LEE COUNTY MEDICAL SOCIETY INC.

Bulletin

Physicians Caring for our Community

Editor: John W. Snead, M.D.

Volume 38 Issue 8

October 2014

2014 Meetings & Events

General Membership Meeting
November 13, 2014
6:30 p.m.- Social
7:00 p.m. - Dinner/Meeting
Cypress Lake Country Club
6767 Winkler Road
Fort Myers, FL 33913

PROFESSIONAL RESOURCE NETWORK (PRN) DISCUSSION
Speakers:
Penelope P. Ziegler MD,
Medical Director
$25 per attendee RSVP Required

SAVE THE DATE
DECEMBER 8, 2014
7:00 p.m. – 11:00 p.m.
LCMS / ALLIANCE
ANNUAL HOLIDAY PARTY

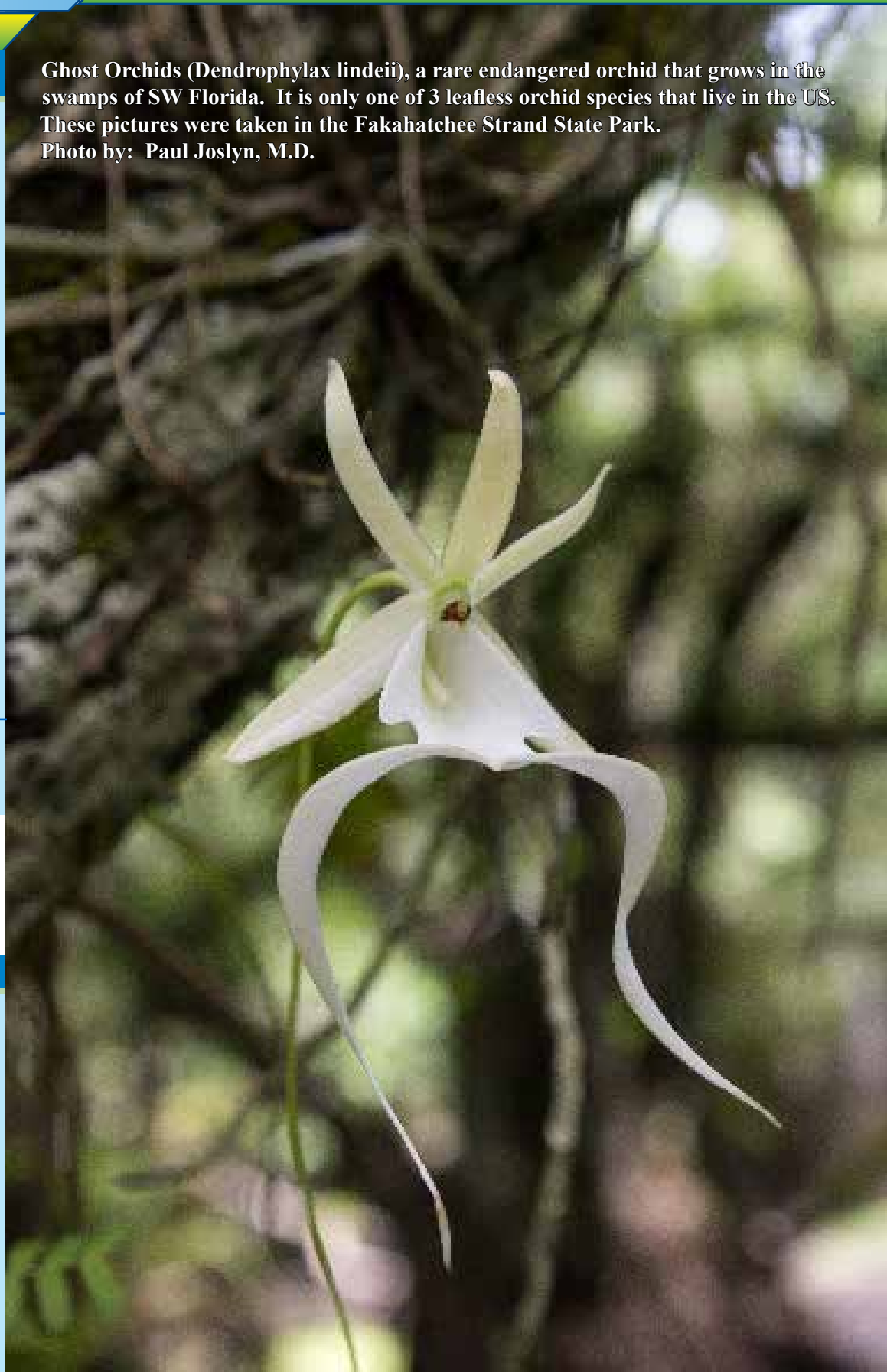
Gulf Harbour Yacht & Country Club
14500 Vistea River Dr.
Fort Myers, FL 33908

Sponsored by:
FineMark National Bank & Trust
The Doctors Company
$65 per attendee RSVP Required

RSVP to: Lee County Medical Society
13770 Plantation Road, Ste 1
Fort Myers, FL 33912
Tel: 936-1645 • Fax: 936-0533
Email: Valerie@lcmsfl.org

Inserts:
Vote No on 2
Medical Marijuana Issue in Florida
CME's Go Through CE Brokers
Survey on Physician Wellness

Inside This Issue:



Ghost Orchids (Dendrophylax lindeii), a rare endangered orchid that grows in the swamps of SW Florida. It is only one of 3 leafless orchid species that live in the US. These pictures were taken in the Fakahatchee Strand State Park.
Photo by: Paul Joslyn, M.D.

LEE COUNTY MEDICAL SOCIETY BULLETIN

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

The editors welcome contributions from members. Opinions expressed in the Bulletin are those of the individual authors and do not necessarily reflect policies of the Society. Advertisements do not represent sponsorship or endorsement by the Lee County Medical Society nor necessarily implies the accuracy or reliability of any advertisement displayed in this publication.

PRINTERS
The Print Shop

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 enforcement 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 meeting minutes are available for all members to review.

Membership News

New Members

Coghill, David Lee, MD
Edelstein, Travis H., DO
Harmon, Daniel J., DO
Klossner, Roy Taylor, MD
Kovach, Bradley T., MD
Midney-Martinez, Elizabeth, MD
Miller, Kristin R., MD
Nyberg, Carl, MD
Oldham, Robert K., MD
Prabakaran, Rajeev, MD
Roden, Robin L., MD
Robin, Jeffrey B., MD
Sadat, Mohammad Ayaz, MD
Sanchious, Alyson Lewis, MD
Santucci, Raymond, MD
Schneiner, Chelsey, Swaiko, MD
Teet, James John, DO
Tibbetts, Michael D., MD
Toldi, James, DO
Zack, Lisa D., MD
Zughbi, Cindy, MD

Reactivated

Wendy Bond, MD
Orthopedic Center of Florida
12670 Creekside Lane
Fort Myers, FL 33919
Tel: 239-482-2663 Fax: 239-482-7585

Relocated

Lynne Einbinder, MD
LPG (Associates in Cardiac Care)
8960 Colonial Center Drive, Ste 302
Fort Myers, FL 33905
Tel: 239-343-9700 Fax: 239-349-699

New Applicants

Jeffrey B. Robin, MD – Dr. Robin received his MD degree from Jefferson Medical College, Philadelphia, PA in 1978. He completed an internship at Harbor-UCLA Medical Center, Torrance, CA from 1978-1979. a residency at Georgetown University Medical Center, Washington, DC from 1979-1982 and a Cornea and External Disease Service fellowship at Estelle Doheny Eye Foundation, USC Department of Ophthalmology, Los Angeles, CA from 1982-1984. He is board certified by the American Board of Ophthalmology. Dr. Robin is in group practice at Frantz EyeCare, 12731 New Brittany Blvd., Fort Myers, FL 33907 Tel: 239-418-0999.

Rajeev, Prabakaran, MD – Dr. Prabakaran received his MD degree from University of Miami School of Medicine, Miami, FL in 2006. He completed an internship at Boston University Medical Center, Boston MA from 2007-2007, a residency and fellowship at Boston University Medical Center, Boston MA from 2007-2012. He is board certified in Internal Medicine by the American Board of Internal Medicine. Dr. Prabakaran is in group practice at Digestive Health Physicians, 7152 Coca Sabal Lane, Fort Myers, FL 33908 Tel: 239-939-9939.

Raymond D. Santucci, MD – Dr. Santucci received his MD degree from Loyola University Chicago Stritch School of Medicine, Maywood, IL in 1999. He completed his residency at the University Hospital , University of Cincinnati, Cincinnati, OH from 1999-2002 and a Pulmonary Disease and Critical Care fellowship at the University Hospital, University of Cincinnati, Cincinnati, OH from 2004-2007. Dr. Santucci is board certified by the American Board of Internal Medicine in Internal Medicine, Critical Care Medicine and Pulmonary Medicine. He is in group practice with Pulmonary, Critical Care and Sleep Medicine Specialists of SWFL, 7335 Gladiolus Drive, Fort Myers, FL 33908 Tel: 239-985-1925.

Cindy Zughbi, MD – Dr. Zughbi received her MD degree from the University of Sint Eustatious, Netherlands Antilles in 2011. She completed a residency at Memorial Health University, Savannah, GA from 2011-2014. Dr. Zughbi is board certified in Family Medicine by the American Board of Family Medicine. She is in group practice with Internal Medicine Associates of Lee County, 13813 Metro Parkway, Fort Myers, FL 33912 Tel: 239-936-1343.

President's Message:

by Peggy Mouracade, MD

Thinking Outside of the Box

While on a break during a meeting, I had some time to read a newspaper and came across an article regarding habits. It was an article that had consisted of several interviews of successful people in various fields. What struck me as important was a comment made by a professional athlete, "…it's really important not to fall prey to habit. Success on the court means being able to adapt to changing conditions, to different players, to different playing styles and more." Sounds rather applicable to many of us in the medical field. Habits are routines of behavior that we practice and adopt for the most part as a means of efficiency. What many of us are discovering is that in order to exist in our present culture, we are having to change our habits; we are having to think and act outside of the box.

Lately I have across several occasions when thinking out of the box seems to have become more of the norm. I have an interest in functional and regenerative medicine and while attending a recent symposium was amazed by how focusing attention on the biochemical and metabolic pathways associated with subcellular organelles could possibly lead to a nutricuetical approach to treat and prevent disease. Whether or not, this is something that I will adopt entirely, not sure, but may be enough for me to change my treatment habits. I was sitting in on an addiction module and had never considered thinking of linking neurology, endocrinology and immunology together. However, when presented with this approach, a different understanding was gained of the potential process that may be at the root of such a devastating condition.

In August, I attended the Florida chapter of the ACP (American College of Physicians). During a lunch meeting, I initially eavesdropped but then later become involved in a conversation among a couple of younger health professionals, three family practice residents and an ARNP (Advanced Registered Nurse Practitioners). The residents were discussing their futures and how they were going to set up their practice. They had decided to share an office and in an effort to minimize overhead to staff and design it as if only one would be in the office. They had decided that with the advent of telemedicine that they could each have their own "cyberoffice" and could interact with patients as needed. The thought was to send out ancillary staff to do a housecall if warranted and then an office visit with physician or ARNP could be scheduled. However, focus was to keep patients at home or if too sick to go to the hospital but to minimize actual office visits. A bit out of the box for me but perhaps maybe a plausible way to cope with upcoming changes and stresses that our primary care specialties are experiencing. When questioned these young physicians were earnest and steadfast that their model was going to succeed. The ARNP practices in a state where scope of practice is more liberal so that she can practice on her own. She is contemplating on creating and managing a "locum tenens ARNP" service.

The amount of change and more importantly the pace of the changes that have occurred in the last couple of years are only going to escalate as many of the issues that we had heard about are now going to be initiated. Change seems to incite creativity and ingenuity as well as potential chaos and frustration. In order to survive and thrive, thinking outside of the box will become a necessary part of the armenterium.

MED STATS

Florida Board of Medicine News:

September 9, 2014

On Friday, August 22nd, the U. S. Drug Enforcement Administration (DEA) published a Final Rule moving hydrocodone combination products (HCPs) from Schedule III to the more-restrictive Schedule II. This Final Rule imposes the regulatory controls and sanctions applicable to Schedule II substances on those who handle or propose to handle HCPs. The rule goes into effect 45 days from its publish date.

The entire rule text may be found here: https://www.federalregister.gov/articles/2014/08/22/2014-19922/schedules-of-controlled-substances-rescheduling-of-hydrocodone-combination-products-from-schedule.

UPDATE: September 10, 2014

DEA Reschedules Hydrocodone Combination Products

Under a final rule published in the Federal Register, the pain reliever tramadol is classified as a Schedule IV controlled substance (CS) starting August 18, 2014. Drug Enforcement Administration (DEA) will require manufacturers to print the "C-IV" designation on all labels that contain tramadol, including its salts, isomers, and salts of isomers.

DEA restricts use of hydrocodone drugs, moves to Schedule II

Contributed by: American Medical Association (AMA)

The U.S. Drug Enforcement Administration (DEA) published a final rule Aug. 22 that changes the controlled substance scheduling of hydrocodone combination products (HCP) from Schedule III to Schedule II. The change is scheduled to take effect Oct. 6.

The AMA and many other groups have opposed the DEA proposal and sought to maintain HCP in Schedule III or, at a minimum, provide special rules for long-term care facilities in which these drugs often are an essential part of pain management.

The new rules include these requirements:

- HCP prescriptions issued **on or after Oct. 6** must comply with requirements for Schedule II prescriptions. Refills are prohibited.
- HCP prescriptions issued **before Oct. 6** with authorized refills may be dispensed in accordance with DEA rules for refilling, partial filling, transferring and central filling Schedule III-V controlled substances until April 8, 2015.
- Compliance with the Schedule II requirements for HCP prescriptions means that effective Oct. 6, HCP prescriptions must be written on paper or electronically transmitted. Fax transmission is not allowed. Except for emergency situations that are governed by specific requirements, HCP prescriptions also cannot be called into a pharmacy.

AMA Applauds New Effort to Modernize State Medical Licensure

Statement attributed to Robert M. Wah, M.D., President, American Medical Association

"The American Medical Association (AMA) has long supported reform of the state licensure process to reduce costs and expedite applications while protecting patient safety and promoting quality care.

"State-based licensure is an important tenet of accountability, ensuring that physicians are qualified through the review of their education, training, character, and professional and disciplinary histories.

"The interstate compact released today by the Federation of State Medical Boards (FSMB) aligns with our efforts to modernize state medical licensure, allowing for an expedited licensing pathway in participating states.

Recruit three new members this year and your 2015 dues will be free of charge.

THE PRN - The Professionals Resource Network

By Penelope P. Ziegler, M.D., Medical Director

The Professionals Resource network (PRN) is Florida's program that addresses the issues of healthcare professionals who have illnesses and other health problems that could impair their ability to practice with skill and safety. Founded in 1980 as the Committee for Impaired Physicians of the Florida Medical Association, PRN now works with all licensed or certified healthcare professionals, applicants and students, except nurses and other practitioners licensed through the Board of Nursing, who have their own program, Intervention Program for Nurses (IPN). PRN assists professionals who have substance use disorders, psychiatric illnesses, behavioral disturbances, boundary violations, cognitive impairments, and physical disabilities

Our mission, as articulated by our Board of Directors, is to protect the citizens of Florida by identifying, referring for evaluation and treatment, and monitoring practitioners who may be impaired, and in the process, to preserve the careers and lives of healthcare professionals who need assistance. Now an independent, 501(c)(3) organization, PRN has a full time medical director, professional staff and a 22-member Board of Directors composed of allopathic and osteopathic physicians and concerned citizens who oversee the program's operations, financial and legislative affairs, and research activities.

PRN serves as a consultant on impairment to the Department of Health, Division of Medical Quality Assurance (as legislated in Chapter 456.076 of the Florida Statutes), and works with 30 different Boards and Councils to ensure that licensees who are identified as being in need of treatment and monitoring are safe to practice. We also work with medical schools and other professional training programs to provide education about impairment, information for students and services to individual students who may be in need of treatment and monitoring.

Referrals to PRN come from many different sources, including:

- Self-referral: a professional or student may contact our program directly to request services.
- Referral from a treatment provider: a therapist, counselor, physician, psychiatrist or treatment program may refer a professional or student who is receiving care for a potentially impairing condition, either by contacting PRN directly or by having the individual call us.
- Employer/school referral: often a practitioner's employer or school refers an individual to us due to concerns about possible impairment.
- Health care organizations referral.
- Family member/friend/concerned colleague referral.
- Attorney referral.
- Referral from Department of Health/Licensing Board: PRN receives referrals of applicants for licensure who report a history of problems in the past or in other jurisdictions; licensees about whom an investigation has been opened; licensee facing disciplinary action; and licensees who have already been disciplined in another state. Veterinarians, who are licensed by the Department of Business and Professional Regulations, are also referred tp PRN via the Department of Health as specified in Florida Statute 474.221.

Once a practitioner has agreed to work with PRN, the first step in the process involves obtaining an evaluation performed by a professional with expertise in the area in which the person is experiencing difficulty. PRN has a group of evaluators in Florida and around the U.S. who have been credentialed and trained in doing this specialized type of comprehensive forensic assessment. The evaluator makes diagnoses, treatment recommendations, monitoring recommendations, and a statement about the individual's ability to practice with skill and safety.

If treatment is indicated and monitoring is recommended, PRN then proceeds to develop a contract with the practitioner. Several types of contracts are available, including a contract for substance use disorder, a contract for psychiatric illness, a contract for co-occurring substance use, and psychiatric disorders, a behavioral contract, a boundary violation contract, a pain management contract, and a physical/cognitive disabilities contract. Contracts are individualized to meet the needs of each practitioner, and vary in length from one year to licensure-long. However, the average length of a substance use disorder contract is five years.

Many PRN participants work with us to develop a treatment and monitoring plan, and are compliant with that plan, experiencing no relapses or complications. Some participants do experience complications and require additional intervention, but the majority of practitioners are able to return to work and resume their careers. Unfortunately a few individuals, because of the severity of their illness or refusal to work with PRN, are unable to qualify for PRN advocacy and are felt to constitute a danger to the citizens of Florida. In those cases, PRN must report them to their respective licensure Boards to insure protection of the public.

In addition to PRN's work with individual practitioners, we provide education and information to Florida healthcare professional and students in professional education and training programs. This outreach effort includes presentation to county medical societies, hospitals and other healthcare facilities, schools of medicine, dentistry, pharmacy, and other institutions. PRN's Medical Director and Associate Medical Director are also active in state and national organizations that study and promote wellness and recovery for healthcare professionals and conduct research into various aspects of professional health. PRN is currently conducting research on medical students involving all eight of Florida's medical schools, and is participating in multi-state studies on long-term outcomes for addicted professionals who have completed monitoring programs.

Research studies of professionals' health programs such as PRN show that education early intervention, effective treatment, and monitoring provid the most effective route to preventing impairment-related injuries to patients, and also preserve the careers and skills of practitioners with potentially impairing illnesses. Unlike punitive, disciplinary approaches, which tend to foster secrecy and hide unsafe practitioners, PRN promotes wellness, prevention and support for doing the right thing, and getting help for healthcare professionals.

Professionals Resource Network (PRN), P.O. Box 1020, Fernandina Beach, FL 32035, www.flprn.org .

FMA 2013 Physician Workforce Annual Report

By: Jarerod Fowler, M.H.A.

November 2013

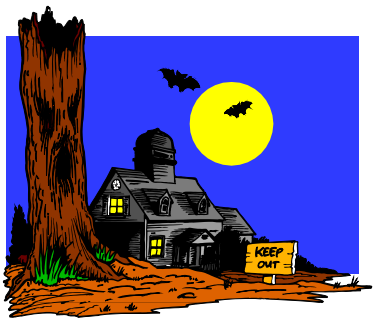
Executive Summary

The 2013 Physician Workforce Annual Report presents a summary analysis of the 2012 and 2013 Physician Workforce Surveys1 and an update on the Florida Physician Workforce Strategic Plan - Key points in this report include:

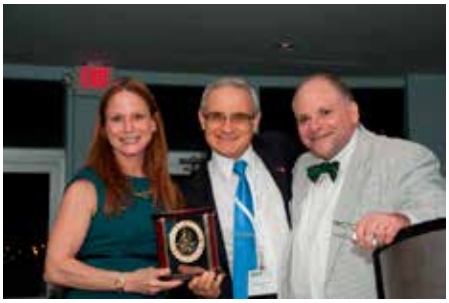
- A total of 62,312 physicians responded to the 2012 and 2013 surveys.
- Of the state's licensed physicians, 43,406 (69.7%) are actively practicing in Florida.
- Nearly two-thirds (26,778 or 61.7%) of the actively practicing physicians are age 50 or older.
- Of the state's active physicians, 14,502 (33.4%) are practicing in primary care specialties, which include family medicine, internal medicine, and pediatrics.
- The top three specialties practiced by physicians in Florida are: medical specialist (6,364 or 14.7%), internal medicine (6,250 or 14.4%), and family medicine (5,961 or 13.7%).
- Physicians are notably concentrated in areas containing medical schools and large population centers.
- Nationally, Florida is below the state median of active primary care physicians of 9.1per 10,000 population, with 7.7 primary care physicians per 10,000 population. (Association of Medical Colleges (AAMC) 2011 State Physician Workforce Data Book)
- In 16 of Florida's 67 counties, over 20.2% of their physicians plan to retire in the next five years. Statewide, 5,724 (13.2%) physicians plan to retire in the next five years.

The report findings will be instrumental to the Physician Workforce Advisory Council in its work to provide advice and recommendations to the State Surgeon General and the Department on matters concerning physician workforce needs in this state. As part of its work, the Council will examine physician workforce planning in its entirety, with particular focus on graduate medical education and medical school pipeline programs.

1 The Physician Workforce Survey is part of the licensure renewal process for physicians and administered by the Department's Division of Medical Quality Assurance. Licensed physicians are divided into two groups, with each group renewing every other year. The result is the combination of two years of data for a total set of Florida physician workforce data.



Internist of the Year – Daniel Bendetowicz, M.D.



From left to right: Dr. Michelle Rossi, FACP President of the Florida Chapter, ACP, Dr. Daniel Bendetowicz, FACP And Dr. Michael Zimmer, FACP, Past President

Dr. Daniel Bendetowicz was presented a few days ago with a new award, "Internist of the Year" given by the Florida Chapter of the American College of Physicians to the "Physician who has demonstrated outstanding leadership and dedication to the practice of Medicine". In the year 2013 he was presented with the "Key Contact Award" due to his efforts advocating on behalf of patients.

Dr. Bendetowicz has been active in the Florida Chapter since relocating to Florida in the year 2000. He has been a member of the Governor's Advisory Council for the Southwest district since 2009. This is a committee formed by doctors that advise the ACP Governor about different subjects.

The American College of Physicians (ACP) is the largest organization of internists of America and the entire world. The ACP Florida Chapter is one of the biggest and most active chapters of the country. Although one of the largest states in the country, one particular feature is that the Florida Chapter covers the entire state without any sub-chapters, unlike other states.

By The Numbers: Florida's Physician Workforce

By FMA, Jarrod Fowler, M.H.A.

Florida Physicians by Specialty:

Based on data from the Florida Department of Health's 2013 Physician Workforce Annual Report, Florida is home to 43,406 active licensed physicians. Of those active licensed physicians, 33.4 percent practice in primary care specialties of family medicine, general internal medicine and general pediatric medicine.

Figure 5: Physician Specialty Group Counts

Specialty Group	Count	Percentage
Anesthesiology	2,322	5.3%
Dermatology	908	2.1%
Emergency Medicine	2,205	5.1%
Family Medicine	**5,961**	**13.7%**
General Surgery	976	2.2%
Internal Medicine	**6,250**	**14.4%**
Medical Specialist	6,364	14.7%
Neurology	888	2.0%
OB GYN	1,851	4.3%
Other	3,592	8.3%
Pathology	853	2.0%
Pediatric Subspecialist	1,384	3.2%
Pediatrics	**2,291**	**5.3%**
Psychiatry	1,698	3.9%
Radiology	1,963	4.5%
Surgical Specialist	3,087	7.1%
Unspecified	813	1.9%
Total	43,406	100.0%

Source of Image: Florida Department of Health 2013 Physician Workforce Survey

Be Cybersecure: Protect Patient Records, Avoid Fines, and Safeguard Your Reputation

Contributed by: The Doctors Company Risk Tips

Cybercrime costs the U.S. economy billions of dollars each year and causes organizations to devote substantial time and resources to keeping their information secure. This is even more important for healthcare organizations, the most frequently attacked form of business.[1] Cybercriminals target healthcare for two main reasons: healthcare organizations fail to upgrade their cybersecurity as quickly as other businesses, and criminals find personal patient information particularly valuable to exploit.

The repercussions of security breaches can be daunting. A business that suffers a breach of more than 500 records of unencrypted personal health information (PHI) must report the breach to the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). This is the federal body with the power to enforce the Health Insurance Portability and Accountability Act (HIPAA) and issue fines. To date, the OCR has levied over $25 million in fines, with the largest single fine totaling $4.8 million.[2] A healthcare organization's brand and reputation are also at stake. The OCR maintains a searchable database (informally known as a "wall of shame") that publicly lists all entities that were fined for breaches that meet the 500-record requirement.[3]

If you think you may not be fully compliant with HIPAA privacy and security rules, consider taking the following steps:

- Identify all areas of potential vulnerability. Develop secure office processes, such as:
  - Sign-in sheets that ask for only minimal information.
  - Procedures for the handling and destruction of paper records.
  - Policies detailing which devices are allowed to contain PHI and under what circumstances those devices may leave the office.
- Encrypt all devices that contain PHI (laptops, desktops, thumb drives, and centralized storage devices). Make sure that thumb drives are encrypted and that the encryption code is not inscribed on or included with the thumb drive. Encryption is the best way to prevent a breach.
- Train your staff on how to protect PHI. This includes not only making sure policies and procedures are HIPAA-compliant, but also instructing staff not to openly discuss patient PHI.
- Audit and test your physical and electronic security policies and procedures regularly, including what steps to take in case of a breach. The OCR audits entities that have had a breach, as well as those that have not. The OCR will check if you have procedures in place in case of a breach. Taking the proper steps in the event of a breach may help you avoid a fine.
- Insure. Make sure that your practice has insurance to assist with certain costs in case of a breach.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

References

[1]Visser S, Osinoff G, Hardin B, et al. Information security & data breach report—March 2014 update. Navigant. March 31, 2014. http://www.navigant.com/~/media/WWW/Site/Insights/Disputes%20Investigations/Data%20Breach%20Annual%202013_Final%20Version_March%202014%20issue%202.ashx. Accessed June 17, 2014.

[2]McCann E. Hospitals fined $4.8M for HIPAA violation. Government Health IT. May 9, 2014. http://www.govhealthit.com/news/hospitals-fined-48m-hipaa-violation. Accessed June 24, 2014.

[3]Breaches affecting 500 or more individuals. U.S. Department of Health & Human Services. http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachtool.html. Accessed June 23, 2014.

Sports Injury or Suspected Concussions

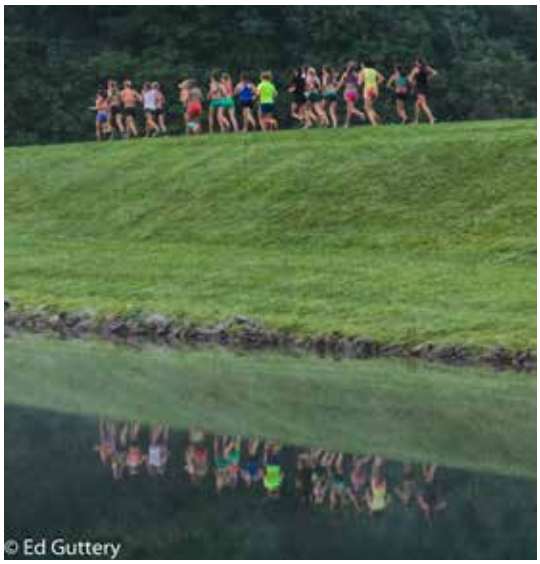
By: Sarah Geary MA, ATC, LAT, District Athletic Trainer

The American Academy of Neurology recommends that an appropriate healthcare professional (AHCP) or an athletic trainer be present at all sporting events, including practices, where athletes are at risk for concussion or for those classified as a collision sport, whenever possible. It is mandated by the Florida High School Athletics Association (FHSAA) to immediately remove an athlete if they are suspected of sustaining a concussion. All coaches and officials are trained in recognizing the signs and symptoms of a concussion, and can assist in the removal of potentially injured athletes. Once an athlete is removed from play an athletic trainer, if available, can assist with the sideline evaluation. However, they cannot provide written clearance to return to participation. If upon evaluation by the athletic trainer that the athlete does demonstrate symptoms consistent with a concussion, the athlete must be referred for further evaluation and management by an ACHP. If an athlete is diagnosed with a concussion, an FHSAA AT18 form must be utilized for appropriate return-to-play. The form requires that the athlete be asymptomatic, have a normal neurological exam, has returned to normal classroom activity, and off any medication related to the injury. Also, if available, any completed neuropsychological testing has returned to baseline. The graded return-to-play protocol is a six step process that can be monitored by an athletic trainer, if available, or by a coach. Each step must be completed symptom free and initialed by the person monitoring the activity. Once completed, the form is to be returned to the treating ACHP for review and final clearance to return to full competition. This includes filling out the Return to Competition Affidavit (AT18 pg. 2). When this process is completed and all portions of the AT18 form are signed by everyone involved, the athlete may return to full participation with the understanding to immediately stop playing and report the return of any symptoms.

Fort Myers High Girls XC travels to North Carolina for "Running Camp"

On August 1st the Fort Myers Girls XC team traveled to Brevard, NC (Connestee Falls) to be exact for a week of running in the Western North Carolina Mountains. One year ago, Coach Kelly Heinzman-Britton, who is starting her 14th year of coaching XC at FMHS, took her team to North Georgia for a week of running. As the grandfather of one of the girls on the team, I thought it might be nice if the team could come up to my house in North Carolina this summer for their "running vacation." My daughter-in-law, Angela, helped to plan the trip with Kelly and I was very happy to have the team come to Connestee for the week of August 2nd-8th.

The group, which included 26 girls, stopped at Clemson University to run and also ran at Furman before arriving in Brevard. The group included 4 seniors, 5 juniors, 12 sophomores, and 2 freshmen. Coach Kelly, Coach Sara Strong, Angela and 2 college bound runners rounded out the group. Just to clarify, they stayed at my house and another rental house. I moved up the street! The weather was great and the girls were able to run in DuPont Forest on several nice trails, while traveling to Bridal Veil Falls and Hooker Falls. They also ran in Pisgah National Forest along the famous Davidson River, ran to the top of John's Rock, slid down "Sliding Rock Falls" and visited Looking Glass Falls. A trip to Lake Lure to "Zip Line" and trips to nearby Asheville and the NC State Arboretum where they trail ran, playing Laser Tag at the Tim and Barbara Lewis' house in Connestee, running the Connestee Golf Course as well as swimming and Kayaking in Lake Atagahi and running the berm at Lake Wanteska completed a great week. They also ran at Brevard College. Oh, and on the way home; they stopped and ran at the University of Florida XC course!



This was a great group of girls. They allowed me to tag along and take photos and I loved every minute!

Sincerely,
Ed Guttery, M.D.

Career Burnout: The Root Cause is Loss of Purpose

Career burnout is characterized clinically by loss of passion, physical and emotional exhaustion, cynicism and detachment, and feelings of ineffectiveness and lack of accomplishment.

"Career burnout can lead to stress-related illnesses such as insomnia, anxiety, and ulcers. The Center for Disease Control estimates that 80 percent of doctor's office visits are due to stress-related illnesses. "Dr. Romie" Mushtaq, MD"

Take charge of your Stress --- Breathe Deeply several times a day.

ALL PHYSICIAN CME'S GO THROUGH CE BROKERS
SEE INSERT FOR MORE INFORMATION

Free Workers' Compensation and Workplace Safety Seminars and Webinars

Sheryle Birdsong, Compliance Bureau, Division of Workers' Compensation Dept. of Financial Services

The State of Florida, Department of Financial Services, Division of Workers' Compensation offers **Free Seminars and Webinars** for Florida employers regarding Workers' Compensation and Workplace Safety.
In addition, the Division of Workers' Compensation has partnered with OSHA (Occupational Safety and Health Administration) and the University of South Florida's "Safety Florida Consultation Program" to bring valuable safety information to Florida employers.

Free Seminars are held in various locations around the state.

Free Webinars are also available to Florida employers. The Webinars contain the same information as the classroom settings and are held monthly via your computer and telephone.

CEUs
Continuing Education Units (CEUs) are available to contractors licensed by the Florida Department of Business and Professional Regulation: Construction Industry Licensing Board; Electrical Contractors Licensing Board; and the Board of Accountancy

To register for any of our events please complete the appropriate registration form and email it to me at BocSeminars@MyFloridaCFO.com or fax it to (813) 233-3742.

If you would like to publish or forward this information to other interested parties, please do so. We would appreciate your help in getting the word out regarding these events.

Should you have any questions, please let me know. Thank you.

Conflicting Guidelines on Mammograms Can Pose Risks

Contributed by: The Doctors Company

Misdiagnosis, delayed diagnosis, and failure to diagnose breast cancer are liability risks, particularly for radiologists, gynecologists, general surgeons, and family medicine practitioners, according to closed claims data from The Doctors Company from 2007–2013. Several factors contribute to these risks:

- Conflicting guideline screening recommendations.
- False negative mammograms, which fail to detect some cancers.
- False positive mammograms, which lead to breast biopsy.
- Radiation exposure.

The 2008 American College of Radiology and 2003 American Cancer Society guidelines recommend annual mammography screening for asymptomatic, average-risk women age 40 and older.[1] However, the guidelines set forth by the U.S. Preventive Services Task Force in 2009 recommend starting routine mammograms for women with an average risk of breast cancer at age 50.1 Although the presence of numerous professionally endorsed options arguably gives physicians a broader set of clinically valid choices, inconsistent guidelines may also leave physicians feeling more exposed to malpractice claims.[2]

Adding to this dilemma is that some states are now requiring physicians to notify women who have dense breast tissue,[3] which makes it more difficult to read mammograms. However, there are no guidelines on what physicians should do if a woman has dense breast tissue.

In addition, interpreting mammograms can be difficult because normal breasts vary in their mammographic appearance.[4] Physicians should consider a personalized approach that best assesses the individual patient's need.

Physicians can reduce risks and promote patient safety by:

- Communicating with patients about conflicting guideline recommendations.
- Discussing why you believe your recommendation is right for the patient.
- Reviewing the patient's breast-related medical history and breast cancer risk factors to assess their impact on breast cancer risk.
- Ensuring that an adequate follow-up system for mammogram reports is in place.
- Clearly communicating mammogram test results to the patient in a timely manner and ensuring that the patient understands the significance of the findings and recommendations.
- Documenting all discussions with patients in the medical record.

For medical groups, all member physicians should agree on and follow consistent practice guidelines for breast cancer screening.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

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What Providers Need to Know Before They Balance Bill

By Karina P. Gonzalez, Esq.
Florida Healthcare Law Firm

Balance billing occurs when a provider collects from a patient the difference between the amount billed for a covered service and the amount paid for that service. Balance billing does not apply when collecting deductibles, copayments or coinsurance.

Under Florida law, a provider may not balance bill a patient for any service, if an HMO is liable and responsible for payment. Contrary to what many people believe, this is true whether you are in-network or out-of-network. Even hospital based out-of-network physicians, such as anesthesiologists, pathologists, radiologists or emergency room physicians cannot balance bill HMO members where the hospital has a contract with the HMO or there was authorization given for an episode of care.

Under Medicare managed care, any Medicare participating provider (as a condition of its participating provider status) must accept payment from a Medicare Advantage plan as payment in full, even though the provider may be nonparticipating.

Medicare prohibits the provider from balance billing Qualified Medicare Beneficiaries for Medicare cost-sharing (which includes deductibles, coinsurance and co-payments) for Part A or Part B cost sharing. Medicare payments or Medicaid payments are considered payment in full to the provider for services given to a Qualified Medicare Beneficiary. A Qualified Medicare Beneficiary is someone whose income does not exceed 100% of the Federal Poverty and who is eligible for Medicaid paying Medicare premiums, deductibles and coinsurance, also known as dual eligibles.

Out-of-network providers can balance bill patients who are covered under a self-funded employer plan These types of plans are self funded by the employer or a union and employer or union assumes financial risk for providing healthcare benefits to its employees. In Florida, there isn't a mandatory requirement that a provider submits a balance bill, but there is no prohibition either. Balance billing is also permitted for nonparticipating PPO providers and for participating providers whose contract permits it.

The key aspect to consider in whether to balance bill is knowing who the payor is and the sort of service provided.

Life as a Resident

Dr. Sherry Farag, Resident Physician, LMHS Medical Residency Program

When I was asked to write an article about the life of a resident, I was happy to share my story and a little bit about who I am. My name is Sherry, I am a second year resident who chose to join the FSU Family Medicine Residency at Lee Memorial Hospital, I have traveled across the country to be able to join a wonderful group of people who work here. Having moved around a lot in the last couple of years, I have come to enjoy chasing new adventures. I appreciate change and being able to start a new chapter. Fort Myers is the 6th city I have lived in over a period of 5 years, and once I stepped off the plane I felt like I was home. I have chosen to come to Lee Memorial to finish my Family Medicine Residency, which I started one year ago at the University of Kentucky. After training in a large academic medical center, I appreciate the close-knit environment of a community hospital, where everyone makes the effort to get to know your name and your story. So I decided to share my story and a little bit about the life of a resident.

I travelled often growing up and I learned to adapt to new environments wherever I went. Starting new has become a part of who I am. Many people have asked why I would move across the country to a new residency program after my intern year and really venture into the unknown. The answer to that question is that I wanted to shape a new program and be a part of the class that leads the way for all the residents that will eventually train here. I love to work with interns and students and I have a passion to teach, and this program allowed me the opportunity to teach and to set a standard for our future classes.

Once I started my training at Lee Memorial, I quickly realized that many of the people I am working with have never worked with a resident and don't really know the functioning capacity of a resident. I was a little scared at first, however this was a blessing in disguise as I got to know many of the nurses, techs, and MA's who always greeted me with a smile and asked about residency. I got to tell them about what I do. I got to tell them that I take care of my own patients, see them in the hospital and in the clinic, put in orders and round on them daily. I also admit and discharge and work closely with other providers. I tell them that as a Family Medicine resident I see people of all ages, and work with men, women and children and take care of their every need. I deliver babies and follow them in clinic. I work with the underserved population of this community, who desperately need the attention and care. They are usually pleasantly surprised, as they initially thought that we were "just students." I always tell them with a big smile that being a doctor means that you are a student for life and I take pride in that as I get to learn every day and my patients become an open book. They always end the conversation with "welcome, we're so glad to have you." I can't explain in words how great it feels to hear that. I was used to being a number, one out of 3000 others who carried a pager around at all times.

Being a resident means that we get to work long hours. On most rotations we can average about 80 hours per week, and have four days off a month – that's easily double the amount of time an average person works. The long hours can halt our life outside of the hospital and clinic, but residency essentially becomes our life as we realize that we are responsible for the lives of others, and we gladly put their needs ahead of our own. This is what I chose to do and I haven't looked back since and I wouldn't change a second of it. Watching our bright intern class start their first few days of residency put a smile to my face. I had my first opportunity to lead our inpatient team as the first chief resident on the hospital service for this program. The new interns were so excited and so happy to take on the responsibility of saving lives; their enthusiasm and willingness to jump in was priceless.

So as a patient, if you hear the words "the resident will see you now", consider this, you get a young growing doctor unrestricted by time. We are hopeful and enthusiastic. We are there for you and your family. We listen intently. Maybe you think we're asking too many questions, but we're determined to get a complete history. We know our job is to listen and be meticulous about our physical exam. Seriously, when was the last time you had someone listen to you so earnestly? We will report our findings and our plan back to our supervising physician; and make sure you don't leave without all your questions answered and all your needs met. We don't rush you or look at the clock as you describe in detail a long list of medical problems. We care. We are young. We are at the intersection of theory and reality. We practice medicine according to the most recent guidelines and base our treatment plan on evidence based research. Consider it a good thing, you get a second set of eyes that looks for anything that may be causing you discomfort; and most importantly, you may become instrumental in shaping a young doctor's career path.

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