LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

Bulletin

Volume 33, Issue 2 | Editor: John W. Snead, M.D. | July 2009

2009 Meetings and Events

LCMS General Meeting
Thursday
September 17, 2009
6:30 p.m. Social Time
7:00 p.m. Dinner

LOCATION CHANGE
FineMark Bank
12681 Creekside Lane
Fort Myers, FL 33919

RSVP Medical Society Office
LCMS, PO Box 60041, Ft Myers 33906
Tel: 936-1645 Fax: 936-0533

Happy 4th of July!

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness."

Inserts

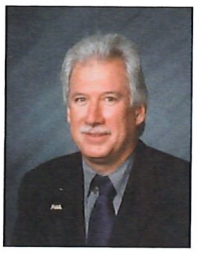
- **Awareness Months Sign Up**
- **Hill, Barth & King Ad**
- **News-Press Health Care Reform Page**

Inside this issue:

President's Message

Briefly

Larry Hobbs, M.D.



National: At the time of this writing it seems the plans for health care reform will be centered on the establishment of a government sponsored health insurance plan. The idea is that all Americans will have the opportunity to purchase affordable health insurance. The problems with this idea are numerous and complex. How will the government fund it? That will require raising taxes, taxing the insurance or borrowing from the future. Will it be mandatory? That worked "well' in Massachusetts! Will it help to increase patient access? If this program ends up paying physicians less then Medicare rates there will be very limited access to specialists. Florida Medicaid is evidence of that problem. How will the existing health insurance plans compete? (Who cares?) As a leading health insurance coalition stated, "A public plan cannot operate on a level playing field and compete fairly if it acts as both payer and regulator".

State: By now we all know that the FMA efforts as well as our individual contributions paid off in getting the governor to sign SB 1122. We thank Dr. Steve West for his 'Herculean' efforts. He traveled the state writing editorials and meeting with newspaper editorial boards as well as local media informing the public of the bill's true intentions. His clear and concise presentations had most of the editorial boards comment in our favor. Also, this should be an interesting 18 months coming up as many state races for US Senate, Congress, governor, and state legislative elections heat up and the players are identified. Remember that funding pro-medicine candidates is the best way to win over friends. They in turn help support our efforts in advocating for our patients. Please contribute to FMAPAC, MD1000 Club, and LeePAC. Try to make time to attend the FMA Annual Meeting on July 24-26th in Boca Raton. It is always interesting and usually a lot of fun as attendees help shape future legislative priorities.

Local: My last article entitled 'Patient Advocacy' has stirred up some interest. The LMHS Board of Directors has identified this problem with patient flow as needing to be corrected. Physician leadership at the hospitals has begun the process of standardizing and improving hospitalist care. A definition of what a hospitalist should be was approved by the medical executive committees at each hospital. This begins the process of working on developing a section or department of hospitalist medicine at each hospital. The hospitalist physicians and other concerned physicians will then participate in developing credentialing criteria as well as propose rules and regulations to hopefully improve delivery of patient care for hospitalized patients. I propose that the leaders of the LCMS, IPALC, LPG and the other primary care groups meet to discuss their needs and develop strategies for better patient flow from physician office to hospital and back.

And finally, I would like to reintroduce you to the Lee County Volunteer Healthcare Connection (VHC) program. This program, administrated by the United Way of Lee, proposes to help physicians provide 'pro bono' services to eligible low-income uninsured adults needing specialty care. This program offers state sovereign immunity and prescreening of patients referred from a primary care physician. Medical records, imaging studies, etc. are administered by the program. Volunteer physicians would only be asked to see one patient per month. The VHC is in the process of reorganizing its board of directors to include mostly physicians. So when one of our colleagues calls on you or your practice to participate, please help out. It is not only the right thing to do for uninsured, low income patients but it shows how much we care as physicians about our community. The LCMS supports this program and I hope you will too.

Enjoy your summer break!

Larry

LEE COUNTY MEDICAL SOCIETY BULLETIN
P.O. Box 60041
Fort Myers, Florida 33906-0041
Phone: (239) 936-1645
Fax: (239) 936-0533
E-Mail: awilke@lcmsfl.org
www.leecountymedicalsociety.org

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

CO-EDITORS
Mary C. Blue, M.D.
John W. Snead, M.D.

EDITORIAL BOARD PRESIDENT
Larry Hobbs, M.D.

PRESIDENT ELECT
Craig Sweet, M.D.

SECRETARY
Shahid Sultan, M.D.

TREASURER
Cherrie Morris, M.D.

PAST PRESIDENT
Dean Traiger, M.D.

MEMBERS-AT-LARGE
Howard Barrow, M.D.
Stuart Bobman, M.D.
Barry Blitz, M.D.
James Butler, D.O.
Valerie Dyke, M.D.
Douglas Hendricks, M.D.
Stephen Laquis, M.D.
Richard Macchiaroli, M.D.
Kenneth Towe, M.D.

MANAGING EDITOR
Ann Wilke, 936-1645

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
Insta Print

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 Activity

New Practice/Address
Pedro Marcucci, MD
Premier Urology
2721 Del Prado Blvd. S, Ste 220
Cape Coral, FL 33904
Phone: 239-458-0168

Otto J. N. Kunst, MD
Diagnostic Radiology/locum tenens
13151 Parkline Drive
Fort Myers, FL 33913
Phone: 239-561-5161

Reggie Augusthy, DO
Spine & Pain Center at The Sanctuary
8960 Colonial Center Drive, Ste 204
Fort Myers, FL 33905
Phone: 343-9465

Retired
Lloyd Caudill, MD

Moved Out of Area
Deanna Ohms, DO

Relocated
Carmen Barres, MD
Lee Physician Group
8960 Colonial Center Drive Ste 300
Fort Myers, FL 33905
Phone: 239-343-9470

Edward LaMotta, MD
1699 Periwinkle Way
Sanibel, FL 33957
Phone: 395-2444

Dropped/Not Renewing
H. Kurtis Biggs, DO
Frank E. Campanile, MD
Katie E. Drake, DO
Patricia Dury, MD
George P. Fitzgerald, MD
Davis Gates, MD
Alan S. Goldstein, MD
John Howard, MD
Douglas Hughes, DO
Robert Martinez, MD
Lillian Palmon, MD
Angel Pietri, MD
Stephen P. Schroering, MD
Kim L. Spear, MD
Glenn A. Tovar Dias, MD
Anthony Vernava, MD
Michael Verwest, MD

ATTENTION MEMBERS…

Are you retiring, moving, or closing your practice? The Lee County Medical Society can help, we offer:

- Retirement Packet & Relocating Packet - That provides addresses and websites of agencies to notify, checklists, and how long to keep certain records.
- Direct Mail Labels - Useful for open houses and announcements
- Keep information on file so that patients can locate their records

Always notify the Medical Society when making changes to your practice.

Members in the News

Congratulations to Ronald Castellanos, MD. Dr. Castellanos has been reappointed to another 3 year term with MedPAC.

Congratulations to Ralph Garramone, MD who won the gift basket at our May 21st CME meeting "Doctors in the Movies". The basket included over $150 prizes included movie night in as well as dinner and a movie out.

Corrections

We apologize to Carl Schultz, DO who wrote our May *Bulletin* article "Ship's Physician". We left off his name for his wonderful article. Dr. Schultz is an emergency physician with Cape Coral Emergency Physicians and has been an LCMS member for over 11 years.

New Member Applicant

Arnaldo De La Vega, MD, attended Faculty Of Medical Science, Camaguey, Cuba and obtained his M.D. degree in 1975. He completed his internship at Ramon Ruiz Arnau University Hospital, San Juan, Puerto Rico (2005-6) and residency at San Juan City Hospital, San Juan, PR (2005-8). Dr. De La Vega is a pediatrician in solo practice at De La Vega Pediatrics, 31 Barkley Cir Unit 1, Ft Myers, FL 33907.

As I Recall...

Roger D. Scott, M.D.

"18-U-CHUZ2"

The November 1996 **AIR** article **18-U-CHUZ** was the 16th article this novice author had prepared with great difficulty & time consumption and was anxiously awaiting its publication. When the article appeared in the *Bulletin* it had been essentially destroyed by the editors who stated that there was not enough space to publish the full article. I was justly p.o.ed (put out- not the 2000 interpretation of p.o.ed) and disappointed. After a discussion with the editors it was agreed that in the future they would not make major changes to my articles without my consent, and subsequently there have been no problems. So now I would like to relieve my 14 years of disappointment by updating it from the 1996 version to the 2009 version so we now have **18-U-CHUZ2**.

Prior to 1973 all Florida license plates were the same color and were renewed and replaced each January first with new plates made by the inmates of the Florida State Prison at Raiford. (As a Boy Scout in 1939 I toured the prison and saw license plates being made and also "old Sparky", the electric chair.) I believe it was in the early 1930s that each of the 67 Florida counties were assigned a permanent number based upon the number of license plates previously sold in that county.

The list was: 1 Dade, 2 Duval, 3 Hillsborough, 4 Pinellas, 5 Polk, 6 Palm Beach, 7 Orange, 8 Volusia, 9 Escambia, 10 Broward, 11 Alachua, 12 Lake, 13 Leon, 14 Marion, 15 Manatee, 16 Sarasota, 17 Seminole, 18 Lee, 19 Brevard, 20 St. Johns, 21 Gadsden, 22 Putnam, 23 Bay, 24 St. Lucie, 25 Jackson, 26 Osceola, 27 Highlands, 28 Pasco, 29 Columbia, 30 Hardee, 31 Suwannee, 32 Indian River, 33 Santa Rosa, 34 DeSoto, 35 Madison, 36 Walton, 37 Taylor, 38 Monroe, 39 Levy, 40 Hernando, 41 Nassau, 42 Martin, 43 Okaloosa, 44 Sumter, 45 Bradford, 46 Jefferson, 47 Citrus, 48 Clay, 49 Hendry, 50 Washington, 51 Holmes, 52 Baker, 53 Charlotte, 54 Dixie, 55 Gilchrist, 56 Hamilton, 57 Okeechobee, 58 Calhoun, 59 Franklin, 60 Glades, 61 Flagler, 62 Lafayette, 63 Union, 64 Collier, 65 Wakulla, 66 Gulf, 67 Liberty, 68 Governmental Agencies (yellow tags), 90 Duplicates. (How many of you had any idea of names and numbers of counties in Florida?)

In addition weight and type of vehicle were designated by letters following the county number. Lightweight autos had only the county numbers but heavier cars had "C, D, W, or WW", and rental cars had "E" immediately following the county number. Each plate began with the permanent county number (no name), then a space or hyphen and then sequential numbering for that county. Trucks had "G" or "GH" following the county number. That's about all I can remember. It was always fun as we traveled to try to remember and identify the counties by the license plate numbers. It was also fun to try to identify other states license plates by their colors and logos before we could read the actual state name. I still try to do this today but you'll see later in this article why I have practically given up on Florida license plates identification.

In the summer of the early 1960's we were driving a California rental car at least 80 mph on the road to Sunset Crater National Park Arizona when a blue four-door Buick with an obvious Florida 18W license passed us at about 95 mph. Remember Lee County was relatively small with about 55,000 people and the only blue Buick I knew was owned by Tommy Hart of Hart's Dairy in Fort Myers. We speeded up to closely follow the blue Buick to the parking lot of the park and thought we would surprise the Hart family whom we knew well. It wasn't the Harts, but was Wayne Bishop a North Fort Myers schoolteacher whom I surprisingly had not previously known.

Well all of this changed in 1973 when for the first time personalized plates could be ordered for an extra $12 each year. The basic color and motto remain the same; however, there were three types to choose from and these plates could be taken from one car when it was sold and placed on a new car for a total of three years usage. The three types available were: all numbers from one to 99 with no hyphens allowed or all capital letters up to seven digits with no hyphens or a mixture of letters and numbers with hyphens allowed. Bet this change drove the prisoners at Raiford crazy trying to figure these out. Somewhere around this time the county numbers were discontinued and the county name was written on the plate as it is today. Validation stickers also began at a cost the same as for a new plate. Also in 1973 the driver's license program was changed to permit two or four year licenses rather than obtaining a new one each year. The good news was that if you selected the four-year license you only had to have your picture taken one time and you saved fifty cents over the four years! Somewhere along the way it was decided that your license plate would be renewed on your birthday rather than on January the first each year.

By December of 2000 it was also possible for you to choose one out of 52 specialty plates with all sorts of colors & logos thus further confusing the visual identification of a Florida car by its license plate and the inmates if they were still making license plates.

In 2005 we really got wild with a choice from 186 types of license plates as follows: standard/personalized 5, disabled persons 2, legislative/diplomatic 6, commercial vehicles 8, military services 13, Native American 2 (They used to get these free but I don't know if that's true today as they're rich casino owners.), historic vehicles 5, others 9 (amateur radio, X-series, dealer standard and motorcycle, manufacturer standard and motorcycle, press, temporary employment, and temporary license plate), collegiate 36 (Some schools I've never even heard of and I am a native.), professional sports 9, environmental/wildlife 15, special-interest 40, governmental 26, authenticated 1.

Now ain't progress summin, I just had to quit trying to see if more varieties are produced today.! At least "FLORIDA" remains on each license. It is illegal to cover the state name with a frame, but perhaps they've even erased that law now. **Thank our troops for being able to celebrate July 4 in freedom.**

Try to visit the Museum of Medical History display case at the first floor auditorium at Gulf Coast Medical Center.

Liability Factors Entailing the Hospitalist Model

Cliff Rapp, LHRM, VP, Risk Management, First Professionals Insurance Company/Anesthesiologists Professional Assurance Company

While there are myriad types of hospitalist models, none possess a distinct risk management advantage over another. In some models, medical groups schedule primary care physicians (PCPs) to act as dedicated admitting physicians. In other models, full-time hospitalists are employed for the exclusive provision of all inpatient care. Gaining in popularity is a model being utilized by both large and small group practices that uses hospitalists to admit patients from the emergency department, manage long-term admissions, assist with transitioning of patients from ICU to skilled nursing and in discharge planning. The most common model is that of the "traditional" hospitalist model (if there is such a thing); dedicated hospital staff physicians whose primary professional focus is hospital medicine. Under this type of model, hospitalists manage patients throughout the continuum of hospital care, serving as the physician of record for hospitalized patients referred by a PCP upon admission and referred back to the PCP upon discharge.

Most practicing hospitalists (more than 80%) are trained in internal medicine.[2] However, hospitalists have evolved into a medical specialty group that is growing both in number and sophistication. There are definite advantages for both physicians and patients in the hospitalist model.[3] Work flow efficiency and economics are decided PCP pluses. Some of the advantages cited by the American Medical Association (AMA) include:

- Increased experience with inpatient conditions and procedures that could translate into better outcomes;
- Improved quality of care and clinical outcomes, particularly with severely ill patients;
- Improved efficiency and patient satisfaction in the inpatient setting because hospitalists are available full time;
- Improved quality, efficiency and patient satisfaction in the outpatient setting because office-based physicians are not interrupted by inpatient rounds, emergencies and travel time to the hospital;

The AMA also notes disadvantages to the hospitalist model [4] that include:

- Compromised quality and continuity of care;
- Overall loss of communication between the patient and their PCP during hospitalization;
- Decreased satisfaction in hospitalized patients unable to see their PCP;
- Erosion of certain hospital-based skills and judgment attributed to the lack of PCP participation in inpatient care;
- Decreased physician satisfaction by not seeing inpatients;
- Possible loss of hospital staff privileges.

Discontinuity of medical care between inpatient and outpatient care is the most prevalent root cause of malpractice claims in the hospitalist model.[5] Discontinuity of care encompasses such risks as abandonment, allegations of negligent referral, and patients lost to follow-up. However, perhaps the greatest risk is that of patients that are unaware or who do not understand the hospitalist model. Such patients may feel as if they have lost control over their medical care and been abandoned by their PCP. Physicians that participate in a hospitalist model should inform their patients that hospitalists may care for them in the event that they require hospitalization. It should also be stressed to the patient that while a hospitalist may provide inpatient care, their primary physician will remain informed and available to confer, when necessary, with the hospitalist. Informational brochures are a good way to educate patients in this respect and go a long way in helping to establish realistic expectations. They also become powerful exhibits in the event a claim should arise.

Communication between the hospitalist and PCP is an absolute factor in the success or failure of a hospitalist model, regardless of type. Faulty transition between inpatient and outpatient care can result in the lack of communication of important clinical information at the hand-offs between PCP and hospitalist. Consequently, the hospitalist should adhere to a communication process and information exchange that keeps the PCP informed about hospitalized patients at points of admission, significant junctures of care, change in clinical condition and at discharge. From a liability standpoint, the hospitalist has a responsibility to notify the patient's PCP of the diagnosis, clinical status, discharge plan and any necessary follow-up. To ensure an adequate exchange of clinical information, the PCP and hospitalist should maintain open dialogue and agree upon a "game plan" of periodic updates.

Communication upon Admission

- History of illness
- Current medications
- Recent relevant test results
- Pending tests
- Advance directives
- Pertinent social history/circumstances
- Current clinical status
- Medical game plan

Communication during Hospitalization

- Diagnosis and revisions to same
- Significant changes in management strategy
- Condition downgrade
- Transfer to critical care unit
- Important consultations
- Complications and misadventures
- Death

Communication upon Discharge

- Final diagnosis and clinical condition
- Results of significant procedures and lab values
- Pending or incomplete test results
- Discharge medications and regimens
- Out-patient services and equipment ordered
- Specific follow-up needs and recommendations
- Information given to the patient and/or family

Consider the malpractice case brought against a hospitalist and PCP involving a 73- year-old female, discharged on Coumadin after a brief hospitalization. The patient's PCP was informed of the admission but not of the need to follow up for an INR and continued anticoagulation management when the patient was discharged. Consequently, the patient's Coumadin dose was never adjusted after she was discharged, contributing to a cerebral hemorrhage two weeks later that resulted in permanent brain damage. The hospitalist was unable to defend his failure to inform the PCP of the need for follow-up. The PCP was unable to defend the lack of communication with the hospitalist and the patient. Settlement of the case was necessitated in the amount of $2.67 million.

Continued Next Page

The greatest risk to both hospitalist and PCP in a hospitalist model is that the patient will be lost to follow-up after hospital discharge. In most cases, a hospitalist will direct the patient back to the PCP for any continued outpatient care and treatment. Therefore, discharge summaries should be provided to the patient together with other pertinent information that the PCP may need to maintain a continuity of care.

Risk Management Guidelines for Hospitalists

- Notify the PCP of admissions. Include the admitting diagnosis
- Establish a communication plan with the PCP
- Notify the PCP of clinical impressions, diagnoses and treatment plans
- Document all communication with the PCP in the patient's medical record
- Advise the PCP when multiple hospitalists will attend the patient
- Periodically update the PCP with the patient's progress
- Notify the PCP of significant changes in the clinical status and diagnosis
- Refer the patient back to the PCP at discharge
- Complete the discharge summary in a timely manner and copy the PCP
- Directly notify the PCP of any discharge instructions, final diagnosis and other salient clinical information
- Provide a complete list of medications to the PCP (or the next physician when a patient is referred or transferred) and the patient or caregiver

Risk Management Guidelines for PCPs

- Implement a structured process for communicating with the hospitalist by telephone, fax or other electronic method
- Advise the hospitalist as to how and when to be contacted
- Provide the hospitalist with current clinical information, the most recent history and physical, outpatient records, medication list, allergies, and pertinent diagnostic studies
- Ensure that the hospitalist has direct access to you or a designated practitioner
- Ask to be notified of any complications during the admission
- Contact the hospitalist at least once during each patient's admission
- Ask the hospitalist to communicate pending or outstanding test results
- Request that the hospitalist call should the patient require prompt follow-up in the office
- Document all communication to and from the hospitalist

With a modicum of risk management effort, the most prevalent liability issues entailing a hospitalist model can be minimized. As is the case with most loss prevention measures, effective communication remains the chief caveat.

For additional information on hospitalists, visit the National Association of Inpatient Physicians website at www.naiponline.org.

References

(1) Wachter, RM, "Hospitalists in the United States-Mission Accomplished or Work in Progress," NEJM, 350: 1935-1936, May 6, 2004
(2) American Medical Association Council on Medical Affairs. CMS Report 4-A-98. *The Emerging Use of Hospitalists*, presented by Arthur B. Traugott, MD.
(3) American Medical Association Council on Medical Affairs. CMS Report 4-A-98. *The Emerging Use of Hospitalists*, presented by Arthur B. Traugott, MD.
(4) Id.
(5) Lucas, BD, Working with hospitalists to improve continuity of care. Patient Care 2000 Jan 15; 34(1):138-42

Cliff Rapp, LHRM, is Vice President, Risk Management for First Professionals Insurance Company and Anesthesiologists Professional Assurance Company. Headquartered in Jacksonville, Florida, FPIC and APAC are leading professional liability insurers for physicians, dentists and other healthcare providers.

Addressing Health Care Change

Ronald Castellanos, MD
Past President LCMS and a Member of MedPAC

Today's economic crisis, together with our unprecedented federal spending and the growing number of uninsured people puts a tremendous pressure on the health care delivery system.

Comprehensive overhaul of the health care system is no longer an option but a necessity.

Slowing the growth of the health care costs escalation is one of the most important things we can do to improve the long term fiscal health of our nation. Health care reform is an integral part of our economic recovery legislation and a central pillar of President Obama's recovery plan.

Our governments' focus is preserving Medicare for future generations. The physician's focus is providing the best possible care for our patients. Physicians need to start thinking and getting involved on how to serve society, as well as our patients.

We need to join the battle to make health care more affordable and sustainable for our patients, ourselves and for the future generations.

We need to make sure that our patients get everything they do need but also make sure they do not get a lot of the things they do not need.

We cannot escape the fact that Medicare spending on physician services has grown at a rapid rate. Studies have shown that about 30% of what physicians do may not be necessary. I think that we all agree that not every single thing we do is absolutely necessary. There are many reasons for this increase in volume of services to include:

- a broken malpractice system
- defensive medicine
- patient demands
- technology advances
- geographic variation
- gaps in our understanding of what works best
- poor care coordination

We can either address the cost issues ourselves, or others will do it for us. These are not comfortable times for physicians in America. Our world is changing. Others may not also have the best interest of our patients at heart. We can let others chart the course for us or we can take the helm and help guide the changes ourselves.

LCMS Volunteers Perform Student Athlete Participation Physicals

Abbott Kagan II, MD

On Saturday, May 9, 2009, volunteers from the Lee County Medical Society donated their time to perform student athlete pre-participation physical examinations for the 2009 – 2010 school term at Bishop Verot High School. As in previous years, a nominal fee was charged for each athlete, and the monies collected were donated to the school athletic department.

This year we examined 129 student athletes. There were 87 males and 42 females. The exams took about three hours to complete, but additional time was required to review the results and make decisions about further referrals. This time requirement does not include set up time for the facility, nor does it include clerical and administrative time.

In all, we cleared 122 student athletes for sports participation, but referred seven (two females, five males) for further evaluation or follow-up. Referrals were made to:

Left to right: Drs. Milt McCurdy, Jaime Alvarez, Chris Marino, Don Moyer, Paul Bretton, Abbott Kagan, Todd Atkinson, Paul Liccini, Subhash Pal, Alex Lozano, Tim Underhill, Natasha Johnson ATC, Travis Gresham, Michelle Petrites RN, and Mark Petrites. Not Pictured: James Butler DO, and Stu German, PAC.

- Cardiology – two.
- Orthopedics – five. Three under active care for existing problems were referred back to their treating physician for clearance.

It was particularly gratifying to follow up with several athletes who had medical conditions discovered at our last examination return to sport after successful treatment.

Five students were referred to the school nurse for further monitoring of high blood pressure noted at exam time.

We are thankful for being able to offer eye exams as part of our physicals. For many years, Travis Gresham OD and Tim Underhill OD have brought equipment to measure not only visual acuity, but also stereoscopic visual function which is extremely important for skill athletes. Their screening revealed eight students failed visual acuity tests, eight failed stereoscopic vision testing, and six failed both evaluations.

My most sincere thanks to all the physicians who graciously gave their Saturday morning to help these student athletes, and special thanks to Natasha Johnson (Athletic Trainer) who coordinated these exams.

News from the Board of Medicine

Patient Boundaries

Crystal A. Sanford, CPM, Program Operations Administrator, Florida Board of Medicine

This portion of the *Top 10 Tips to Avoid Problems with Your License* series is about patient boundaries. You might think this is pretty straightforward – you don't date your patients. However, in this day and age, sometimes the line may not be so clear to the practitioner.

Let me give you an example. A male physician treats a female patient in a walk-in clinic. A month or so later, the physician is looking for a partner on one of the online dating services. He meets a lady, starts emailing with her and they decide to meet. Well, guess who shows up . . . his patient. Would you know what to do if this happened to you?

Here is another example. A physician's significant other asks for a refill of a prescription that his/her primary care physician provided because he/she forgot to get the refill before the couple went on a trip/cruise. By writing that refill, a physician-patient relationship was created and all the rules of the physician-patient relationship apply. Remember, spouses do not always remain spouses and significant others don't always remain so either.

First let's establish the meaning of a physician-patient relationship. Although there is no specific definition, the relationship is established at the point the physician agrees to "treat" the patient for a specific condition. Once that has occurred, the physician is under an ethical and legal obligation to care for the patient until that relationship has been formally terminated.

So, exactly how do you terminate a physician-patient relationship? Although there are no laws or rules regarding this specifically, we recommend that you send your patient a certified letter withdrawing care. In your letter you will

- Include the date the physician will no longer assume care – should be approximately 30 days to allow the patient time to obtain a new physician
- Include that the physician will continue caring for the patient on an emergency basis for the duration of the 30 days
- Advise the patient that his/her medical records are available and instructions for obtaining the records
- Advise the patient if his/her condition requires continued treatment and stress to the patient the importance of obtaining another physician as soon as possible

The Board has found that sexual misconduct in a physician's practice is a violation of not only the law but also the trust upon which the physician-patient relationship is founded and; therefore, the board has a zero tolerance for sexual misconduct. Penalties for a sexual misconduct violation first offense include a one (1) year suspension, reprimand, and a $5,000 - $10,000 fine. Second offense is permanent revocation. Don't let yourself get caught in this situation. In addition to using common sense, know the laws and rules.

The laws and rules that apply to physician-patient boundaries are:

- s. 456.063, Florida Statutes
- s. 458.329, Florida Statutes
- s. 458.331(1)(j), Florida Statutes
- Rule 64B8-9.008, Florida Administrative Code
- Rule 64B8-8.001, Florida Administrative Code

Florida Statutes (laws) can be found at http://www.leg.state.fl.us/statutes/index.cfm and Florida Administrative Code (Rules) can be found at http://www.leg.state.fl.us/statutes/index.cfm.

Update: The Board of Medicine's *Web Board* has changed. The old site is no longer available. For a no-cost, automatic e-mail of every new item put on the Board website, you can subscribe and unsubscribe by going to this web site: http://flems.doh.state.fl.us/mailman/listinfo/boardofmedicine

Health Management Association Scholarship in Memory of Robyn Wright

At Health Management Association's request, Florida Gulf Coast University Foundation has established a scholarship fund entitled HMA Scholarship in Memory of Robyn Wright. All Contributions given in Robyn's memory will be place in this fund.

The goal of HMA is to establish an invested fund that will continue to generate an annual scholarship in perpetuity (endowed fund). Ten Thousand dollars or more establishes an endowment.

HMA will continue to raise funds throughout 2009. We will be collecting contributions at each luncheon. Terri Bohinic has donated a quilt that will be raffled at the Holiday Luncheon in December. Raffle ticket sales will be donated to the scholarship.

All donations will be matched by the HMA. Our goal is to reach $10,000 mark by 12/31/09. Donation for the scholarship may be sent to: HMA Scholarship in Memory of Robyn Wright
10501 FGCU Blvd S • Fort Myers, FL 33965
239-590-1067 (credit cards accepted)

Is the Healthcare Clinic Establishment Permit right for your practice?

Sharon Roberts, PharmD, RPh, JD - Strawn & Monaghan, PA

Question: Does your office practice order prescription drugs for office administration?

The new permit

Effective January 1, 2009, many health care practitioners' places of business including physicians' offices, clinics, veterinarian offices, etc., became subject to a new Florida law requiring a health care clinic establishment (HCCE) permit to purchase prescription drugs for administration to patients in the office. This permit does not apply to physicians who dispense drugs to patients.

If your practice is organized as a professional association, (P.A.) or professional limited liability corporation (PLLC), you may want to consider obtaining a HCCE permit for your practice. Depending on your business model, the HCCE permit may actually be necessary for your practice to maintain compliance with the Florida laws and rules. However, it is also true that many practices may have already obtained this permit in error, thereby subjecting themselves to unnecessary regulation and surprise inspections.

Historical issues

Historically, physicians and other health care practitioners had their office manager, nurse or other office staff place the orders for the medical supplies, including the prescription drugs, without much thought except for perhaps the close eye that was kept on controlled substances or pain medications to assure they were secure in the office. Often times, the physician had no knowledge of where the prescription medications came from, how they got to the office or which physician or practitioner used which prescription drugs. Much of the paperwork generated and kept on file by the wholesaler and physician office was inadequate and many times the vendor of the prescription drugs was not properly licensed or did not pass the proper paperwork on to the physician offices.

These types of practices left physician practices wide open for regulatory scrutiny, and in recent years, State inspectors have begun to ask question of these practices like:

Multiple physician/practitioner offices:
Which practitioner owns the prescription drugs in the medication room?
Are all the doctors using the same prescription drugs?
Are the dispensing practitioners using the same prescription drugs as the non-dispensing practitioners?

Multiple practice sites for one physician:
Are the physicians/practitioners taking the prescription drugs with them from one practice site to another?
Does the practice order and pay for prescription drugs from their corporate location and have the drug delivered to one of the practice site locations?

Why more regulation?

Unfortunately, times are changing and there is a growing problem of drug diversion to the habitual user and for profit. In addition, physician practices are starting to notice that the costs of the prescription drugs are increasing substantially and that regulations are creating obstacles to getting drugs needed for their office practice.

In an effort to track the flow of prescription drugs to health care practitioners, the State of Florida has implemented a new law that would allow a business entity to register with the State as a Health Care Clinic Establishment (HCCE). This permit enables the practice to own and control the prescription drugs at each physician practice address. This new permit can be beneficial to the practitioner because it gives the office practice a clear audit trail and ability to keep and track their prescription drugs. The permit also gives the State better knowledge and control over the flow of prescriptions drugs.

When this law was first implemented, many practices were told incorrectly they had to have this permit to order prescription drugs. For some practices the permit would be beneficial. However, for most practices, the permit only serves as another tax while raising the risk of annual inspections by state regulators.

If your office practice has recently applied for, received or is considering a HCCE permit this may or may not be right for your practice. Either way, make sure your office ready to face a State Inspector.

Sharon Roberts PharmD, JD, is a past Florida Department of Health, Drug Inspector who is currently a Licensed Clinical Pharmacist as well as a practicing healthcare and regulatory attorney with Strawn and Monaghan, PA in Palm Beach County.

Lee County Medical Society Alliance and Foundation News

Mary Macchiaroli, President, Lee County Medical Society Alliance

The Lee County Medical Society Alliance has new leaders! A new presidential committee was elected and installed at the annual Installation Luncheon, held May 20th at The Renaissance Club. The committee is comprised of Nancy Barrow, Lynne Gorovoy, Nicole Laquis, Mary Macchiaroli, Barbara Rodriguez, Betty Rubenstein, and Sherri Zucker. Once again, the group will share the duties of the president.

Anne Wittenborn will be e-mail contact person for the Alliance and serve as Secretary; Sherri Zucker will serve as Treasurer; Nicole Laquis will host and chair Board meetings; Barbara Rodriguez will serve as Membership Chair; Lynne Gorovoy will serve as the phone contact person for the Alliance; Betty Rubenstein will serve as Legislative Chair; and, Mary Macchiaroli will serve as Newsletter Chair.

The new leaders will guide the work and progress of the Alliance in the 2009-2010 leadership year. They are already hard at work planning events for next fall.

The traditional "Potluck in Paradise" is taking on a new twist this year. It has been renamed "Fall in Love with Lee County" and will take place on October 10th at Dr. Jim and Mrs. Betty Rubenstein's beautiful home. Rather than bringing a potluck contribution, it will be fully catered by Danny Mellman, and there will be a small fee for attending. It will still be a festive, purely social evening, just without the hassle of bringing a covered dish! You won't want to miss it.

We are hard at work planning the annual Welcome Brunch as well. Juli Bobman and Tracey Cullimore are chairing the event. Please let them know if you have or will have new physicians in your practice so we can invite them and their spouse (if applicable) to the brunch. The date has been set for September 9th.

John Miksa is back as Supper Club/Happy Hour Czar for the coming year. Those events will start in September.

Thank you to all who made this past year a success. Huge thanks go to the Presidential Committee: Nancy Barrow, Lynne Gorovoy, Nicole Laquis, Barbara Rodriguez, Betty Rubenstein and Sherri Zucker. They really pulled together when we needed leadership at the beginning of the year. Thank you Lynne Gorovoy for hosting all of our board meetings in your beautiful home (and for all the delicious treats!) as well as for hosting the Supper Club events. Thank you Howard and Nancy Barrow for hosting, and Nancy and Barbara Rodriguez for chairing our fundraiser February. Thank you Anne Wittenborne and Siobhan Benbenisty for chairing the Holiday Charity Basket raffle. Thank you Sherri Zucker for chairing the Holiday Sharing Card. Thank you Steve and Jane West for chairing and hosting our Potluck in Paradise at your beautiful home! And finally, thank you Betty Rubenstein and Sherri Zucker for chairing and hosting the Welcome Brunch!

We are truly lucky to have so many wonderful members in our Alliance. We are also incredibly fortunate to have the wonderful staff of the Lee County Medical Society to support all of our efforts. Thank you Ann, Cynthia and Marion for all that you do to keep us thriving!

Physician Profiling: What You Don't Know Can Hurt You

Written by AMA Private Sector Advocacy staff

Big news related to physician profiling came out of New York last year, when Attorney General Cuomo announced his landmark settlements with insurers operating in his state. Resulting from these settlements, the insurers are now required to submit the rating criteria they use to place physicians in tiered networks, in which members pay lower co-pays or otherwise receive discounts for seeing favored physicians. In addition, these insurers must abide by a set of standards for their physician profiling programs and hire an independent Ratings Examiner to report to the Attorney General every six months or incur penalties.

Shortly after the insurers signed agreements with Mr. Cuomo, members of the Consumer-Purchaser Disclosure Project adopted The Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs. Under this voluntary agreement, health insurers will follow a set of standards, hire an independent entity to audit their programs to ensure they use valid measures to rate physicians, and work toward pooling their data.

Although neither the New York settlements nor the Patient Charter is a panacea for the problems associated with physician profiling, they represent important steps forward. However, the AMA contends that all physician-profiling programs must follow standards that require the use of valid methodologies, promote transparency at all levels, and assure accurate results. In order to encourage legislation on physician profiling programs, the AMA developed a model bill, which mandates profiling programs adhere to a set of standards, use valid quality standards, properly adjust for risk, use sufficient sample sizes, and correctly attribute episodes of care. Additionally, insurers must fully disclose the methodology used to profile physicians and disclose the limitations of the methodology, profile physicians at the group level, establish a reconsideration or appeal process, and hire an independent third party to oversee the program.

Recently, Colorado Gov. Bill Ritter signed legislation aimed at regulating the physician rating systems used by many of the state's health insurers. The Colorado law requires health insurers to make their processes for profiling, rating or characterizing physicians more transparent, and ensure greater accuracy in the results. The law also provides for an appeal mechanism so physicians can challenge the validity of their rankings prior to their release or use by health insurers.

Regulations like those adopted in New York and now Colorado, and documents such as the Patient Charter are essential to help ensure that the physician performance information that health insurers provide patients is both reliable and meaningful. They establish processes that temper some of the inherent risks that can result from physician profiling.

While the AMA neither supports nor opposes physician profiling per se, when it is done, patients and physicians have the right to understand how the profiles are developed as well as an expectation that the results accurately reflect the realities of the physician practice. Some health insurers have unfairly evaluated physicians' individual work. Not only can incorrect and misleading information tarnish a physician's reputation, it is unfair to patients who may consider it when choosing a physician. Erroneous information can erode patient confidence, trust in physicians, and disrupt patients' longstanding relationships with doctors who know them and have cared for them for years.

In an effort to assist physicians engaged in programs that use physician data, the AMA Private Sector Advocacy (PSA) unit created an entire series of informational pieces designed to help physician practices understand and effectively deal with such programs:

- Physician Pay for Performance Initiatives is a white paper detailing all facets of the pay for performance movement.
- How physician incentives are used to impact medical practice describes the various incentive models in use and provides examples of these models in practice.
- Tiered and narrow physician networks explains how these networks are constructed and gives numerous examples of programs in place.
- Pay for performance: A physician's guide to evaluating incentive plans provides physicians with a roadmap to evaluating pay for performance programs.
- Optimizing outcomes and pay for performance: Can patient registries help? describes how patient registries may be used to enhance pay for performance opportunities.
- Economic profiling of physicians: What is it? How is it done? What are the issues? is another white paper that explains how cost of care measurement is performed and what its abilities and limitations are in providing accurate results.
- How to Challenge Your "Profile" or Placement in a Tiered or Narrow Network is a one-page document that gives physicians a systematic process to follow for challenging their profile ratings.
- Physician Profiling: How to prepare your practice provides physician practices with steps to take to be well prepared for profiling programs.
- TO OUR PATIENTS is a poster designed for physicians' offices to educate their patients on the problems with physician rating systems.
- A Comparison of 4 Physician Profiling Programs is a chart comparing key components of The AMA model bill, the Colorado law, the Patient Charter and Mr. Cuomo's settlement with CIGNA.

Thanks to Representative Nick Thompson

Teresa Stevens, MD, Island Coast Pediatrics

I would like to call the attention of our medical community to legislation created by Florida State Rep. Nick Thompson that allows physicians to communicate with the Department of Children and Families during or after an investigation. "The Zahid Jones, Jr. Give Grandparents and Other Relatives a Voice" bill, was signed by Governor Crist on May 20, 2009 and becomes effective July 1, 2009. The legislation is designed to provide greater involvement of family members in child protection hearings, but an important paragraph addresses communication with physicians, psychologists, and other medical and mental health professionals who are mandatory reporters of abuse.

The tragic death of Zahid Jones, Jr. two years ago and the media attention that followed highlighted the challenges of communication between DCF and its community resources. The Florida Department of Children and Families investigates over 180,000 Hotline reports per year on a limited budget. Substantiated reports result in continued supervision and ongoing care. Reliance on community professionals is increasing, and our legislation needs to evolve to accommodate this.

When reporting physicians can't obtain information about an investigation, and aren't informed about the outcome, their ability to protect their patients is compromised. This creates the sense of futility most Florida physicians currently experience when a report is made. The death of Zahid Jones prompted me to research the statutes and policies in Florida that allowed this to occur. I found that Florida DCF is restricted by privacy legislation that differs from many other states. Rep. Thompson was gracious enough to review these limitations and include these changes in his proposed legislation for Grandparents' rights.

It is important for physicians in Florida to understand the avenues of communication that exist when reporting a case of suspected abuse. We are required to take CME in Domestic Violence, but the approved coursework contains little information on the legal requirements and rights of mandatory reporters. Insight into the physical findings associated with abuse is meaningless if we cannot function effectively within the system that investigates these findings.

Currently, physicians who report a case of suspected abuse to the Hotline can request a written summary of the outcome of the investigation, which they should receive within 10 days after it is closed. They are entitled to information during the investigation if they believe it is necessary for the patient's immediate safety, although they may have difficulty getting the information if the investigator is not aware of this policy. If physicians believe that an investigation is not being conducted thoroughly, or that ongoing abuse is occurring, they can contact law enforcement directly about their concerns. HIPAA regulations do not restrict communication regarding the safety of a child that is disclosed directly to the Child Protection team, the investigating DCF personnel (and their supervisors if necessary), the Sheriff's Dept, the local Police Dept or the State Attorney's office. This information is not well publicized and many physicians are not aware of it.

The new legislation allows for three new communication avenues:

1. When a mandatory reporter places a Hotline call, this legislation requires that they be contacted within 24 hours by the local investigator and be allowed to submit a summary of their concerns *in writing*. This written summary is included in the permanent file that is reviewed by DCF, law enforcement, and the judge who decides the child's placement. Without this written summary, the judge may not know that the report was initiated by a physician because only your name, and not necessarily your profession, is included in the Hotline report. Be specific about your findings and do not assume that they will be confirmed by the Child Protection team. Their exam and interviews may not be conducted until several days after the report. DCF can request medical records after obtaining signed consent from the parents, but this may not occur.
2. When you become aware that your patient has been the subject of a report in the past, or that household members have been investigated previously, you can now request the summary of those reports. This addresses some common situations we face: families switching to a new medical office each time a report is made, injuries treated in multiple ERs, or subsequent births to a parent whose older children are in state custody. Access to this information previously was only available to school principals and governmental agency personnel, and this legislation extends it to physicians, psychologists and other mental health professionals.
3. Records including photographs are to become a permanent part of the investigative record, and the record will be kept until a child is 30 years old. All investigations for a particular child are accessible through the Department tracking system.

These changes allow Florida DCF investigators to interact more effectively with medical and mental health professionals. We can thank Representative Thompson for his willingness to weave a tighter safety net for the children in our communities.

Lee County Medical Society

3805 Fowler Street Ste 2
PO Box 60041
Fort Myers, FL 33906-0041

PRSRT STD
US POSTAGE
PAID
FT MYERS, FL
PERMIT NO 534

CHANGE SERVICE REQUESTED

Together We Are Stronger