribing one of the newer branded medications instead of metformin as the first line oral agent. Nonetheless this process is more abused than of benefit to patients and doctors.*

Retroactive Denials – SB 102 (Steube) HB 579 (Hager) - this bill eliminates the ability of insurance carriers to retroactively deny claims after they have provided authorization and the physician has provided the service.

My Comments: *It saddens me we need such a bill. Also makes me a bit irate. Whatever happened to good faith and trust?*

Maintenance of Certification – HB 723 (Gonzalez) SB 1354 (Young/Mayfield) "The CFMSE supports legislation that prohibits maintenance of certification (MOC) as a condition for medical licensure, medical staff membership or participation in an insurance plan. While our organizations support the value of initial board certification, continuing medical education and competency standards, the MOC process is not scientifically proven to judge ongoing competency and improved relevant performance for practicing physicians."

My Comments: *MOC has become an overly burdensome and expensive process with little evidence showing it improves care or physician competence. Being in the midst of this myself, facing a hands-on practicum in two weeks followed by a written exam in May, after having already completed various modules required by my board, all in addition to required CME hours, I whole-heartedly agree.*

The one we're against:

Independent Practice for Nurse Practitioners and Physician Assistants (PCP HQS 17-01) "The MDs and DOs we represent believe the only way to ensure proper patient safety is to ensure the care provided is from the most qualified people trained to deliver that care. The best outcomes are achieved through a well-trained team of healthcare professionals under the supervision of a physician."

My Comments: *Thus far 22 (or maybe 23) states allow ARNPs full practice rights. Some see that nationwide independent practice rights are inevitable. ARNPs and PAs are crucial parts of our healthcare team. However, physicians should still captain this team.*

Please contact our representatives. If you can't get face time with them, the best way to share your view is to call them. Emails and letters are often filed or subject to algorithms etc. Phone calls reach a live staffer and are dealt with immediately. I found a nice piece on lifehacker.com written by a former staffer on the virtues of phone calls. [http://lifehacker.com/the-best-ways-to-contact-your-congress-people-from-a-f-1788990839]

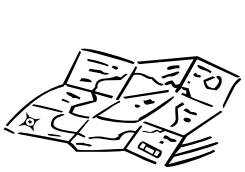
Be well!
Jon

The Ramirez Report

By Julie Ramirez, Executive Director

At the end of February, I had the wonderful opportunity to visit our state's capital for the first time, with my fellow Council of Florida Medical Society Executives (CFMSE) members. Our purpose was to visit our local legislators in their environment and review with them our top bills that we are concerned about this session. I had the pleasure of meeting with Senator Lizbeth Benacquisto, Representative Heather Fitzenhagen, and Representative Dane Eagle. They were all welcoming and it was a pleasure to see them at the Capital. Visiting them made me proud of Lee County and the achievements we strive to make. I look forward to visiting the Capital again next year.

Julie Ramirez, LCMS Executive Director with Representative Fitzenhagen & Senator Benacqquisto.



The Florida Office of Legislative Services is still seeking volunteer physicians for the annual Doctor of the Day program during the Florida Legislative Session, which is scheduled to conclude on May 5. Participating physicians provide health care for members of the Legislature and legislative employees while also strengthening physician-legislator relations. The Office of Legislative Services schedules two physicians for each day of the legislative session: one for the House of Representatives and one for the Senate. You can email Mavis Knight at Knight.Mavis@leg.state.fl.us for more information.

Florida Lawmakers On the Attack Re: Marketing in the Substance Abuse Industry

By Jacqueline Bain

On February 8, 2017, Florida Senator Jeff Clemens (Dem.) filed a bill entitled "Marketing Practices for Substance Abuse Services" (SB 0788). A sister bill was filed in Florida's House of Representatives by Bill Hager (Rep.) on February 13, 2017 (HB 807).

In the most general sense, the bills propose the following:

- creation of a marketing fraud statute specific to substance abuse treatment centers;
- mandating that all recovery residences, even those owned by treatment centers, receive FARR certification prior to suggesting that patients reside there;
- requiring lead generators, call centers and other web based marketing providers to make certain disclosures to consumers;
- requiring lead generators, call centers and other web based marketing providers to be licensed by the State of Florida Bureau of Professional Regulations;
- allowing the State Attorney's office to prosecute patient brokering;
- institutes and increases fines for convictions of patient brokering; and
- expanding the definition criminal definition of "racketeering" to include patient brokering.

The bills also expand investigation and prosecution ability of the State and reduces substance abuse patient privacy in criminal investigations. If passed, the bill would grant law enforcement access to substance abuse patient records in criminal investigations. It also permits the State Department of Legal Affairs to investigate and prosecute patient brokering allegations.

The full text of each bill is available here
http://www.flsenate.gov/Session/Bill/2017/0788/?Tab=BillText
and here.
https://legiscan.com/FL/text/H0807/id/1512726

The bill is a direct response to a Grand Jury Report issued December 8, 2016. State Attorney Dave Aronberg was tasked to form a Task Force to study the issue and recommend changes to Florida law and administrative rules to combat this crisis. In the Grand Jury Report, entitled "Report on the Proliferation of Fraud and Abuse in Florida's Addiction Treatment Industry, a state Grand Jury in Palm Beach County was asked to consider major areas of concern regarding oversight and enforcement in the substance abuse industry. (ii) housing; (iii) DCF's ability to take action; (iv) the strength and clarity of Florida's Patient Brokering Act; and (v) law enforcement ability to take action.

Shortly after the Grand Jury Report was issued, The Palm Beach County Sober Homes Task Force issued its own report named "Identification of Problems in the Substance Abuse and Recovery Residence Industries with Recommended Changes to Existing Laws and Regulations."

The Grand Jury Report thoroughly considered each of the five areas in which it was tasked and concludes with sixteen specific recommendations. The bills proposed by Senator Clemens and Representative Hager address several of those recommendations. However, what both bills ignore are the inherent problems in the treatment model set forth by insurance companies and adopted by Florida treatment providers, referred to as the "Florida Model".

The Grand Jury Report loosely defines the "Florida Model" as outpatient treatment for substance abuse disorders coupled with recovery housing. It is the recovery housing portion of the model that has been subject to recurring and increasing issues. The Grand Jury acknowledged, "The problem is that most of these young adult patients from out-of-state cannot afford housing while in treatment. Without a consistent form of patient housing, this model would not work." The Report goes on, "Detox, residential treatment, partial hospitalization (PHP), and intensive outpatient (IOP) are time-consuming levels of care, and are not conducive to working normal hours." It Grand Jury concluded that "it would be difficult, if not impossible, to eliminate [patient brokering] without addressing the legitimate need for financial assistance with patient housing."

The bills proposed by Senator Clemens and Representative Hager simply do not address this underlying issue. Insurance companies and the States Attorney's Office have taken the position that a treatment center can do nothing to financially assist outpatient patients to obtain housing, stating that any such aid is a "kickback". The State Attorney has stated that, as a result of these kickbacks

https://floridahealthcarelawfirmblog.com/2015/08/12/the-anti-kickback-statute-what-constitutes-a-referral/, or patient brokering https://floridahealthcarelawfirmblog.com/2016/10/28/the-patient-brokering-act-and-addiction-treatment/ , there exists an economic incentive for both the patient and the treatment provider to recycle through treatment.

If residents of sober homes cannot pay, and treatment centers cannot provide help, where are persons in outpatient treatment supposed to live? And if the expectation is that sober homes or recovery residences are to provide free housing while a recent graduate from inpatient treatment obtains a job and waits for his or her first paycheck in order to pay rent, how is the sober home expected to pay its bills? The Grand Jury had proposed "a new DCF license that allows treatment providers to assist PHP and IOP patients with housing by providing a limited, needs-based scholarship for rent," but the Sober Homes Task Force did not adopt that recommendation in its Report and neither bill adopted this proposal.

Right now, it seems the State's resources are focused only on enforcement, instead of what can be done to improve patient outcomes and success rates. This isn't to say that there isn't fraud and abuse occurring in the substance abuse and addiction treatment industry. However, shouldn't there at least be some State resources devoted to: (i) decreasing access to opioids and other highly addictive substances; (ii) helping this vulnerable population find qualified and suitable providers of care and treatment; and (iii) increasing involvement of a patient's treating providers in setting appropriate pathways for care on a case-by-case basis?

Perhaps the one-size fits all approach to substance abuse and addiction treatment suggested by the Florida Model and insurers is not the most appropriate method of care for those struggling with addiction. We've repeatedly heard from our treatment center, psychiatrist, social worker and mental health

counselor clients that many times they are required to step down their patients in care well before they clinically believe that a step-down is appropriate and that they feel that repeated peer-to-peer consultations fall on deaf ears with the insurance companies. So while it may be true that this vulnerable population is falling prey to aggressive marketing campaigns and that the result is relapses and endless rounds of treatment, it is also true that the professionals treating these clients are handcuffed from providing additional care and treatment when they in good faith believe it is clinically appropriate.

At the end of this very public battle, the hope is that those in treatment receive the care and treatment they deserve, and that the professionals and treatment centers that are legitimately servicing the industry are able to provide it and be paid for their services. But the short-sighted approach of enforcement just isn't enough without the concurrent step of improving treatment. If the State is going to devote resources to only a portion of the problem, then the problem isn't going to go away.

Retiree Luncheon
February 28, 2017

RedSox Ballgame - March 11, 2017

Millennial Medicine:
BY CLAY DUVAL, MD

I still remember it like it was yesterday – I was a third-year medical student on my surgical core clerkship. I had been scrubbed into one surgery after another, unencumbered by resident duty hour restrictions, for about 40 hours straight (if my memory serves). The experience I gained during that marathon of a "day at work" was so valuable, but I don't think at any time in my life I had been that tired. And I've done some pretty tiring things! I've climbed through mountain trails in the rural Philippines, hiked through kilometers and kilometers of primary growth rainforest in Central America, and lived in the back country of the Grand Teton National Park in Northwestern Wyoming for a few months. While all of those things were physically exhausting, it was a "body fatigue". What I hadn't expected to encounter in medicine as a profession was that peculiar combination of physical fatigue and mental fatigue that by now we all know quite well.

That day after the shift, I was supposed to drive from New York City metro area to a good friend's wedding in Toronto. Not surprisingly, I was not up to the task. Luckily, my best friend always wanted to take his girlfriend to Toronto anyway, and so he drove my wife and I to the wedding while I slept in the passenger seat of the car. When I awoke, I realized I had slept for most of the 8 hour drive. I reveled in almost guilty pleasure – "I got more than 6 hours of contiguous sleep!", I thought ecstatically. I at once felt infinitely better than I had before, and yet I still felt like I could have slept for another 8 hours. My mother called me and asked how I was doing and I recounted the events of the last few days. She was quite alarmed by it all, to put it lightly. But my friends in the car (all medical students), thought it was perfectly normal. And then I realized something I've since found to be almost universally true: Doctors view sleep in a variety of ways, but they definitely don't view it the way most people do.

Maybe you can relate to this. Many medical students I knew back then viewed sleep as the enemy. In their minds, nothing would have been impossible for them if they could just have kept studying without having to stop and sleep. Their implicit assumption was that if their raw aptitude had not been restricted by the confines of sleep, they would have gone to Duke for under grad, Harvard for medical school and Johns Hopkins for residency training in some almost mythical specialty (like Fetal Cardiothoracic Surgery or something) and be marveled by all humanity as an unique and

shining bastion of supreme knowledge and skill. But alas, the human need for sleep would not permit them that glory. For others, sleep was somehow viewed as a sign of weakness. We all knew those students who would brag about how little sleep they got, and wear it as a badge a pride; surely, they would think, if someone is chronically sleep deprived, they must have an impeccable work ethic and truly substantial intestinal fortitude. Unfortunately, they were often the ones falling asleep when they least expected it, often woken by a displeased attending and thoroughly reprimanded in a public forum. Others, though precious few, viewed sleep as a luxury, a treasured commodity to be guarded at all costs. Those are the medical students who often refused social events stating "I have to get my 9 hours of sleep to function". But they also, in my experience, were the ones with the most life balance and the top scores. For students in all groups, however, sleep seemed to comprise a third of that ubiquitously known but oft unspoken medical school life-triad: Sleep, Eat, Study – and repeat.

Recently, I had the privilege of hearing a great lecture by local Neurologist and Sleep Specialist, Dr. Jose Colon M.D., MPH entitled "The Fundamental Nature of Rest, Movement and Nutrition". It was a fascinating look at the underpinnings of sleep, exercise and nutrition in the maintenance of human health. For me, it really exposed the fallacies I had entertained regarding those topics. It was a much needed "kick in the pants" that helped me to reprioritize things, and to begin taking the time out of my schedule to focus on sleep, exercise and nutrition. Luckily, those efforts were successful and I lost about 20 lbs in an 8 week time period. The truth is that even though many physicians are years (some of us even decades) away from our medical training, our work culture often promotes and perpetuates a culture of sleeplessness.

With the recent news that the ACGME has now permitted residents to begin working shifts > 24 hours, this topic is becoming increasingly pertinent to medical training but I also believe it is pertinent to practicing physicians – and most importantly, to our patients. Perhaps the best investment we can make for ourselves and for others is to become staunch advocates and practitioners of sleep. And with that, good night!

Life as a Resident

By Clint Walls, M.D. FSU/LMHS Medical Residency Program

We find ourselves entrenched in a profession that is currently under much public scrutiny. Less than a decade ago, the prevailing governmental forces of the era imposed a total overhaul of our country's medical system. While the original system was admittedly imperfect, arguments can and have been made that the overhaul did not improve the situation.

As a result, we already again face a second major overhaul. In any and all circles, the mere mention of the word "healthcare" stirs a veritable tinder box of impassioned opinions and heated debate.

As our newest class of residents prepares to begin this summer, I know the most important question on their mind will simply be, "how do I survive my intern year?" We were all there at one point; I was there not long ago myself. But as a fully licensed physician about to enter my final year of formal medical training, I now find myself wondering more about the global future of our profession. Will it be as marvelous moving forward as it once was before the days of Big Medicine, bureaucracy, mandates, and multiple-choice coding?

I doubt there is a single one of us who could answer that question. On the contrary, I find it highly likely that our own personal definitions of what would be considered an ideal system vary as widely as our spectra of practices. Maybe that in itself underscores the real truth: that a one-size-fits-all system may be akin to a one-size-fits-none system.

With that in mind, it is my hope that we as a community of healthcare professionals may continue to be pioneers of innovation in whatever system we find ourselves. There are so many ways we can practice our profession and be of benefit to our patients. For the sake of those incoming interns, let us never lose sight of that.

HIPAA Checklist
Florida Healthcare Law Firm

HIPAA requires Medical Practices and certain other healthcare providers to have in place certain policies and procedures in order to allow providers to (1) maintain compliance with the law; (2) assure periodic assessments of areas of risk; and (3) respond appropriately when a breach is suspected or detected. Failure to have these required policies and procedures in place drastically increases fines and penalties in the event of a regulatory audit or, worse, a reportable breach.

HIPAA Policy Checklist *for Medical Practices*

THE FLORIDA HEALTHCARE LAW FIRM
The Law Offices of Jeff Cohen, P.A.
Daytona Beach • Delray Beach • Fort Myers • Fort Lauderdale • Melbourne • Naples • Pensacola • Tampa

- ❑ Breach notification
- ❑ Risk analysis
- ❑ Risk management
- ❑ Employee training
- ❑ Emergency mode plan
- ❑ Information system activity review
- ❑ Duties of a security official
- ❑ Response and reporting to security incidents
- ❑ Data backup plan
- ❑ Disaster recovery plan
- ❑ Business associate relationships
- ❑ Patient authorizations for disclosures
- ❑ Employee discipline and sanctions for non-compliance

Checklist prepared by Jacqueline Bain, Esq., leader of the Florida Healthcare Law Firm's compliance department and certified healthcare compliance expert by the Health Care Compliance Association.

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CHANGE SERVICE REQUESTED

LCMS Member Dues

The 2017 LCMS membership dues were payable by January 1, 2017. You or your group can pay at http://www.lcmsfl.org/en/join or call 239-936-1645. To pay your FMA dues, go to flmedical.org, and to pay your AMA dues go to ama-assn.org.

Together We Are Stronger