“Doctors paved the road to hell with pain pills”

That is an eye catching title isn’t it. While I used quotation marks because I could not find a sarcasm font, this was the actual title of an article in Bloomberg science a couple weeks ago. Since the CDC released its current recommendations for prescribing of opioids because of the “doctor driven” epidemic, there has been a fire storm of media articles and press releases. Unfortunately most of these stories do not paint our profession in a good light. While the profession a medicine is definitely not without fault, many of factors that led to the expansion of narcotic prescribing are not touched upon. It is amazing the change over the last 20 years of the perception and ethics of narcotic prescribing. I looked back over the last 20 years or more at the discussions and published literature on narcotic prescribing and it is quite fascinating.

In the late 80s there seemed to be great concern over physicians’ unnecessary fears about prescribing pain medication. There arose terms such as “opiophobia” in respectable journals such as the New England Journal of Medicine and the Journal of the American Medical Association. There was debate on the unethical approach that physicians had in not treating chronic pain. The DEA was seen as a hindrance and new laws and regulations started to be enacted to make prescribing narcotics easier. There is soon began to be actions by state medical boards, regulations and laws against physicians considered not to be adequately treating chronic pain. The California medical board began abdicating for a positive legal duty on the part of physicians to effectively treat pain and suffering. In 1997 California assembly enacted “The Pain Patient’s Bill of Rights.” In 2001 assembly Bill 487 was introduced into the California assembly which mandated the California medical board order physicians to complete mandatory continuing education for those physicians who were felt to inadequately treat patients’ chronic pain.

In 1998 the joint commission on accreditation of healthcare organizations began to explore its role in making the quality of pain management a priority with hospital accreditation. The new standards were developed and became part of compliance scoring in 2001. The joint commission even published a guide sponsored by Purdue Pharma stating “Some clinicians and hospitals are implementing restrictive guidelines about addiction, tolerance and the risk of death. This attitude prevails despite the fact that there is no evidence that addiction is a significant issue when persons are given opioids for pain control.” The joint commission released a statement on the 18th this month stating that they never required the treatment of pain and the assessment of pain on every patient is not necessary (it was necessary until this rule was changed in 2009). Clearly they were trying to absolve themselves of any responsibility in this mess.

CMSs deluded effort to improve quality led to the introduction of the HCAHPS scoring system which included assessments for patient satisfaction with their pain control. I recently looked at my HCAHPS scores which my clinic uses with its participation in PQRS and saw the question “was your pain adequately controlled?” Two of our PQRS measures are assessment of pain on every patient and plan if the pain score is not zero. In 2013 Forbes magazine noted that hospitals were using HCAHPS scoring as a punitive measure affecting physician payment. CMS tried absolving itself a blame and a recent JAMA editorial noting “there are reports that some hospitals link individual physician or physician group financial incentives to performance on this aggregated HCAHPS responses. This is contrary to the survey is designed and policy aim.” Unfortunately CMS did not address this issue at all when discovered in 2013 despite being known to them.

In line with the CMS HCAHPS surveys, Press-Ganey surveys are used frequently by hospitals and institutions to influence salaries and payments to physicians. Press Ganey has already stated that narcotic seekers do not return patient satisfaction surveys at the rate regular continued on page 6
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2016

TRUVEN HEALTH ANALYTICS

ECMS | 2
**E.C.M.S. Bulletin**
The Bulletin is a publication for and by the members of the Escambia County Medical Society. The Bulletin publishes six times a year: Jan/Feb, Mar/Apr, May/Jun, Jul/Aug, Sept/Oct, Nov/Dec. We will consider for publication articles relating to medical science, photos, book reviews, memorials, medical/legal articles, and practice management.

**Vision for the Bulletin:**
- Appeal to the family of medicine in Escambia and Santa Rosa County and to the world beyond.
- A powerful instrument to attract and induct members to organized medicine.

**Mission:**
The mission of the Escambia County Medical Society is to promote the art and science of medicine in order to improve the health of our community. | Tradition – Honoring the history of medical care in Escambia and Santa Rosa counties. | Service – Serving the needs of our community through the service of our members in the practice of medicine. | Leadership – Meeting the challenges of the future and safeguarding our community’s health through organized collaboration on the local, state, and national level.

**Never Forgotten**
Leopoldo Delfinado Villanueva, M.D. (1938-2016)
Leopoldo Delfinado Villanueva, M.D. of Pensacola, FL passed away on Divine Mercy Sunday, April 3, 2016 at age 77 due to complications from diabetes. He was born August 9, 1938 in Bacnotan, La Union, Philippines, he was the only child of Emancio and Pepita Villanueva. He graduated a Doctor of Medicine from Far Eastern University in Manila in 1965. He was an active member of ECMS from 1976-present.

**ECMS STRATEGIC PLANNING 2016-18**
**ARTICLE ON PAGE 4**
When I was told that we were undertaking a “re-branding” of the Escambia County Medical Society in an effort to modernize and to make sure that the society was fully representing the interests of our member physicians, I was very excited, as was the entire ECMS board. However, when I was informed that this would require the board to meet on a Saturday for an all-day strategic planning session, my enthusiasm waned, momentarily, anyway. I thought, couldn’t we find a way to do a conference call or Skype it all in? The answer was, of course, no, we couldn’t, this was to be a serious strategic planning workshop with the aim of defining our future goals for the society and to begin the implementation phase of creating a more modern medical society.

Under the leadership our President, Dr. Brian Kirby, Vice President, Dr. Hillary Hulstrand and the other board members that attended, Secretary-Treasurer, Dr. Karen Snow, Dr. Jennifer Miley, Dr. John Lanza, Dr. Brett Parra and myself, along with our Executive Director, Erica Huffman, we formulated what I believe to be a sound long-term plan for our society. I am convinced that the members of our society are going to embrace the efforts of the board as we move to modernize, not only the day to day workings of our society, but the mission of our society. This plan calls for our society to commit to the preservation of the professionalism of medicine which is rapidly eroding at this time and to become more proactive in advancing the physicians’ ability to practice medicine in our community.

One of the goals of the strategic planning committee includes increasing the value of membership by working to unite physicians, employed and independent, of all specialties and backgrounds, as we attempt to advance positive change. We will strive to provide more opportunities for networking, socializing, and interacting in order to promote collegiality and physician camaraderie. In the hurried world of medical practice, the chance to enjoy being with fellow physicians is lacking and we would like for that to change. We will plan and promote more meaningful CME opportunities and strive to keep those educational opportunities relevant, low-cost or free.

The ECMS will strive to increase its visibility in the community by promoting health education campaigns, charitable efforts, excellence in medicine recognition, and promoting the ECMS foundation. This will reflect positively on our member physicians and will highlight those physicians involved intimately in individual projects. Many physicians participate in these types of outreach programs anyway, we as a society, however, will be more active in promoting what our members are doing. This promotes good will in the community and helps us to remain in the eyes of the public as the true authorities on the promotion of wellness and the primary advocates for the medically needy in our community. As an example, we are sponsoring “Walk with a Doc” later this year. Patients will be able to do a walk with their physician and this will be used to promote health awareness. Please consider joining us in this effort. There will be many more of these types of opportunities presented to our members.

As the society works to fulfill its goal to preserve our professionalism and to modernize in this ever more complex medical landscape, we must become more active legislatively. The board has authorized the formation of a legislative advancement team (LAT) which will commit to understanding medical politics and to bringing those important issues to the medical society. For instance, we had a legislative update last month attended by Representative Mike Hill and an attorney from the FMA giving us a run down on the past legislative session. This was very informative about what happened last session. However, what we actually need to know is what is coming up in the next legislative session so we can try to influence the outcome in a way that preserves our professionalism and advances our ability to practice medicine in our community thereby coming full circle on the goals outlined in our strategic plan.

There are exciting changes coming. The ECMS board invites all members to join us in our efforts to modernize and make our society more responsive to the needs of our members. Consider joining one of our advancement teams. The board has approved several of these teams including community health advancement team (CHAT), education advancement team (EAT), membership advancement team (MAT), so, there are teams to suit any interest. Also, please be more active by attending meetings and giving your input regarding what we are trying to do. Please encourage other physicians to look again at the ECMS as they may appreciate these efforts and may want to once again be more active.

When I decided to become active in “organized” medicine, I did so because I realized that if I didn’t, someone else, usually a non-medical type, was going to make decisions for me that would affect my ability to practice medicine and those decisions almost always have a corrosive effect on the profession of medicine, a profession that we all love. I think many of us feel that way. Now, is the time to start doing something about it and being more active in the ECMS is a great way to start.
2016 ECMS Doctors Day Celebration
Thursday, April 14th
Wahoos Baseball Game
patients do. Unfortunately none of these claims could be backed up with actual statistics. When you add in online doctor rating sites such as Health Grades or Yelp along with pressure from JACHO, CMS, and employers, there is incredible pressure and sometimes requirements to prescribe pain medication.

So now the pendulum swings and we start back the other way. The North Carolina medical board has just announce they will be beginning investigations of all the top percent of narcotic prescribers in the state. While I agree that there is an epidemic in this nation, narcotic prescribing needs to be addressed, regulation is not the answer, patient satisfaction is not the answer, and is what got us into this predicament to begin with. Unfortunately I suspect in the next 10-15 years I will be reading articles and press releases discussing how physicians, are afraid to treat pain and of course it will be our fault. Now more than ever we need to work together and make our voice heard and unfortunately the 996 pages of MACRA rules and regulations released this week are not going to help. Physician’s and organized medicine can make a difference, if we do it together. I look forward to seeing you all at the next meeting.

Thank you to our sponsors who helped to make this event possible for our physicians!
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TERMINATING THE PHYSICIAN-PATIENT RELATIONSHIP

by: Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor

The physician-patient relationship is created by mutual agreement between the physician and the patient. As such, the physician may terminate the relationship for any non-discriminatory reason. Valid reasons may include (but are not limited to) non-compliance with medical advice, combative or threatening behavior, or outstanding medical bills.

Patient non-compliance is one of the most common reasons for terminating the physician-patient relationship. Patients who routinely miss or cancel appointments or refuse to heed medical advice may be considered non-compliant.

Non-compliant patients might be your practice’s biggest liability risk. Patients are less likely to get better when they don’t comply with medical advice, placing them at higher risk for adverse outcomes. By properly terminating non-compliant patients, you may help reduce your risk of malpractice claims. It also is appropriate for practices to terminate hostile, aggressive, or verbally abusive patients.

Proper termination is important to help avoid a claim of patient abandonment. While the legal definition of abandonment varies from state to state, the following elements typically exist in a patient abandonment claim:

• termination of a professional relationship between the physician and patient without good reason or at an unreasonable time
• termination occurred when the patient was in need of continuing medical care
• the patient was not given reasonable notice sufficient to secure an alternate physician, and...
• the patient was harmed as a result.

The American Medical Association (AMA) summarizes your responsibility this way: once a physician-patient relationship exists, physicians are ethically obligated to place the patient’s welfare above all other considerations, including the physician’s own self-interest.

Once you’ve determined it’s prudent to terminate a patient from your practice, lower the risk of a patient’s claim of abandonment or malpractice by:

• Evaluating the patient’s condition and rendering stabilizing care, if needed. Avoid discharging a patient during treatment for an acute condition until the treatment is finished or the condition is resolved.
• When possible, discuss the termination and your reason(s) for termination with the patient. You may conduct the conversation via telephone or in person. We encourage the physician to have this conversation with the patient. Be sure to document this discussion in the patient’s medical record.
• Send a written letter to the patient confirming his or her termination from the practice. We suggest sending the letter by both regular mail and certified mail with return-receipt requested. If you choose to include the reason for termination in the letter, be sure you are objective and tactful in your choice of words. We suggest you include the following:
  • A specified period of time during which you will continue to provide care. The AMA suggests at least 30 days’ notice; however, there is at least one state that requires at least 60 days’ notice. Review your state’s laws before you terminate a physician-patient relationship.
  • A statement encouraging the patient to find another physician as quickly as possible.
  • Referral services to aid the patient in finding another physician. These services may include the local medical society or the state board of medicine.
  • Information on how the patient can get a copy of his or her medical record. You may want to consider including a release-of-records form to make this process easier.
  • A signature. We encourage the terminating physician to personally sign the letter and retain a copy of the letter in the patient’s medical record.

We also encourage you to contact any third-party payer or managed care provider that may be involved in the patient’s care. Some third-party payers and managed care providers have specific contractual obligations you must follow prior to terminating one of their covered patients.
One of the largest physician surveys ever completed in the United States, Survey of America’s Physicians: Practice Patterns and Perspectives paints a portrait of an evolving physician workforce whose practice styles and attitudes are changing. Based on over 20,000 physicians nationwide, this physician survey is conducted by Merritt Hawkins on behalf of The Physicians Foundation, a non-profit organization that seeks to advance the work of practicing physicians and help facilitate the delivery of healthcare to patients.

Data about today’s doctors derived from the survey include:
- 81% of physicians are at capacity or are overextended
- 26% participate in ACOs
- Only 35% are in private practice, down from 48% two years ago
- Physician morale is highest in North Dakota, lowest in Montana
- 13% of physicians plan to switch to concierge practice
- 33% participate in state or federal exchanges created by the Affordable Care Act
- Physician work an average of 53 hours per week

The biennial survey features over one million data points, and includes comparisons of survey responses by age of the physician, gender, state, specialty and practice status (employed physicians vs. independent).

The Survey of America’s Physicians offers an unrivaled resource of information on today’s doctors for hospital and medical group executives, physician recruiting professionals, members of the media, policy makers, the public and for physicians themselves.


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THE THREE OPTIONS IN A RANSOMWARE ATTACK: RESTORE IF POSSIBLE, PAY, OR LOSE PATIENT INFORMATION

by: Craig Musgrave, Senior Vice President, Information Technology, The Doctors Company

The news made national headlines: Hollywood Presbyterian Medical Center’s computer systems were down for more than a week¹ as the Southern California hospital became yet another victim of ransomware—an attack where a business or individual’s computer system is held hostage by cybercriminals until a ransom is paid. Hollywood Presbyterian Medical Center ended up paying $17,000 to restore its systems and administrative functions.

“The quickest and most efficient way to restore our systems and administrative functions was to pay the ransom and obtain the decryption key,” said Allen Stefanek, president and CEO of the medical center. “In the best interest of restoring normal operations, we did this.”

No healthcare provider wants to be in Mr. Stefanek’s position. Once ransomware is in your medical practice or hospital system, there are only three basic options:

1. If you have performed frequent backups, restore your system.
2. If you have not performed frequent backups, pay the ransom.
3. Put your system back to the default setting—and lose everything.

If before the attack you’ve performed incremental backups, you can restore the areas affected, with minimal data loss (for example, an hour). If you have point-in-time backups, you can restore with increased data loss (for example, a week). If you have no reliable backups, you can reset the technology back to its “out-of-box,” or default, state and lose all the data, if no paper records exist. The only other option would be to pay the ransom.

The key to handling any type of attack is to stop the spread once it’s identified. For example, Ottawa Hospital in Canada took the right steps when four of its 9,800 computers were hit by ransomware.² The hospital was able to find the virus, isolate it before it spread, and wipe the drives clean on the infected computers. The hospital was able to prevent loss of any patient information and avoid paying any ransom because it had saved critical data on servers instead of desktop computers.

Besides loss of business, inconvenience to patients, and damage to reputation, a ransomware attack also poses liability risks. The possibility of adverse events and subsequent claims for professional negligence increases when computerized systems necessary for various functions such as CT scans, documentation, lab work, and pharmacy needs are offline. If hospital systems are down for any significant period of time, certain patients should be transported to other hospitals.

Adverse events can occur when healthcare workers do not have access to EHR systems. However, if this type of case was litigated, the patient would have to prove that something in the records may have had a bearing on the treatment being provided. In the case of emergency care, the claimant would have to successfully argue that the staff should not have undertaken the care until the medical records could be accessed.

Another risk involves theft of patient records during the attack.

If patients’ personal information such as social security numbers and addresses are stolen, the physician practice or healthcare facility may be subject to claims for damages due to identity theft. If a HIPAA violation occurs because patients’ healthcare information is compromised, the practice or healthcare facility would face an investigation by the federal government and could face fines.

Hospitals, medical practices, and businesses should take full precautions to prevent a hack that results in ransomware being installed. Prevention strategies include:

- Provide security awareness for all employees. Over 80 percent of attacks are made possible by human error or human involvement. Train staff members to avoid downloading, clicking on links, or running unknown USB on computer systems.
- Block the malware at the firewall, by using intelligent firewalls to stop the malware from downloading.
- Install intrusion detection software to monitor illegal activities on computer networks.
- Stop the malware from executing on desktop computers by installing application whitelisting software, anti-virus, or anti-malware.
- Perform regular system backups.
  - Ensure that critical systems and business data are backed up—even backed up hourly for critical systems.
  - Test that the backup restore process works.

Avoid relying solely on encryption. Encryption does not protect a business from a ransomware attack. If a cybercriminal has your login, encryption doesn’t do anything to stop the hacker.

- Perform penetration testing on a regular basis to determine any existing vulnerabilities that should be patched.

Much of the decision to pay or not to pay the ransom is based on the circumstances surrounding the attack, the extent to which all or part of the systems have been compromised, and the degree to which recovery or restoration of the system can be achieved. Any decision must be viewed in light of all of the information and made on a case-by-case basis.

References


Contributed by The Doctors Company. For more cybersecurity articles and practice tips, visit www.thedoctors.com/cybersecurity.
Following the 2013 HIPAA amendments, several states followed suit by amending their privacy statutes to help reduce disclosure of protected health information (PHI). That said, you may disclose PHI without patient authorization in certain situations. There are also situations where you may be obligated to disclose PHI.

There are two situations (outlined by HIPAA) where a covered entity is required to disclose PHI:

1. When the patient makes a valid request with certain limited exceptions;
2. When requested by the Department of Health & Human Services to do a HIPAA-compliance audit.

In addition, one of the most common types of medical record requests is a subpoena. A subpoena differs from a court order in that it is typically signed by a court clerk or attorney, not a judge. If you receive a subpoena, consider several factors prior to responding or objecting.

HIPAA allows a covered entity to disclose PHI “in the course of any judicial or administrative proceeding” in response to an order of a court or administrative tribunal, or a subpoena, discovery request, or other lawful process. Each has restrictions.

A disclosure of PHI in response to an order of a court or administrative tribunal is limited to “only the PHI expressly authorized by such order.” A subpoena signed by an attorney or court clerk must be accompanied by either a signed patient authorization or satisfactory assurances of patient approval/notice. Notice means the individual who is the subject of the PHI was notified of the request and given an opportunity to object.

Importantly, most states provide extra protection for certain types of PHI. For example, psychotherapy notes require authorization from the patient even if there is a court order compelling production of the medical record.

Another example of protected PHI is alcohol and/or drug abuse. Absent a few narrow exceptions, a covered entity may not disclose PHI related to alcohol and/or drug abuse without the patient’s express authorization.

What should your facility do after receiving a subpoena or court order requesting documents? We suggest the following:

1. Determine whether the subject of the request is or was a patient.
2. Review the request to determine whether the information requested is in your possession.
3. Look to see whether the document is a court order signed by a judge or if it is a subpoena signed by a court clerk or attorney.
4. Look to see whether the information requested contains psychotherapy notes, alcohol and/or drug abuse information, or any other protected information based on state law.
5. If the document is a subpoena and not a court order, is it accompanied by the appropriate “satisfactory assurances” required by HIPAA?
6. If you have any doubt, contact your liability insurer or local legal counsel to determine whether the authorization is proper.

Another type of PHI request is one from a law enforcement officer for law enforcement purposes. This may include, but is not limited to, reporting certain types of wounds such as gunshot or knife wounds, grand jury subpoenas, or court-ordered warrants or subpoenas.

HIPAA allows disclosure of limited information to law enforcement for identifying and locating suspects, fugitives, material witnesses, or missing persons. Information that may be disclosed is limited to name and address, date and place of birth, social security number, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death (if applicable), and distinguishing physical characteristics.

Your facility also may be permitted to disclose certain PHI to law enforcement officials for suspected victims of crimes, decedents, crimes on your premises, or reporting a crime in an emergency. Each of these instances contains specific provisions and limitations that should be reviewed prior to complying with a request.

A common question involves what to disclose after receiving a request. Generally speaking, limit your disclosure to the information outlined in the written request. The request may contain time restrictions (e.g., care provided between certain dates), treatment restrictions, or occurrence restrictions (e.g., care provided relating to a patient’s broken leg). However, some requests may ask for the entire record.

State law defines what constitutes a medical record, and definitions vary. Usually a medical record includes any and all information a healthcare provider has in his or her possession. That may include physicians’ clinical notes, notes from other healthcare providers, billing information, referrals, imaging studies and reports, and phone call notes from another provider.

Here is an example of a medical record definition from Michigan: “Medical record means information oral or recorded in any form or medium that pertains to a patient’s health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a health care provider or health facility in the process of caring for the patient’s health.”

Ohio’s definition of a medical record differs slightly. It states a medical record “means data in any form that pertains to a patient’s medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient’s health care treatment.”

These examples are ambiguous about whether items like billing records fit into the definition of a medical record. Be sure...
to contact your liability insurer or local attorney if you have any questions.

Remember when you receive a request for PHI—no matter whether from a court, attorney, or law enforcement official—HIPAA almost always dictates how you respond. Identify your facility’s most common record requests and familiarize yourself with HIPAA and state law that dictate your obligations. This will help streamline your process and aid efficiency.

SOURCES
1 45 CFR 164.502(a)(2).
2 45 CFR 164.524 & 164.528.
3 45 CFR 164.502(a)(2).
4 45 CFR 164.512(e).
5 45 CFR 164.512(e).
6 45 CFR 164.508(a)(2).
7 42 CFR Part 2.
8 45 CFR 164.512(f)(1).
9 45 CFR 164.512(f)(2).
11 45 CFR 164.512(f)(3-6).
12 MCL § 333.26263(i).
13 ORC § 3701.74(A)(8).

Authors: Vanessa Mulnix, RN, BSN, CPHRM, CPHQ, ProAssurance Senior Risk Resource Advisor, and Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor.

Copyright © 2015 ProAssurance Corporation. This article is not intended to provide legal advice, and no attempt is made to suggest more or less appropriate medical conduct.
It has been a busy first Quarter for the ECMS Foundation. I would like to share some of the things that have been accomplished.

- **We Care** Doctor of the Year was awarded at the Medical Society Ball in January.
- The Go Senior’s Program, which provides transportation vouchers to doctor’s offices, has been expanded and made more efficient.
- The 4th year medical student scholarship was provided and presented.
- The initial 100 home blood pressure monitors have been donated to Health & Hope, Escambia Community, St. Joseph’s and Good Samaritan Clinics.
- “Walk with a Doc” is being planned in conjunction with the Health Department.
- The **We Care** program is being expanded to include as many specialties as possible.

All of these programs have been made possible by your generous donations. Please remember that there is virtually no overhead involved with your commitment to the Escambia County Medical Society Foundation. Donations may be sent to 8800 University Pkwy., Suite B, Pensacola, FL 32514.

Personally,

Kurt A. Krueger, M.D.
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**BAPTIST HEALTH CARE NEWS**

**Baptist Health Care to Build $6 Million Medical Park in Pace**

Baptist Health Care is building a $6 million medical park in Pace, FL. BHC is growing to improve access to its quality services and programs. Located at 3874 Highway 90, Baptist Medical Park – Pace will feature Baptist Medical Group (BMG) primary and specialty physicians, Andrews Institute Rehabilitation, walk-in care, imaging and lab services. The project is to be completed late summer 2017.

**Baptist Heart & Vascular Cardiologist Published in JACC**

Interventional cardiologist, Saurabh Sanon, M.D., of Baptist Heart and Vascular Institute and other colleagues recently published an article in the Journal of the American College of Cardiology. The research article is titled “Perioperative Cardiovascular Risk of Prior Coronary Stent Implantation Among Patients Undergoing Noncardiac Surgery.” The goal of this study was to assess the independent relationship between prior coronary stent implantation and the occurrence of perioperative major adverse cardiac and cerebrovascular events (MACCE) and bleeding and its relation with time from stenting to non-cardiac surgery (NCS).

**Andrews Institute Physician Leads Research on Sudden Cardiac Death in Athletes**

Michael Milligan, M.D., primary care sports medicine physician at Andrews Institute, is a leading author of the recent report “Positive Predictive Value of ECG Screening by Seattle Criteria in Collegiate Athletes.” The research explores sudden cardiac death, a leading cause of death in athletes. Sunny Intwala, M.D., a cardiology fellow in the Department of Medicine at Northwestern Medicine in Chicago presented the research on behalf of the research group at the American College of Cardiology meeting.

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<td>Cassiano, James</td>
<td>Wake Forest Baptist Medical Center</td>
<td>General Surgery</td>
<td>NC</td>
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YOU TEND TO YOUR PATIENTS, WE TEND TO YOUR FINANCIAL WELL-BEING.

Announcing the establishment of a new financial planning and wealth management team that specializes in the unique needs of physicians in the Pensacola area.

With a CERTIFIED FINANCIAL PLANNER™ professional and a team that has 28 years of combined investment industry experience, we have the skills you need to help navigate your financial goals.

OUR TEAM’S EXPERTISE INCLUDES

<table>
<thead>
<tr>
<th>Asset Protection</th>
<th>Estate Planning</th>
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<tr>
<td>Financial Planning</td>
<td>Tax Planning</td>
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<tr>
<td>Retirement Planning</td>
<td>Risk Management</td>
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<tr>
<td>Investment Management</td>
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We’re also able to create business retirement plans (including 401(k) and defined benefit plans) and succession plans (including buy/sell agreements, key person insurance and other catastrophic risk considerations).

So whether you’re affiliated with a hospital or have your own practice, we have solutions for you.

We know you work long hours and that it’s not always convenient to meet during the business day; therefore, we are happy to meet at a time and location that’s convenient for you. Our technology allows us to meet with you virtually anywhere.

RICK LAMBERT, MBA, CFP®
Wealth Strategist
rick@ironhorsews.com
3000 Langley Avenue, Suite 200 // Pensacola, FL 32504
O 850.361.4978 // F 850.466.3382 // ironhorsews.com