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

13770 Plantation Road, Ste. 1
Fort Myers, Florida 33912
Phone: (239) 936-1645
Fax: (239) 936-0533
www.lcmsfl.org

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

EDITOR
John W. Snead, M.D.
Ellen Sayet, M.D.

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MANAGING EDITOR
Julie Ramirez, 239 -936-1645
E-Mail: jramirez@lcmsfl.org

BULLETIN STAFF
Valerie Yackulich • Kristine Caprella

PRINTER
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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.

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Cover Photo:
Pointe du Hoc is a promontory with a 100 foot cliff overlooking the English Channel on the coast of Normandy in northern France. During World War II it was the highest point between Utah Beach to the west and Omaha Beach to the east. Photo by: Keith Harris, MD

Calendar of Events

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

Monday, December 4, 2017
Medical Society Holiday Party
Gulf Harbour Yacht & Country Club
See Insert for more information

Cocktail Hour at Cru
December 8, 2017
6 p.m. - 7:30 p.m.
RSVP to www.lcmsfl.org

Sponsored by: Busey Bank

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

Tuesday, December 12, 2017
MACRA/MIPS Presentation
Jarrod Fowler, Florida Medical Association
Hilton Garden Inn Airport
See insert for more information
Sponsored by: HIE Network

January 26 - Hyatt Regency Coconut Point
Eighth Annual Medical Service & We Care Awards
See insert for more information

All RSVP's can be made online at *www.lcmsfl.org*

New Members

Khalid Alam, MD
LPG Gastroenterology
16410 HealthPark Commons
Fort Myers, FL 33908
Tel: 239-343-6202 Fax: 239-437-8537
Board Certified: Internal Medicine,
Internal Medicine - Gastroenterology

Rebecca Appelgren, MD
US Anesthesia Partners
4048 Evans Ave., Ste 303
Fort Myers, FL 33901
Tel: 239-332-5344 Fax: 239-332-7246
Board Certified: Anesthesiology

Harry Alberti, MD
Lee Health Administration
Cape Coral Hospital
636 Del Prado Blvd., S.
Cape Coral, FL 33990
Tel: 239-424-2305 Fax: 239-424-4040
Board Certified: Family Medicine

Edwin Alberto Mercedes, MD
LPG Hospitalist Group
2776 Cleveland Ave., Ste 808
Fort Myers, FL 33901
Tel: 239-343-2052 Fax: 239-343-3164.
Board Certified: Internal Medicine

Melissa Bacchus, MD
Physicians' Primary Care of
Southwest Florida
1261 Viscaya Parkway, #101
Cape Coral, FL 33990
Tel: 239-573-7337 Fax: 239-574-5883
Board Certified: Pediatrics.

Ernesto Badui, MD
LPG Hospitalist Group
13681 Doctor's Way, Ste 19021
Fort Myers, FL 33912
Tel: 239-343-2052 Fax: 239-343-1009
Board Certified: Internal Medicine

Tameca Bakker, MD
LPG Hospitalist Group
9981 S. Health Park Dr., Ste 159
Fort Myers, FL 33908
Tel: 239-343-2052 Fax: 239-343-5348
Board eligible

Leah Boyette, MD
LPG Emergency Physicians
2776 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-2606 Fax: 239-343-3695
Board Certified: Emergency Medicine

New Members *(cont'd)*

James Breen, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Suzanne Bryce, MD
Lee Health Emergency Medicine
9981 HealthPark Drive
Fort Myers, FL 33908
Tel: 239-343-2606 Fax: 239-343-3695
Board Certified: Emergency Medicine

Jennifer Carrion, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Elie Checo Heinsen, MD
LPG Hospitalist Group
9981 S. HealthPark Dr., #159
Fort Myers,FL 33908
Tel: 239-343-2052 Fax: 239-343-5348
Board Certified: Internal Medicine

Sarah Churton, MD
The Woodruff Institute
23471 Walden Center Dr., Ste 300
Bonita Springs, FL 34134
Tel: 239- 498-3376 Fax: 239-498-3379
Board Certified: Dermatology

Leopoldo Duluc Vega, MD
LPG Hospitalist Group
2776 Cleveland Ave., Ste 808
Fort Myers, FL 33901
Tel: 239-343-2052 Fax: 239-343-3164
Board Certified: Internal Medicine

Angela Echeverria, MD
Gulf Coast Vascular Surgeons
8010 Summerlin Lakes Drive, Suite 100
Fort Myers, FL 33907
Tel: 239-939-1767 Fax: 239-939-5895
Board Certified: Surgery

Arieal Felix, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

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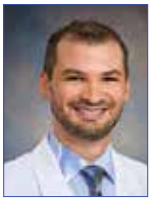
2017 New Members

David Greschler, MD
Pain Management Consultants of SWFL
23 Barkley Circle
Fort Myers, FL 33907
Tel: 239-333-1177 Fax: 239-333-1169
Board Certified: Anesthesiology

Stephen Jones, DO
Collins Vision
6900 International Center Blvd.
Fort Myers, FL 33912
Tel: 239-936-476 Fax: 239-225-6775
Board Certified: Ophthalmology



Emmanuel Kai-Lewis, MD
Quigley Eye Specialists
6091 South Pointe Blvd.
Fort Myers, FL 33919
Tel: 239-466-2020 Fax: 239-466-7150.
Board Certified: Ophthalmology

Shayna Klein, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Daniela Kloos, MD
LPG Hospitalist Group
9981 S. HealthPark Dr., #159
Fort Myers, FL 33908
Tel: 239-343-2052 Fax: 239-343-5348
Board Certified: Internal Medicine

Robert Kopp, MD
ENT Specialists of FL
39 Barkley Circle
Fort Myers, FL 33907
Tel: 239-936-0939 Fax: 239-936-0837
Board Certified: Otolaryngology

Murilo Lima, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Andrea Lloreda Forero, MD
Golisano Children's Hospital Pediatric
Hospitalists
9981 S. Health Park Dr.
Fort Myers, FL 33908
Tel: 239-343-5052 Fax: 239-343-5652

Mina Masry, MD
LPG Hospitalist Group
13681 Doctor's Way, #19021
Fort Myers FL 33912
Tel: 239-343-2052 Fax:239-343-1009
Board Certified: Internal Medicine

Hazem Matta, DO
Radiology Regional Center
3660 Broadway, Fort Myers, FL 33901
Tel: 239-936-2316 Fax: 239-425-4798
Board Certified: Radiology

Danielle Matta, DO
Radiology Regional Center
3660 Broadway, Fort Myers, FL 33901
Tel: 239-936-2316 Fax: 239-425-4798
Board Certified: Radiology

Thomas Moran, DO
LPG Hospitalist Group, 9981 S.
HealthPark Dr., Ste 159
Fort Myers, FL 33908
Tel: 239-343-2052 Fax: 239-343-5348
Board Certified: Internal Medicine

Monica Necula, MD
LPG Hospitalist Group, 2776
Cleveland Ave. #808
Fort Myers, FL 33901
Tel: 239-343-2052
Fax: 239-343-3164
Board Certified: Internal Medicine

John Neiner, MD
ENT Specialists of FL
39 Barkley Circle
Fort Myers, FL 33907
Tel: 239-936-0939 Fax: 239-936-0837
Board Certified: Otolaryngology

Christine Norton, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Kristen Noud, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

2017 New Members

Nicholas Perez, MD
Korunda Pain Management
14131 Metropolis Ave., #103
Fort Myers, FL 33912
Tel: 239-591-2803 Fax: 239-594-5637
Board Certified: pending

Guillermo Philipps, MD
Golisano Children's Hospital
15901 Bass Rd.# 108
Fort Myers, FL 33908
Tel: 239-343-6050 Fax: 239-343-6051
Board Certified: Psychiatry and Neurology

Nika Priest Allen, MD
Quigley Eye Specialists
6091 South Pointe Blvd.
Fort Myers, FL 33919
Tel: 239-466-2020 Fax: 239-466-7150
Board eligible

Krishna Raju, MD
Pulmonary, Critical Care & Sleep Medicine
7335 Gladiolus Drive
Fort Myers, FL 33908
Tel: 239-985-1925 Fax: 239-321-6044
Board Certified: Internal Medicine
Pulmonary Disease

Jaime Realsen Hall, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Hannah Schrubbe, MD
FSU College of Medicine Family Medicine
Residency Program at Lee Health
2780 Cleveland Ave.
Fort Myers, FL 33901
Tel: 239-343-3831 Fax: 239-343-2392

Maudeen Scott, MD
LPG Hospitalist Group
2776 Cleveland Ave., Ste 808
Fort Myers, FL 33901
Tel: 239-343-2052 Fax: 239-343-1009
Board Certified: Internal Medicine

Mohammad Sheikh, MD
LPG Hospitalist Group
13681 Doctor's Way, Ste 19021
Fort Myers,FL 33912
Tel: 239-343-2052 Fax: 230-343-1009
Board Certified: Internal Medicine

Kelly Sawczyn, MD
LPG Pediatric Oncology
9981 S. HealthPark Dr., 5th Floor
Fort Myers, FL 33908
Tel: 239-343-5333 Fax: 239-343-5321
Board Certified: General Pediatrics and
Pediatric Hematology/Oncology

Stephanie Slagle, MD
Golisano Pediatric Hospitalists
9981 S. Health Park Drive
Fort Myers, FL 33908
Tel: 239-343-5052

Gesner Torchon, MD
LPG Hospitalist Group
2776 Cleveland Ave., Ste 808
Fort Myers,FL 33901
Tel: 239-343-2052 Fax: 239-343-3164
Board Certified: Internal Medicine

Alfredo Vargas, MD
Golisano Children's Hospital
Pediatric ER Medicine
9981 S. Health Park Dr.
Fort Myers, FL 33908
Tel: 239-343-5052, Fax: 239-343-5653
Board Certified: Pediatrics

Jean-Jacque Vel, DO
LPG Hospitalist Group
9981 S. Health Park Dr., Ste 159
Fort Myers, FL 33908
Tel: 239-343-2052 Fax: 239-343-5348
Board eligible

Michael Worobel, DO
Pain Medicine Group
13782 Plantation Rd., Suite 101
Fort Myers, FL 33912
Tel: 239-277-7611 Fax: 239-277-7608
Board Certified: Physical Medicine and
Rehab

Membership News

Relocation
David Gutstein, MD
Millennium Physician Group
15740 New Hampshire Court, Ste B
Fort Myers, FL 33908
Tel: 239-466-8838 Fax: 239-466-7669

Retired
Richard H. Davis, MD - Cardiologist

President's Message
By Jon Burdzy, D.O.

Valediction

During the past year I have come to know many of you I didn't know before; physicians employed by LeeHealth, 21 C., Radiology Regional, many smaller groups, and even some of the few remaining solo practitioners. We are a pretty amazing bunch! Regardless of who employs us, regardless of our specialty, religion, political affiliation, or any other equally important individual attribute, collectively we are physicians. And we need to hang together.

Our vocation is intrinsic to the world. We are healers, we are an incredibly well-trained cadre dedicated to promoting and preserving health. We diagnose, we treat, we cure, advise, console, advocate, hold hands, shed tears, teach, reassure, exhibit confidence and hide doubts that shatter our self worth. We are complex people practicing a complex art serving complex patients during complex times.

In my columns, I have tried to avoid being 'the whining doctor'. We all know how difficult it is to maintain a high level of expertise in our craft and are well aware of the barriers thrust before us by our boards, our patients, our government, and the various payers with whom we must dance. Adding to this chorus would be redundant. Instead, I tried to explore ways to improve our wellness and consider our human side as practitioners.

As president of our society, my goal has been to improve the relationships we have with each other and to grow new ones amongst us. Relationships are the basis of our art. Doctor to doctor relationships are nearly as important as the sacred doctor/patient relationship. Better rapport between treating physicians leads to better patient care, our prime objective.

We also need to care for our colleagues. When one of us is drowning there needs to be a helping hand. Our Physician Wellness Program (PWP) is one such lifesaver. So far nine of our colleagues have utilized this service and sought counseling. It is immensely gratifying to see such early wins. I wish I could take credit for having thought up the PWP, but that credit belongs to my predecessor Dr. Shari Skinner. She deserves our collective gratitude for her efforts in creating and building this noble program.

Caring for our profession is more of a challenge. Political action is the critical change agent in undoing the deleterious changes ravaging our profession. Active participation in the Florida Medical Association is vitally important. Many of us are concerned with the direction our state organization is heading. Physician advocacy seems to have taken a back seat to political accommodation. The last legislative session saw only defensive wins such as protecting our scope practice from paraprofessionals. No pro-physician legislation, even an innocuous bill such as the one allowing Direct Primary Care to become a viable care delivery model, was passed. To change this we must become even more involved.

As we all know, money talks. Supporting the FMA-PAC makes our voices louder in the ears of our lawmakers. FMA has a loud voice, far more powerful than those of the newer, smaller organizations that have arisen in response to FMA's legislative failures. We need to work on changing our medical associations and profession from within. If we fail to hang together, one by one we will be hung alone. This applies equally to our individual physician groups, our county, our state, and our nation.

If we do not hang together, we shall surely hang separately.

— commonly attributed to Benjamin Franklin

Physician unity is the key to reform. As an Osteopathic Physician I am grateful to see graduate medical education becoming unified under a single accreditation system. This will help ameliorate our growing physician shortage. By uniting, internists successfully rolled back some of the ABIM's onerous requirements for maintaining board certification. This will allow them to devote more time and energy to caring for their patients and themselves. These are small examples of how physician centered cooperation can be applied to larger problems. Imagine what we could accomplish were physicians to unify on a larger scale.

Finally, I would like to thank all of you for allowing me to serve as President of the Lee County Medical Society this past year. I must also thank my wonderful and ever supportive wife Gwen and our children Nathanael and Hannah for tolerating my many nights away from home at meetings and events, as well as the time away from them spent writing these columns, taking phone calls, and answering emails related to the LCMS. Thanks also to Julie, Val, and Chris, our very talented office staff. Last but not least, my thanks go out to the other officers and board members of the LCMS for their hard work and support. Dr. Rick Palmon will be taking over the reins in January and will provide great leadership as President.

Be well and God Bless !

Jon

Why Burned Out Physicians Often Don't Seek Help

By Avery Hurt, Physician Practice Work/Life Balance

It has long been known that physicians are at high risk of depression and suicide, and the problem is not getting better. A study published this July in Academic Medicine found that suicide was the second leading cause of death among resident physicians from 2000-2014 (the first in males). And it's clear that burnout can contribute to the problem, experts say. When Michael Myers, MD, was researching his book Why Physicians Die by Suicide: Lessons Learned by Families and Others Who Cared, he interviewed surviving family members of physicians who had killed themselves. "What they described was straightforward burnout," says Myers, professor of clinical psychiatry at SUNY-Downstate Medical Center in Brooklyn, NY, and specialist in physician health.

Real Risks

Despite the high risk, physicians are far less likely than those in other professions to seek help for emotional problems. "Physicians are programmed to think of themselves as being able to handle stress," says Clifton Knight, MD, senior vice president for education at the American Academy of Family Physicians (AAFP). "There is a kind of guilt and shame associated with it—'if I'm suffering from stress, I am weak and a bad physician,' the thinking goes." That attitude makes reaching out for help nigh impossible. It also compounds the suffering. Not only are you depressed, the very fact that you are depressed brands you as a loser.

Physicians, however, have a much more practical reason for keeping secret the same emotional problems they encourage their patients to seek help for. They are understandably concerned that having a record of mental illness could cause them to lose their licenses. In a recent study of 94.1 percent of medical licensure board applications, only one-third of states had questions that were congruent with policies of the American Medical Association, American Psychological Association, and the Federation of State Medical Boards, nor were they in compliance with the Americans with Disabilities Act. "The Federation of State Medical Boards is very concerned about this," says Myers. Despite the presence of mental health questions, the danger may not be as great as many physicians think. "It is very, very rare that a renewal is refused as long as you're being treated," says Myers.

A Safe Space

There are places to seek help where those in charge are aware of the special concerns of physicians. "The state medical association in each state has a physician wellness program," says Knight. While it may vary from state to state, most of these programs offer confidential self-reporting. In Dr. Knight's home state of Indiana, for example, as long as you have an evaluation and stay in a treatment program, you will not be reported to the licensing board. The AAFP also has a variety of wellness resources for family physicians.

The risks to yourself and to your patients is too great to ignore this problem. If your burnout has reached the point where you are suffering from depression, it's time to get help. And there are safe ways to do so

Lee County Medical Society 2018 Board of Governors

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Secretary: Annette St. Pierre MacKaoul, MD
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Ryan Lundquist, MD (2019)
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Richard Macchiaroli, MD, Chair

We wish to thank the physicians who will be leaving our Board and who gave their time and decision making for the Medical Society. From the Board: Shari Skinner, MD Past-President; Alejandro Miranda-Sous,a, MD, Member-at-Large; Chelsey Scheiner, DO, Ex-Officio Member

Pallister-Killian Syndrome Awareness Day

By Peter Yung, MD and Edythe Park, MD.

Everyone wants everything to be perfect when they are expecting their first child. You register for all the cute baby things, read up on all the parenting books, and create a Pinterest perfect nursery. The last place you want to be is in a doctor's office being told that after your level III ultrasound, they are not sure what is wrong with your child, but that they are not going to be normal. That is where we found ourselves 7 years ago. We got a phone call about 1 week after our daughter was born that she has Pallister-Killian Syndrome. As both of us are physicians, we were asked if we had ever heard of it, which we had not. Our initial instinct was to research everything there was to know about the condition but there was not much useful clinical information available. We were told that she was one of only 300 known cases in the world with this diagnosis. We were fortunate that our geneticist actually knew of another patient who had it and was able to connect us to other families affected by this syndrome.

Pallister-Killian Syndrome (PKS) is an extremely rare genetic disorder caused by the presence of isochromosome 12p, which is a version of chromosome 12 made up of two p arms. It is present in a tissue limited mosaic state, in that some cells have the usual two copies of chromosome 12, while other cells have the isochromosome 12p. These cells thus have a total of 4 copies of chromosome 12p, which is why we recognize December 4th (12/4) as PKS Awareness Day.

Most infants with PKS are born with significant hypotonia, which can cause difficulty breathing, feeding, and the normal development of motor skills such as sitting, standing, and walking. About 30 percent of affected individuals are ultimately able to walk without assistance. Additional developmental delays result from intellectual disability, which can vary from mild to profound. Speech is often limited or absent in people with this condition. PKS is also characterized by distinctive facial features, hearing loss, temporal alopecia, pigmentary skin differences, vision impairment, seizures and may also include other birth defects such as congenital heart defects, skeletal abnormalities and diaphragmatic hernias. The most severe cases involve birth defects that are life-threatening in early infancy.

PKS is diagnosed by a physical examination and genetic testing. If this syndrome is suspected, diagnosis can sometimes be made via amniocentesis, microarray at birth, or skin biopsy in older children but even then there are a large number of false negatives. Thus it is very important to pursue further or repeat testing if a clinical diagnosis of PKS is suspected.

We are hoping to raise awareness of PKS to aid in early diagnosis, which is key in helping children succeed as much as possible through early aggressive therapies, getting appropriate medical screening for associated anomalies, as well as connecting affected families for support. There are an estimated 300 cases worldwide but some researchers believe that could be as high as 2000 in the United States alone. We aim to educate our community of medical professionals to consider this diagnosis and pursue further testing if necessary. We also hope to raise funds to support the ongoing research for a cure. Currently, research is being conducted at the Children's Hospital of Philadelphia to eradicate or suppress the isochromosome responsible for this syndrome. Additional information can be obtained through the national nonprofit support group PKS KIDS at www.pkskids.net.

pkskids™
Education, Awareness, Support

To: Lee County Medical Society

I wasn't sure how best to reach the contributors to September's Bulletin.
Please see that they receive this.

This is the best issue of the Bulletin that I can remember in my 31 years in Lee County. Dr. Sayet, thank you for your leadership as editor. I am so proud of my colleagues! Thank you, all, for your time and caring and science. I feel grateful to have been able to practice pediatrics along side many of you.
Medicine has a bright future.

Eleanor "Gennl" Blitzer, MD
Empire, Michigan

Need help with life's difficulties?

Please visit our website at:
www.lcmsfl.org/pwp

Thank you to our Friends in Medicine

LCMS friends in Medicine program is open to area businesses that can offer member only benefits and discounts. We encourage our members to patronize these businesses that have been selected by the LMMS for their outstanding services and products.

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Tele-Health Standard of Care in Florida

By Isabel D. Barroso, Esq.

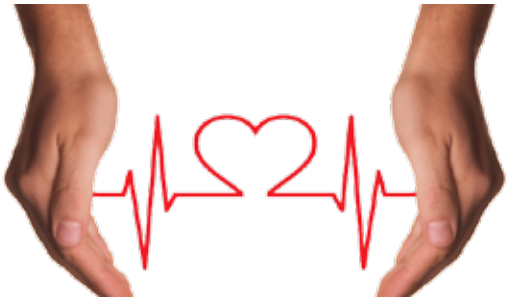
Throughout the United States, including Florida, there is an increasing shortage of health care providers to serve a growing and aging population. According to a 2016 report by the Florida Tele-health Advisory Council, the number of areas with a significant decrease of physicians and other health care providers grew to more than 623 in December 2016. In fact, the Florida Department of Health estimates that throughout Florida there will be a need for more than 3,000 primary care physicians the next ten years. For that reason, the use and adoption of tele-health technology is seen as a novel approach to address these growing workforce deficiencies.

Tele-health is not a type of healthcare but rather a "means or method used to deliver health care." Tele-health services enable real-time communication between patients and healthcare providers through video-conferencing. Tele-health also facilitates the storage and forwarding of clinical information to offsite locations for evaluation by specialists.

Tele-health can also involve remote monitoring of a patient's chronic condition with sensors or monitoring equipment.

Tele-health can also involve remote monitoring of a patient's chronic condition with sensors or monitoring equipment. The technology is now so advanced that there are wearable devices (mobile health) that can detect patient information, such as EKG readings and blood sugar levels in diabetic patients.

Tele-health is the "mode of delivery" and nothing more. The standard of care for providing health services should not change, notwithstanding how those services are provided. In its report, the Council recommended that the standard of care, as set forth in Florida Statute 766.102, must be adhered to, and suggested that, if necessary, regulatory boards could be given the authority to develop tele-health specific standards. Otherwise, the standard of care for tele-health would be the same as the standard of care for in-person services. Therefore, Florida practitioners will need to understand and comply with established standards of care whether treating patients in-person or through tele-health.



Five Best Practices to Meet MACRA Requirements by the End of the Year

By Kim Hathaway, MSN, CPHRM, The Dotors Company

As the end of the third quarter of 2017 approaches, practices that have not yet developed their Medicare Access and CHIP Reauthorization Act (MACRA) plan face great urgency to complete their plan—and those who have started may be feeling overwhelmed. Regardless of the reporting stage, these steps can help guide practices to succeed:

1. Review past performance in quality measures such as the Physician Quality Reporting System (PQRS) or specialty measures that your practice has reported. These are strong indicators of how your practice will do in the future. Align activities and quality measures with what you are already doing in your practice and determine how to make capturing the needed data part of your team's workflow. Educate and engage the entire workforce about what you are trying to accomplish and why. Ask for input from the frontline of your practice about the most efficient ways to collect the necessary data elements. Even if you participated in PQRS in the past, there are differences that will require a team effort to be successful. Don't try to do it alone. Consider making quality measurement part of the annual review for employees.

Don't try to do it alone. Consider making quality measurement part of the annual review for employees.

2. Study the specifications for measures you are reporting to better understand its value. For claims or registry reporting, go to Quality Payment Program website and choose the appropriate file under "Documents and Downloads." If you are reporting through your electronic health record (EHR), the vendor can be very helpful in choosing your measures. In fact, not all EHRs will report all measures and there are some that collect data but don't report to the Centers for Medicare and Medicaid Services (CMS). Clarify with the EHR vendor when and how the documentation is captured and counted toward the measure. The same applies to the various registries. Be sure to do your homework and know about pricing and any requirements related to system compatibility.

3. Monitor your data on a weekly or bi-weekly basis. Compare the reports that you run in your office to those generated by your EHR or registry. Investigate any discrepancy so that it can be corrected now by coaching the team on documentation or timeliness of reporting. Don't wait until the end of the reporting period to look at your performance data. There may not be time nor the ability to correct it later.

4. Understand that the scoring process for the quality measures is very different than it was in PQRS. Under PQRS, if you reported the measure enough times, you received credit. And if you reported on one patient, you would get a pass.

Under the PQRS scoring process (based on 100 patients):

- Provider 1: 95 patients' performance met, 5 patients' performance not met = PASS

- Provider 2: 5 patients' performance met, 95 patients' performance not met = PASS

- Under the quality measure, your rate will determine your score (based on 100 patients):

- Provider 1: 95 patients' performance met, 5 patients' performance not met = PASS

- Provider 2: 5 patients' performance met, 95 patients' performance not met = PASS

Under the quality measure, your rate will determine your score (based on 100 patients):

- Provider 1: 95 patients' performance measure met, 5 patients' performance not met = 95% Performance Rate

- Provider 2: 5 patients' performance met, 95 patients' performance not met = 5% Performance Rate

On top of the change in how much you report versus the performance rate, the scores will be determined based on national benchmarks, with the highest performing deciles receiving a greater point value.

5. Review the Quality Resource Utilization Report (QRUR) to fully understand how the practice performs in quality and cost. Use the 2015 or 2016 QRUR (publishing fall 2017) to identify potential weaknesses and address them before cost returns as a scored category in 2019—because cost will carry a weight of 30 percent toward the MIPS composite score. This is a complex report that requires familiarity to truly understand its content. The biannual report outlines the quality and cost data from PQRS and compares it to a national benchmark. Costs are determined by claims data. There are no reporting requirements for the cost category in 2017. CMS will provide feedback on cost for the 2017 performance period, but it will not be counted in the final composite score for 2017 or 2018.

Groups and solo practitioners may access their QRUR through the CMS Enterprise Portal. The person who accesses this report for the group will need to create a login at CMS' Enterprise Identity Management (EIDM) system. This is a very secure site. It contains questions to verify and confirm the identity of the person registering, as well as information about specific providers in the group. Security is very strict around these reports because they include patient health information so that groups may identify which patients may be attributed to them. For help with interpreting the information on your QRUR, consult the CMS website regarding QRUR analysis and payment. You will find additional resources and links to the EIDM System and what to do if you believe your QRUR is not accurate.

By Kim Hathaway, MSN, CPHRM, Healthcare Quality and Risk Consultant, The Doctors Company

Doctors Examine Injury Risks with Malpractice Closed Claims

By Robin Diamond, The Doctors Company

Physicians are always seeking ways to enhance patient safety. Taking a close look at research into real-life malpractice claims and incorporating some of the findings into their practices is one way physicians are reducing risks of adverse events. Studies provided by The Doctors Company provide insight into thousands of closed claims and shine a light on preventive actions. The following are examples of doctors who learned from these malpractice closed claims studies and, as a result, took patient safety in their practices and hospitals to the next level.

Cardiology

• Doctor spotlight: Sandeep S. Mangalmurti, MD, JD, cardiologist at the Bassett Healthcare Network in Cooperstown, New York.

• Risk trend: The Cardiology Closed Claims Study outlines liability pitfalls of improper medication management. Cardiovascular medications have inherent risks even when used correctly.

• Solution: This risk led Dr. Mangalmurti to change his daily practice when managing certain high-risk medications such as anticoagulants. "Coumadin, in particular, is associated with high-liability risk because of the risk of bleeding and its narrow therapeutic window," said Dr. Mangalmurti. To avoid medication mishaps or breakdowns in communication, he makes a point to be very clear about whether the general practitioner or cardiologist will manage the anticoagulant medication.

> *"Diagnosis in medicine is often challenging."*

Emergency Medicine

• Doctor spotlight: Roneet Lev, MD, FACEP, chief of the emergency medicine department at Scripps Mercy Hospital in San Diego, California.

• Risk trend: The Emergency Medicine Closed Claims Study identified the need for rapid recognition of stroke patients and treatment for tissue plasminogen activator (tPA).

• Solution: Across the entire hospital system, Scripps Mercy Hospital now initiates its emergency protocol for potential strokes when the call is placed to 911. The patient is taken straight to the CT scan without stopping at an emergency department bed. This expedites patient care as they activate the stroke team.

Hospital Medicine

• Doctor spotlight: John D. Nelson, MD, internal medicine hospitalist at Overlake Medical Center in Bellevue, Washington.

• Risk trend: The Hospitalist Closed Claims Study reveals spinal epidural abscess—a disease relatively uncommon in the general population—is appearing in medical malpractice claims more frequently. A diagnosis-related error involving spinal epidural abscess can lead to dire consequences, including paralysis.

• Solution: "This study should serve as a strong reminder for hospitalists of the importance of maintaining a very high index of suspicion for spinal epidural abscess," said Dr. Nelson. Problems with back pain, leukocytosis, and fever are red flags, but Dr. Nelson states the literature isn't so simple. These symptoms alone do not equate with epidural abscess. It requires a great deal of judgment to decide which cases are deemed appropriate for this diagnosis. "If you think a patient could have it, and it's worth pursuing, you should pursue it now rather than later. So, for example, get an MRI tonight rather than tomorrow."

Internal Medicine

• Doctor spotlight: Howard Marcus, MD, internal medicine physician in Austin, Texas.

• Risk trend: The Internal Medicine Closed Claims Study found that 39 percent of claims resulted from a diagnosis-related allegation (failure, delay, or wrong).

• Solution: Dr. Marcus has conducted small group discussions with physicians in his multispecialty medical group of over 300 doctors to improve understanding of the underlying methodological reasons leading to cognitive error. "Diagnosis in medicine is often challenging. There are more than 8,000 diagnostic entities listed by the National Library of Medicine and every patient is unique. It is helpful to understand the effect that psychological biases such as 'overconfidence bias' or 'anchoring bias' may play in medical decision making," said Dr. Marcus.

Obstetrics

• Doctor spotlight: Marcus Tower, MD, obstetrician at the Cleveland Clinic's Hillcrest Hospital, Cleveland, Ohio.

• Risk trend: The most common patient allegation identified in the Obstetrics Closed Claims Study is delay in treatment of fetal distress—specifically, failure to act

when presented with Category II or Category III fetal heart rate tracings.

• Solution: Upon learning of this trend, Hillcrest Hospital now offers physician and nurse classes, providing the opportunity to learn how to identify heart rate tracings in a wide spectrum of scenarios. "From [the classes] we had a standardization process. Everyone became a patient advocate. Everyone focused their attention on, for that moment, identifying something that could be ominous so that we could act in a very timely manner," said Dr. Tower. that we could act in a very timely manner," said Dr. Tower.

Orthopedics

• Doctor spotlight: Ralph A. Gambardella, MD, orthopedic surgery and sports medicine specialist with the Kerlan-Jobe Orthopaedic Clinic in Los Angeles, California.

• Risk trend: The Orthopedics Closed Claims Study reveals patient factors contributed to injuries in 29 percent of claims. It found that patient nonadherence was more likely when there was inadequate communication between the patient or family members and the physician. The study also notes that determining whether a patient is an appropriate candidate for a procedure is an important part of providing good care.

• Solution: With communication being a prominent pitfall, the practice identified two areas where it could influence behavioral change:

1. Incorporating a smartphone application to improve doctor-patient communication.

2. Having the patient work directly with a financial advisor in-office and at the hospital to better understand financial responsibilities.

The hospital also adopted a preoperative screening assessment to identify comorbidities, thereby improving the surgery selection process and lowering risk.

Plastic Surgery

• Doctor spotlight: Phillip Haeck, MD, a plastic surgeon at The Polyclinic in Seattle, Washington.

• Risk trend: The Plastic Surgery Closed Claims Study notes that 10 percent of claims against plastic surgeons involved miscommunication between the patient or family members and the doctor.

• Solution: Dr. Haeck presented the study to his six partners and 35 staff members where they reviewed communication practices. As a result, the practice administered changes to communication protocols among physicians, staff, and patients. It now has clear guidelines to identify each communication, when it took place, and what resulted. All communications—including social media exchanges between patient and staff—are now entered into the EHR to alert the surgeon of new communication.

By leveraging technology, implementing new protocols, and being better equipped to address scenarios that could negatively impact patient safety, these practices and hospitals are taking steps in advancing patient care. Further insights from doctors who are learning from malpractice claims are available in The Doctors Company's Innovations in Patient Safety video playlist.

Contributed by The Doctors Company (thedoctors.com)

Join us for the 1st annual Wellness 5k Run / Walk

Register Today for the LCMSF Wellness 5k and 2k Fun/Run Walk hosted by the Lee County Medical Society Foundation.
The race will be held at Lakes Regional Park on Saturday, FEBRUARY 3, 2018
Registration begins at 7:30 a.m.
5k at 8:45 a.m.
Walk at 9:00 a.m.

Early Bird discount ends Sept. 1st

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"Go Hold your fiancé - she needs you right now". Attending a national conference on global health this fall, the memories of my times serving as a missionary abroad came flooding back. I still remember those words although its been almost 10 years now. My wife and I were in the Philippines as missionaries who were also getting trained by the World Health Organization in Integrated Management of Childhood Illness. The organization we partnered with specialized in reaching out to the tribal communities on the Philippine territory of Mindoro Island. The tribal people group we served, the Munyan people, lived in a pre-industrial mountain village, separated from many of the public health infrastructures we have come to expect in the western world. Their homes were about 10x10 feet structures and were constructed out of bamboo and patchwork, elevated on stilts. Underneath each home, there was a sty where pigs and other assorted domesticated animals would find some shade from the intense Philippine sun. There was no running water. No electricity. No stoves. Chickens ran around everywhere, and village children approached us with widened eyes and dilated pupils in shock to see outsiders had come that far up the mountain.

Indeed, it had been generally prohibited for outsiders to come that far, but because of the special friendship developed over years with our nonprofit organization's leader, an exception was made for our group. When we approached the village, I was thrust into a different world. Not yet having attended medical school at that point in my life, I didn't know how to describe the pathologies I saw. Now looking back, I believe I saw mucocutaneous leishmaniasis, a host of other parasitic infections, dysentery, diffuse fungal skin infections, marasmus and kwashiorkor… the list goes on. I could tell so many stories from that time and many of the things I saw haunt me and motivate me to this day. But nothing prepared me to see my strong, mature, tough, and resilient fiancé so utterly broken.

While I was working long-distance on completing a research project for Duke University in an internet cafe, I briefly was separated from my then fiancé and her mother while they visited a local clinic. That day, the clinic was treating a small infant, with marked malnutrition.The local translator explained to us that sometimes when the mother died (obstetric and maternal mortality rates were very high in the Philippines at that time), the village men would attempt to feed the child on rice water since breastmilk was no longer available. If that didn'twork, sometimes the children were left in the jungle. It's been so long I don't remember the circumstances that lead to the child's ailment, if it was abandoned or simply malnourished due to inadequate breast milk. Either way, it was at the brink of death.

Every effort was made to save its life. My fiancé and her mother did everything they could to support the clinic to have any resources it might need to save the little one's life, but ultimately those efforts proved futile and the child perished. It devastated my fiancé, Elizabeth, who is now a physician at the FSU Family Medicine Residency program here in Lee County. I held her and tried to comfort her but nothing I could say or do could mitigate the emotional impact of what we had witnessed - the health disparities, the desperation, the pain. We had witnessed so much good that had been done – even helping to intervene in a dysentery outbreak that had just started - but the seemingly senseless loss of even one precious child in such a manner shattered our sheltered American worldview and exposed us to the daily realities that still pervade so much of the world today. That pain fueled us to apply to medical school and start this journey of medical practice.

We have sacrificed a great deal of our lives training to have the skills necessary to provide care.

Just last week at this national health conference, I sat a few feet away from a more seasoned missionary who worked with doctors and nurses in the Horn of Africa during the 1990s. My brief time with him showed me that what we had experienced in the Philippines was just the tip of the iceberg and that the desperation and need for physicians is greater now than ever before. He bared his soul and with tears barely held back he described the enormous need for physicians, for public health infrastructure, and for people willing to leave their comfort zones to serve those who have no hope. He described burying up to 20 children a day. Praying that God would send doctors. Doing his best with his small team to providing medicine in scenarios where doing so constantly put his life in danger. And yet his small team fed approximately 50,000 people a day, saving innumerable lives from the agonizing yet certain death of famine and starvation. As a keynote speaker in front of thousands of health workers from around the nation and from nations all over the world, he petitioned us with an impassioned cry "The need is great, but the laborers are few. Will you fight for those who cannot fight for themselves?"

That call, that petition, that desperate plea is at the very heart of medicine. We have sacrificed a great deal of our lives training to have the skills necessary to provide care. And while certainly most of us will practice in the United States for the majority of our careers, I believe there are seasons (some long seasons and some short seasons) where we will feel the inner unction to answer the call to reach those who have not been reached. To serve those who have not been served. To go outside of our comfort zones and even outside of what makes logical sense from a personal perspective to accomplish a greater good. When we answer the call to serve in situations so desperate that hope seems like insanity; when we go to the hurting and infirm even in the face of situations wrought with such despair that we can hardly bear it; then, I believe, we will not only find an opportunity to bring healing to communities but also to our profession and to ourselves. I think we will find a revival of our idealism and our anthem of practice of medicine as the noblest of pursuits. We will once again fortify the medicine as one of the last bastions and defenders of human dignity and compassion for our fellow man. And we will find the strength to fan the flames of our altruism to a global scale. There is a whole world calling for help. Will we be the ones to answer?

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