Last Tuesday was a typical day for me in my family medicine clinic as I saw a variety of patients with some old and some new ailments including a patient with acute sinusitis. This wouldn’t normally be a memorable visit, however, after I finished documenting I realized how many additional required data entry points I was putting in my note. And this number keeps growing! You see, we are implementing our MIPS measures and 1 of them happens to be Measure #331: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse). This measure looks at the percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms. I now have to remember to use the codes: G9286, G9505, or G9287 depending on if an antibiotic was given or not. This patient also has chronic kidney disease, so I also had to remember to abide by Measure #122: Adult Kidney Disease: Blood Pressure Management. In this measure I have to document at EVERY visit if a patient with Chronic Kidney Disease (stages 3-5) has controlled blood pressure, and if not, have a documented plan of care. This is required even if they are being seen for acute sinusitis (as in this case) or an acute complaint such as pain (we we expect the blood pressure to be higher). This will be noted via words, but also with more codes: G8476, G8477 + O513F, G8478, or O513F with 8P + G8477 depending on if blood pressure was controlled or not. Codes, Checkboxes ….. where does it end?

I recently read a political article about what is going on in this part of healthcare today. Politics aside, it predicts a mass exodus (DRexit) by physicians from Medicare and Medicaid if nothing is done to halt MACRA implementation. MACRA (The Medicare Access and CHIP Reauthorization Act) was snuck into the repeal of the SGR Formula in 2015 and we are feeling the burn of it now. The SGR repeal (with the hidden MACRA legislation) passed mostly because the alternative was a 21.2% immediate reduction to Medicare payments. The 21.2% was a build-up of short-term “doc fixes” each year since 2002 that delayed the inevitable payment reductions. MACRA is known as the Permanent Doc Fix because it is budget neutral (i.e incentives to some that are funded by penalties to others).

Under MACRA, the Merit Based Incentive Program (MIP) was born and consolidated 3 incentive programs (PQRS, Meaningful Use, and Value-Based Modifier). The legislation also allows for Advanced Alternative Payment Models (APM). According to the article, we are “incentivized for computer data entry while discouraging the placement of hands on patients. Recent studies show physicians spend twice as much time on technology than we do with patients. Maybe with full MACRA implementation, we can be retrained as data entry clerks to treat conditions instead of people.” I have had many conversations of similar nature to my fellow practicing primary care partners but not as much with my specialist partners or specialists within our medical society. I know that I am in primary care and these particular issues don’t affect all specialties yet, but it is coming! Are there issues in your specialty that you would like to share related to MACRA/MIPS or other issues that can be brought to the FMA meeting?

We have a total of 10 delegates attending the upcoming FMA meeting on August 4-6, 2017. As delegates, we will be a part of the FMA House of Delegates, which is the legislative body of the FMA. We will be accompanied by officers of the FMA, the elected members of the Board of Governors, specialty society delegates, and delegates from all over Florida representing their own county medical societies. The Caucus of Northwest Florida brings us to together with our neighboring county medical societies.
True pediatric care is more than a colorful room with kid-friendly artwork and toys. Only one hospital has been caring for the region’s children for 48 years — The Studer Family Children’s Hospital at Sacred Heart.

Now, the families we serve can take comfort in the fact that the care Sacred Heart offers regionally is also backed by the most comprehensive academic health center in the Southeast — University of Florida Health, recognized among the nation’s best hospitals by US News and World Report in nine children’s medical specialties.

Through our affiliation with University of Florida Health, Sacred Heart is staying on the leading edge of children’s healthcare, providing:

- More subspecialty services to the children of Northwest Florida
- Access to some of the most specialized pediatric programs for a wide range of complex conditions
- The development of a regional pediatric physician network from Pascagoula, MS to Apalachicola, FL, bringing subspecialty care to your local community
- Access to cutting-edge treatments and research only found in large academic health systems.

To learn more about why The Studer Family Children’s Hospital at Sacred Heart is the best choice for your children, visit www.sacred-heart.org/childrenshospital.

The best care for children comes from the heart.
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:

Advancing physicians’ practice of medicine in our community.

NEW MEMBERS

Reisman, David, M.D.
NPI: 1285710152 Baptist Medical Group Oncology
1717 North “E” Street, Ste. 231
Pensacola, FL 32501
(850) 469-7975 Fax: (850) 469-2113
www.baptistmedicalgroup.org

President’s Letter Continued:

before meeting with the entire house. Through these and reference committee meetings, we will hash out whether resolutions written by individual practicing physicians and societies are worthy and cost-effective enough to push through the FMA house of delegates and put in our final votes. A resolution has a long journey that requires support and most notably, finances, to finally become a law.

We have to make a stand to help prevent this predicted DRexit. What are ways that we can do this? We need to fund the FMA PAC which is the only way that the resolutions that do pass at the FMA level will get to the level of making changes by becoming law. Talk to us, those representing you at the FMA House of Delegates, to let us know what issues are important to you. Lastly, don’t ignore what is happening around us- We need to be making the decisions of what happens to our profession in the future.

2017 ECMS Delegates

Your 2017 ECMS Delegates which will represent you at the Florida Medical Association Annual Meeting:

Hillary Hultstrand, M.D.
John Lanza, M.D.
Brian Kirby, M.D.
Ellen W. McKnight, M.D.
Ken Long, M.D.
Brett Parra, M.D.
Nutan DeJoubner, M.D.
Carrie Steichen, D.O.
Kacey Montgomery, M.D

ECMS is always looking for physician members practicing in Santa Rosa or Escambia Counties who would be willing to serve as an alternate delegate. Please call 478-0706 x2 and ask to speak with Erica Huffman.
New Member Benefits For You

Portofino Island Resort - Discounted room rates (June 1, 2017 - March 1, 2018)
Address: Gulf Islands National Seashore, 10 Portofino Dr, Pensacola Beach, FL 32561
Call Jessica Jensen for more information at 850.916.3406 & tell her you are an ECMS member

Orange Theory Fitness - Elite membership $89 or Unlimited membership $149 for physician members & their office staff
Address: 5555 N Davis Hwy, Pensacola, FL 32503
Call (850) 449-2232 and use code ECMS member

Tires Plus on Davis Hwy - 10% off services and $19.99 oil changes
Address: 8565 N Davis Hwy, Pensacola, FL 32514
Call (850) 696-6083 and use code ECMS member

Visit the ECMS website for a complete list of member benefits.
www.escambiacms.org/Member-Benefits

The Doctors Company has started a movement to take the “mal” out of malpractice insurance—to better reflect the kind of forward-thinking partner that practices and organizations are seeking today. Changing the role of the malpractice insurer to one of partner and thought leader—it’s malpractice insurance without the mal.

-This excerpt was taken from a national Doctor’s Company Campaign.

“We have always strived to take a positive approach by being champions of healthcare, so taking the ‘mal’ out of malpractice truly resonates with our doctors. One of our key goals is to nurture our doctors in seeking self-improvement. This movement supports this goal through its focus on helping our doctors improve patient safety by providing data they need to spot risks early.”

Erica Huffman, Executive Director, Escambia and Santa Rosa County (FL) Medical Society
ECMS ADVANCEMENT TEAMS

• Advocacy and Government Relations Legislative Advancement Team (LAT) *Chair: Ellen W. McKnight*, ECMS advocates for physicians and preserving the practice of medicine.

• Member Value and Service Membership Advancement Team (MAT) and Education Advancement Team (EAT) *Chair: Hillary Hultstrand, M.D.*, ECMS unites the profession through membership and delivery of value, service and relevance.

• Trusted Community Resource Community Health Advancement Team (CHAT) *Chair: Hillary Hultstrand, M.D.*, ECMS promotes a healthy community and favorable public image.

• Medical Society Strength Executive Committee Officers, *Chair: Karen Snow, MD*, ECMS sustains the leadership and resources for a dynamic medical society.

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2017 ECMS CALENDAR OF EVENTS

June 13, 2013 | Grand Marlin, Pensacola Beach  
Insurance Co-Op

Tuesday, July 11, 2017 | Location: V.Pauls  
Young Physicians Section Meeting  
Topic: “Physician Wellness” | Speaker: Dr. Rebekah Bernard

Sunday, September 24, 2017 | Location: Painting with a Twist  
Women in Medicine

Tuesday, October 10, 2017 | Location: Hilton on Airport Blvd.  
Topic: “Policy Limits and How They Affect Claims” | Speaker: Attorney Nixon Daniel

Saturday, November 11, 2017 | Location: The Hilton on Pensacola Beach  
Fall CME Conference  
Topic: “HIPPA Compliance” | Speaker: Attorney Amy Winters  
Topic: “Prevention of Medical Errors” | Speaker: Donald Wood
It’s Time to Reset the Medical Malpractice Insurance

by Richard E. Anderson, MD, FACP

In the mid-1970s, malpractice lawsuits and skyrocketing jury awards caused commercial insurance companies to raise physicians’ malpractice rates by as much as 400 percent. The practice of medicine was deemed to be “uninsurable.” Thousands of physicians faced cancellation of their policies. As a result, doctors came together to form their own companies to provide affordable and sustainable coverage. However, today’s physicians need more.

We spoke with more than 800 doctors, practice managers, and group administrators across the country last year. The message was clear: In addition to requiring strong professional liability protection, practices of all sizes also need their insurer to be a proactive partner to help them navigate the challenges ahead.

It is time for our industry to reset the conversation around medical malpractice insurance. We believe we should serve the medical profession by partnering with those who provide care—so that doctors can focus on making decisions based on the best outcomes for patients, rather than on threats of litigation, invasive regulation, or financial loss.

The industry needs to focus on the positive aspects of what we do for physicians by taking the “mal” out of malpractice. We will do this by collaborating with practices and systems to reduce the likelihood of lawsuits, by defending doctors inside and outside the courtroom, and by helping them navigate today’s healthcare landscape.

Evolving to meet changing needs

As healthcare continues to undergo unprecedented change, practicing medicine has become increasingly complex. Faced with a tangle of contradictory regulations, rapidly changing system and reporting mandates, the disruptions of digitization and consolidation, and ever-present cyber threats, those who practice medicine have never been under greater pressure.

In this environment, medical malpractice insurers must evolve to meet the changing needs of the profession. Practitioners struggling to heal patients and stay in business need more than an insurer that simply reacts to claims.

We should offer tools and services that provide guidance. For example, we have created an extensive library of articles and resources openly available to all healthcare providers to help them understand and comply with electronic health record requirements, become familiar with the risks of telemedicine, and stay informed about drug safety laws. We share these articles and resources with healthcare providers worldwide in a number of ways, including social media. We have also initiated online conversations about medicine in the changing healthcare environment through our hashtag #advancegoodmedicine.

Every piece of information that supports practicing medicine safely and effectively in this changing environment has special value. Practices and systems are looking for insurer-led participatory education and coaching, like rare-event simulation, to improve patient safety and reduce the threat of litigation. Our foundation recently provided grants for hands-on medical simulations, institutional- and physician-level process improvements in healthcare delivery, and improved safety systems as a core part of medical education.

Today’s medical malpractice insurance buyers also expect a comprehensive array of tools to help them stay current with emerging best practices in patient care. For example, we analyze data captured from our claims experience with more than 78,000 members and translate it into actionable reports that are shared free of charge with all healthcare providers. We have published reports on cardiology, anesthesiology, emergency medicine, orthopedics, obstetrics, hospital medicine, internal medicine, plastic surgery, and electronic health record claims. In upcoming reports, we will focus on opioid prescription, psychiatry, advanced practice provider, pediatrics, and hospital-based claims. These studies are designed to promote patient safety and minimize liability exposure. The analysis uncovers the newest plaintiff allegations, reveals the most important factors that potentially lead to patient injury, and discusses—in detail—the shared aspects of claims. Physicians nationwide have already begun using the data in these studies to make changes in their practices that benefit patients and reduce the risk of adverse events.

Starting a new conversation

Another reason to reframe the conversation about medical malpractice is that the term “malpractice” is a misnomer. Over 80 percent of our claims are closed with no indemnity payment. It’s time to stop focusing on the inaccurate term “malpractice” and instead emphasize the positive measures insurers take to help doctors, practices, and systems reduce claims. The industry can join in this effort by sharing data and by engaging in collaborative patient safety and risk management programs.

Changing the way we talk about malpractice insurance is the first step in demonstrating our understanding of the contemporary experience of medical practice and becoming a proactive partner that meets rapidly evolving needs.

Richard E. Anderson, MD, FACP, is chairman and chief executive officer of The Doctors Company (thedoctors.com), the nation’s largest physician-owned medical malpractice insurer. He also chairs the board of directors of PIAA, the leading international association representing the medical and healthcare professional liability insurance community.
Reducing Risk for Your Anesthesia Patients

Written by Mr. Jeremy Wale. Mr. Wale is a licensed attorney in Michigan where he works as a Risk Resource Advisor for ProAssurance.

Nearly every hospital in the United States provides some anesthesia services to patients. Most offer surgical services with general anesthesia, providing safe operative care of patients. Such services bring risk exposures, many of which you can proactively mitigate.

General anesthesia demands a patient’s airway be protected and may require a patient to be intubated. As such, related risks include, but are not limited to, dental and airway injuries and respiratory issues. Other potential risks associated with anesthesia delivery include incomplete informed consent discussions, inadequate patient monitoring, and delivery of inadequate or inappropriate medications.

Preventing Dental Injury During Anesthesia
One of the most common general anesthesia injuries is dental injury. Examples include broken or chipped teeth, broken bridges, or dislodged implants. Oftentimes the anesthesiologist may not realize dental damage has occurred. It is not uncommon for cracked teeth or chipped veneers to go unnoticed until the patient detects and communicates the issue.

The patient’s dentition, emergencies, poor intubation or extubation technique, or tools used by the anesthesiologist can factor in dental injuries. Injuries most often occur “during intubation with a laryngoscope in patients where there is limited visibility to the hypopharynx.” In fact, “50-75% of dental injuries occur during tracheal intubation.”

Two types of patients are highest risk for dental injury: difficult patients to intubate and those with poor dentition. Difficult patients to intubate have a 20 times greater risk of dental injury. Patients with poor pre-existing dental status present a five-times greater risk of dental trauma than patients with good pre-existing dental status.

How can anesthesiologists help mitigate dental injury risk? Ensure familiarity with the patient’s general dental condition, which can help identify potential issues before they occur. This effort also may help in the event of an emergency.

Ensure the patient removes all removable appliances from his or her mouth prior to any procedure. This helps prevent damage to the patient’s appliance(s) or teeth.

A well-documented pre-anesthesia assessment of each patient’s dental condition provides an optimal start. This gives the anesthesiologist an opportunity to identify potential problems before he or she begins administering anesthesia—and to discuss those and formulate a plan to mitigate dental injury risk. Additionally, a thorough, documented informed consent discussion identifying potential issues with the patient’s dentition can be invaluable if dental injury occurs.

Likewise, a detailed pre-anesthesia assessment to evaluate the patient for difficulty of intubation will assist the anesthesiologist in avoiding dental injuries. Knowing areas of concern ahead of time aids preparedness to overcome challenges without damaging a patient’s dentition. Such an assessment is part of a comprehensive informed-consent patient discussion.

Some anesthesiologists add a dental exam to the pre-anesthesia form. That form may include a diagram of the teeth with space for anesthesiologist notations regarding potential areas for concern. This not only serves as strong documentation, but provides a good reminder to complete dental exams for each patient. Several devices are available to minimize dental injury risk of dental injuries during general anesthesia. These devices typically are placed on or around the teeth to protect against damage. One institution, the University of Iowa Department of Otolaryngology, “has incorporated dental guards into a protocol for reducing dental injury during laryngoscopy.”

Overseeing Anesthesia for Multiple Patients
In hospitals and surgery centers, it is not uncommon to have one anesthesiologist responsible for multiple patients simultaneously—supervising or consulting for multiple procedures at the same time. This typically occurs when there is a Certified Registered Nurse Anesthetist (CRNA) with each patient, and the physician anesthesiologist is responsible for supervising CRNA care.

Issues can potentially arise when the patient and/or family members are not informed of this team approach. While CRNAs generally are well qualified with specialty training and certification to administer anesthesia, patient knowledge is key. Most patients expect the anesthesiologist will be in the room for the entire procedure unless told otherwise.

If your facility uses the team-care anesthesiology approach, a thorough informed consent discussion explaining the care plan and anesthesiologist availability is advised. This discussion informs the patient and/or family members of the care to be provided and allows questions and concerns to be addressed.

Anesthesiologists Treating Chronic-Pain Patients
An emerging area of risk for anesthesiologists involves treating chronic-pain patients. Some anesthesiologists sub-specialize in pain management, in addition or instead of traditional anesthesia services. Some patients prefer facilities that provide chronic-pain management.

Pain management presents unique risks requiring proactive assessment, direction, and mitigation. Allegations against physicians in this area can include, but are not limited to, failure to treat, accidental overdose, causing addiction, or death.

Start by assessing whether your facility has anesthesiologists and/or other physicians managing chronic-pain patients. If so, consider several important issues.

Do you have a designated area or clinic for treating chronic-pain patients?
A centralized location for treating these patients helps your facility: 1. track patients and providers; and 2. establish facility-wide policies and procedures for handling this unique medical population.

Another consideration when providing care for chronic-pain patients is whether the physician’s qualifications for appropriately treating these patients. Pain management is a growing healthcare subspecialty, due in part to a reported 100 million Americans suffering from pain. According to the American Board of Medical Specialties, pain medicine is a subspecialty of anesthesiology, emergency medicine, and family medicine. Consider employing board-certified pain medicine specialists in your clinic to treat chronic-pain patients. These specialists’ additional education and training will help ensure your chronic-pain patients are being treated by qualified physicians.
Your facility can implement policies and procedures to help lessen potential risks of treating patients who require pain management.

A strong risk-reduction strategy may require each patient to enter into a pain management contract with the treating physician. This contract clearly and concisely outlines the physician’s expectations of the patient and may include:

- The patient agrees not to accept narcotics prescriptions from other providers.
- The patient will not give or sell narcotics to others.
- The patient agrees to refrain from using drugs not specifically authorized by the physician.
- The patient is responsible for managing his or her medication to ensure he or she doesn’t run out before scheduled visits/refills.
- The patient agrees to random drug testing.

This is not a comprehensive list for a pain management contract. Consult with your physicians and legal counsel to create a document that best fits your institution’s needs.

Consider having a policy for ending your pain-management program’s relationship with patients. While best handled on a case-by-case basis, a policy aids consistency. Situations such as illicit narcotics use, persistent missed appointments, or suspected drug diversion are more common instances that typically require action.

Also consider what to do when a chronic-pain patient enters your facility’s ED. When these patients become addicted to opioid medications, they often run out of prescriptions early, and then try to secure narcotics by visiting the ED. An integrated EHR may help notify ED physicians these patients are being treated by a pain specialist; it may further aid understanding that the patient may not receive narcotic pain medications without consulting the pain-management physician. Lastly, depending on your state, physicians may be able to monitor chronic-pain patients’ prescription history via an electronic prescription monitoring program. Several states have implemented such programs to help fight prescription drug abuse and diversion. Depending on the state, physicians may review a patient’s prescription history or access. Be sure to review your state’s rules to understand what you may access.

It is important for patient care and hospital liability that you take steps to proactively manage the risk around your facility’s provision of anesthesia and care of chronic-pain patients. Establishing sufficient protocol and frequently checking in with staff to ensure their understanding are essential steps in effective anesthesia management.

Watch for the Signs: Screen All Patients for Suicidal Thoughts

By Robin Diamond, MSN, JD, RN, Senior Vice President of Patient Safety and Risk Management, The Doctors Company

The suicide of a patient is a tragedy for any physician. Patients with suicidal thoughts or ideation appear occasionally in physician encounters. The Joint Commission recently noted that the rate of suicide is increasing, and suicide is now the 10th leading cause of death in the United States. Most people who commit suicide received healthcare services in the year prior to death, usually for reasons other than mental health issues or suicidal thoughts. It’s a strong reminder that any patient—no matter what issue is being treated and in any setting—could be at risk for suicide.

The patient’s well-being should be the primary concern, but physicians also must consider the potential legal liability that can come from failing to adequately screen patients for suicide risk and taking the proper steps when needed. The remorse a physician may face over missing signs can be compounded by legal action claiming the physician is accountable for the patient’s demise. A consistent and formal screening process, plus a response plan, will protect both the patient and the physician.

Case Study: Reviewing Patient’s Full History Is Key

A recent case illustrates how even if the patient denies suicidal ideation when asked, the physician could be held liable for the suicide if there were other risk factors to consider. The case involved a 60-year-old woman with chronic back pain from an auto accident 10 years earlier, treated by her family practitioner over several years for pain, depression, and hypertension. Prior to her death, the woman had three appointments with the doctor over nine months for insomnia, pain medication adjustment, antidepressant medication monitoring, and blood pressure checks.

The notes from the last encounter state: “No energy; insomnia; denied suicidal thoughts and denied feeling depressed.” Six days later, the patient overdosed on a combination of sleeping medication and anti-anxiolytics. Notes in the medical record from the next-to-last appointment said the patient “complained of insomnia; increased depression and increased anxiety; referral to psychologist.” However, she did not see the psychologist and the family practitioner’s office did not follow up. The defense experts said that the doctor should have considered the entire history instead of just the last visit and concluded the patient was at risk of suicide.

How to Help Prevent Tragedies

These are some key strategies for ensuring that a physician practice or hospital is sufficiently addressing suicide risk in patients:

- Establish a formal policy on screening and responding to suicide risk. Establish a policy that stipulates what screening will be done and how to respond to suspected risk. All employees should be trained. The policy should include front desk staff and other non-clinicians, who may pick up on signs that the patient could be suicidal.
- Implement an effective screening process. The questions typically asked on intake can be more of a formality than a true screening. Ask specific questions that can reveal situations that might put the patient at risk for depression and suicide. Examples include asking whether the patient has recently experienced the loss of a family member, a change in marital status, a change in jobs, sleeping difficulty, or loss of appetite.

• Connect with the patient. If in the screening process, the patient demonstrates suicidal tendencies or it’s suspected that the patient may be suicidal, refer the patient immediately to a mental health professional or ask the patient’s permission to contact family members or outpatient treatment providers.

• Do not be deterred by HIPAA. The patient privacy law can leave clinicians thinking that they may not discuss their concerns about suicide with the patient’s family. The patient can give permission for the physician to talk to others about his or her healthcare, and refusal to grant that permission might be considered another sign of suicidal risk.

• Establish a relationship with mental health professionals for referral. In a hospital setting, the physician should always know who is on call for patients with psychiatric risks. In other settings, the physician should establish a referral relationship with at least one or two professionals who can be called as needed. Be sure to document when and how the contact was made and any follow-up. Remember that simply advising the patient to seek help is insufficient. Contact the mental health professional directly and arrange for the patient to be seen quickly. Be sure to follow up to confirm that the patient has seen the mental health professional.

• Establish safety procedures for the patient who may be suicidal. Once this risk is established, the clinician is responsible for protecting the patient from self-harm. That means keeping the patient away from sharp objects, medications, and bed sheets. Having the patient wait in a typical exam room may not be safe because the patient would have access to scissors, scalpels, needles, and other such items. When appropriate, ask the patient to put on a hospital gown and remove from the room the patient’s shoelaces, belt, and any other items that could be used for harm.

• Monitor the patient closely. If feasible, have staff or the patient’s family monitor the patient continuously, in person or on video, until the next step of care. If continuous monitoring is not possible, check on the patient frequently. Carefully document the monitoring procedure, including frequency and type as well as observed patient behaviors.

• Call for help if needed. Call for additional help if the facility has no ability to isolate the patient from dangerous items or provide adequate monitoring, and also if the patient has already left against medical advice. State laws vary regarding how and when a patient may be held against their will.

Note: In addition to her legal experience, Robin Diamond has a master’s degree in psychiatric nursing from Vanderbilt University. Contributed by The Doctors Company.
County health departments are frequently asked how individuals may dispose of their medical Sharps/needles. Fortunately, there are two options by which this may be accomplished, as will be outlined in this article.

To minimize risks from improper disposal of home-generated biomedical waste, e.g., needles, syringes with needles, diagnostic lancets, etc., many Florida counties have implemented programs that provide accessible and affordable methods to dispose of this type of waste in a safe manner. These programs provide a site where residents can drop off a container filled with needles and other Sharps.

**Residential Sharps/Needles Disposal Program Option**
Escambia County, FL residents can dispose of Sharps/needles at the Perdido Landfill (13009 Beulah Road, Cantonment) Monday through Friday between the hours of 8 a.m. and 4 p.m. Please enter the landfill facility through the weigh station where the staff will provide additional instructions. Needles/Sharps should be placed in a puncture-resistant container such as a heavy-duty detergent/bleach bottle, metal container with a screw top, or Sharps disposal container. Do not use clear plastic or glass. Once again, Escambia residents are requested to utilize this program for the disposal of their used Sharps.

For Santa Rosa County, the Central Landfill (6337 Da Lisa Road, Milton) accepts small quantities of Sharps/needles for a free drop off, during regular operating hours (7 a.m. – 5 p.m., Monday - Saturday). The Landfill accepts Sharps/needles in American Medical Association-approved containers (red Sharps containers). They will give individuals a free replacement receptacle when they bring it to that location for disposal.

**Mail-in Disposal Option**
The United States Environmental Protection Agency (EPA) has several possible options for safe needle disposal. A United States Post Office list provides approved biomedical waste mail-in services. Needles, syringes with needles, diagnostic lancets, etc., are placed into containers provided by these services and mailed to a facility for treatment.

Please provide this information to your patients so that we can all avoid accidental injuries by disposing of Sharps/needles improperly.
The 2017 Florida Legislative Session concluded on Monday, May 8, with passage of the state budget. This year’s session will be remembered as much for the legislation that didn’t pass as for the legislation that did. This was the least active session in terms of the number of bills passed since the Republicans gained control of the statehouse in the mid-1990s. While 3,131 bills were introduced this year, only a handful were approved by both the House and Senate. For the third year in a row, most of the substantive health care legislation got caught up in the political dynamics of the two legislative chambers. Your FMA team of lobbyists tracked 241 bills and numerous amendments that either directly or indirectly affected the practice of medicine in Florida. Following is a summary of some of the key legislative issues that the FMA worked on this session on behalf of our members.

**Legislation That Passed**

### Catastrophic Fund Exemption for Medical Malpractice

In 2016, the FMA succeeded in extending the expiration date for the medical malpractice premiums exemption from the Florida Hurricane Catastrophe Fund from emergency assessments. This year, SB 454 by Sen. Jeff Brandes and HB 359 by Rep. David Santiago repealed the sunset provision and permanently exempted medical malpractice premiums from emergency assessments.

### Board of Medicine Rule Ratification

Over the past several years, the Florida Board of Medicine has worked on updating the office surgery rule. The FMA proposed language that would allow physicians to administer controlled substances in doses appropriate for the unsupervised treatment of insomnia, anxiety or pain in a Level I Office Surgery setting. The language also required that if an office administered benzodiazepines or opiates, then Flumazenil and Nalaxone must be stocked on the crash cart, respectively. As a result of the added crash cart requirements, legislative ratification was needed before the rule could go into effect. The rule was ratified unanimously by the House and Senate.

### Foundation for Healthy Floridians

The Conference Committee for the fiscal year of 2017-18, General Appropriations Act, provided $750,000 to the Foundation for Healthy Floridians in specific appropriations 539A. In an effort to curtail escalating health care costs, this program seeks to leverage the state’s network of primary care physicians to distribute high-quality nutrition education resources to hundreds of thousands of Floridians. A significant percentage of Florida’s population is obese, and obesity-related diseases drive up health care costs each year. Enabling physicians to assist patients in taking responsibility for their own health could help Floridians avoid or modify behaviors that increase health care costs.

**Legislation the FMA Defeated**

### ARNP Independent Practice

During the 2016 Legislative Session, the FMA struck a compromise to allow ARNPs to prescribe controlled substances under several limitations and safeguards, with the understanding that all parties could focus on issues outside of independent practice moving forward. Nevertheless, Rep. Cary Pigman, M.D., sponsored HB 7011, a 185-page bill aimed at granting independent practice to Advanced Registered Nurse Practitioners. A Senate companion was never filed, but the FMA continued to fight HB 7011 as it moved through the House committees.

### Optometry

HB 1037 by Rep. Manny Diaz and SB 1168 by Sen. Jack Latvala reignited the “Eyeball Wars.” HB 1037 would have allowed optometrists to perform laser and non-laser ophthalmic surgery, despite the fact that these practitioners do not have nearly as much training and expertise as ophthalmologists. In addition to surgical privileges, optometrists would have had full power to prescribe controlled substances – including Schedule II drugs. This would have allowed almost 3,000 additional practitioners to prescribe addictive narcotics in Florida. Because of the FMA’s strong opposition, SB 1168 was never heard in committee. HB 1037 barely passed its first committee with an 8-7 vote, was removed from its second committee, and was temporarily ended in its last stop because it did not have the votes to pass.

### Scope Expansion for Pharmacists

The FMA was also successful in stopping SB 1180 by Sen. Jose Javier Rodríguez, which would have expanded the scope of practice for pharmacists. The bill would have allowed pharmacists to order and evaluate laboratory and clinical tests; administer medications; initiate, modify or discontinue medications; and diagnose and treat influenza. The FMA spent a considerable amount of time trying to work on a compromise, but unfortunately, the pharmacy groups would not budge on the abovementioned expansions. A companion bill was never filed, and SB 1180 died in its first committee.

In addition to fighting the bills regarding ARNP independent practice, optometry and pharmacy, the FMA opposed bills that would have allowed ARNPs and PAs to qualify as medical directors (SB 96/HB 129) and that would have created a backdoor route for CRNAs to obtain independent practice by allowing their protocols to be “in collaboration” with a physician instead of under a physician’s supervision (SB 394). Another bill would have changed the composition of the PA Council by removing two physician members and replacing them with PAs (SB 732/HB 1307). Because of the FMA’s vigilance, none of these measures were successful.
Liability for Termination of Pregnancy
Florida’s medical malpractice reform statutes have been carefully crafted over four decades and are specifically designed to ensure that Florida citizens have access to high-quality medical care. SB 1140 by Sen. Kelli Stargel and HB 19 by Rep. Erin Grall sought to unravel this system by targeting one specific medical procedure for disparate treatment.

While the FMA does not typically engage in legislation surrounding the termination of pregnancies, SB 1140/HB 19 would have unfairly subjected any physician who performed this procedure to be sued outside of the medical malpractice system. The bill would have increased the statute of limitations period, and defendant physicians would have been responsible for plaintiffs’ attorney fees – something no other medical professionals face. SB 1140 was never heard, and HB 19 died in committee. This legislation would have created a pathway to chip away at the protections built into the medical malpractice system.

Limitations in Medical Payments
Once again, legislation was filed to dictate what evidence a jury could consider to determine the amount of medical damages in all personal injury and wrongful death actions. SB 146 by Sen. Kathleen Passidomo and HB 583 by Rep. Jay Fant would have made the amount of a health care provider’s charges inadmissible in evidence. This legislation would have created a major access-to-care issue for injured victims by unfairly eliminating their ability to receive the best medical care after being injured by the wrongdoing of others. With fewer health care providers willing to treat people injured by the wrongdoing of others, the victims would have had no choice but to be treated in the emergency rooms of hospitals that (under federal law) cannot turn them away. Therefore, taxpayers would have ended up subsidizing medical care for injuries that the wrongdoers caused. The FMA opposed this legislation, which died in committee.

Legislation That Did Not Pass
Health Insurance Legislation
The FMA supported legislation that would have prevented retroactive denials, allowed physicians to override fail first protocols, and provided for simpler prior authorization procedures. The FMA was successful in passing this key legislation through the Senate, and we achieved more momentum on these policies in the House than ever before. These policies greatly affect patients and physicians alike, and lawmakers’ increasing interest brings this legislation closer to becoming law.

Direct Primary Care
Direct Primary Care (DPC) is a primary care medical practice model that eliminates third-party payers from the primary care physician-patient relationship. The FMA supported legislation by Sen. Tom Lee (SB 240) and Rep. Danny Burgess (HB 161) to establish that DPC agreements are not insurance and therefore not subject to regulation under the Florida Insurance Code. Unfortunately, SB 240 became trade bait and did not pass. The FMA will continue fighting for the DPC model as a way to improve access and quality of care.

Maintenance of Certification
While Maintenance of Certification (MOC) once ensured continuous physician education, it has become prohibitively expensive, unnecessarily time-consuming and burdensome – ultimately taking physicians away from their patients and their own specialty- specific studies. The FMA pushed for legislation that would have alleviated the burdens of the MOC process and placed education back in the hands of Florida physicians. While the FMA made significant strides in promoting SB 1354 by Sen. Dana Young and HB 723 by Rep. Julio Gonzalez, M.D., the MOC issue was unknown to legislators. The FMA will continue educating members of the Legislature about the shortfalls of MOC in preparation for the 2018 Session.

How You Can Make Medicine Stronger
The FMA is the strongest advocate for you in defeating legislation that would negatively affect your practice and the way you practice medicine. Legislative committee weeks for the 2018 Legislative Session begin in four short months, but we need your help now so that we can achieve our goals on your behalf. Make your profession stronger by donating to the FMA PAC. The FMA PAC supports pro-medicine legislative candidates who will fight to eliminate unnecessary administrative and regulatory requirements so that you can focus on patient care. Click here to make a donation to the FMA PAC today. Thank you for your support.
SACRED HEART HEALTH SYSTEM

Sacred Heart Physicians Recognized for Top Patient Ratings

Twenty-one Sacred Heart Medical Group physicians and nurse practitioners were recognized for providing excellence by national healthcare research leader Professional Research Consultants (PRC).

The “Five Star” recognitions are awarded to providers who score in the top 10 percent nationally for excellence in patient attitudes. The awards are based on the survey question asking patients to rate the care they’ve received from a team or an individual provider. Awards are based on how often respondents gave a rating of excellent on the survey question.

The Pensacola area providers who received “5 Star” recognitions include: Dr. Teresa Mahaffey, Dr. Adam Tarnosky, Dr. Brandy Boutin, Dr. Brian Perez, Dr. Anita Westafer, Dr. Amos Prevatt, Dr. Brian Sontag, Dr. Todd Stalnaker, Dr. Heidi Barker, Dr. Wendy Oshan, Dr. Paul Tamburro, Dr. Raymond Noellert and Dr. Andrew Henson.

PRC is a national healthcare marketing research firm that works directly with more than 2,000 hospitals and healthcare organizations in their quest to provide excellent experiences for their patients.

Construction of the new Studer Family Children’s Hospital has begun on Sacred Heart Hospital Pensacola campus and is expected to continue for two years. The construction site has been fenced off, and the crew has begun clearing the site. Digging for underground utility work is ongoing and will continue in phases over the coming weeks. On May 1, utility work shifted to the main drive in front of the current Children’s & Women’s entrance. This road has now closed, and through traffic is no longer accessible.

Earlier this year, fencing went up at Ninth Avenue and Airport Boulevard to house construction materials. Staff members are meeting by department to plan for equipment and furniture needs.

To offset the loss of parking areas due to construction of the new Children’s Hospital, a visitor parking lot will be constructed in the grassy area on the east side of the Ninth Avenue parking garage. The new parking lot will be complete by autumn.

Watch the new Children’s Hospital being built from the ground up! Visit www.sacred-heart.org/childrenshospital to see the live camera feed, mounted on the roof of the hospital to monitor our construction progress.

BAPTIST HEALTH CARE

Baptist Heart & Vascular Institute’s Electrophysiology Lab Earns Accreditation by IAC

Baptist Heart & Vascular Institute’s (BHVI) electrophysiology lab has been granted accreditation by the Intersocietal Accreditation Commission (IAC) in Cardiac Electrophysiology in the areas of testing and ablation, cardiac lead extraction and device implantation.

IAC accreditation is a “seal of approval” that patients can rely on as an indicator of consistent quality care and a dedication to continuous improvement. Accreditation by IAC indicates that BHVI electrophysiology lab has undergone an intensive application and review process and is found to be in compliance with the published Standards.

Live Oak Medical Associates Joins Baptist Medical Group

Baptist Medical Group is pleased to welcome the providers and team of Baptist Medical Group Primary Care – Live Oak to its multispecialty provider network. The practice, formerly Live Oak Medical Associates, is located at 2896 Gulf Breeze Parkway in Gulf Breeze.

Providers David Kellen, M.D.; William Zimmern, M.D.; Julie Baltz, P.A.; Lori Cornwell, ARNP; and Mary Ellen Neal, ARNP, are experienced family medicine physicians.
It is hard to believe, but the second Quarter of 2017 is half over! I would like to bring you up to date on some accomplishments the Foundation has achieved already this year.

- The Blood Pressure Program continues to supply cuffs to patients that cannot afford them. The program thus far has provided 400 cuffs through Hope and Healing, Good Samaritan, Escambia Community Clinic and St. Joseph clinics.
- The We Care Program continues to expand through the Foundation to supply medical care to indigent patients.
- The Go Senior Voucher Transportation Program continues to provide transportation vouchers to doctors’ offices. Already this year there have been 182 senior doctor visits enabled by our program.
- The FSU Medical Student Scholarships continue to be enabled through the Foundation. The Wine Gala held this past March 2nd contributed $5000 toward these scholarships.
- A “Repeat” Gala will be held soon. Mark your calendars for Thursday, October 19th. This will be bigger and better than the first, and will raise funds for our on-going programs.
- Pensacola State College Endowment is partnered with ECMS Foundation to award scholarships to students pursuing degrees in healthcare.

The Escambia We Care Program Needs Your Participation

By John J. Lanza, MD, PhD, MPH, FAAP
2004 ECMS President

The Escambia County Medical Society Foundation We Care Program was established in 1992 to meet the specialty medical needs of uninsured adult residents of Escambia County, Florida. The We Care Program needs specialty physicians to take part in this worthwhile contribution to our community. The program has been administered since its inception by the Florida Department of Health in Escambia County (FDOH-Escambia) with partial financial support from the Escambia Board of County Commissioners. Through the generosity of our medical community countless individuals have received donated specialty medical care that would otherwise have been unavailable to them. To maintain these services to Escambia County, Florida residents, the We Care Program works to make every effort to recruit local physicians, hospitals, and ancillary service providers for participation.

The process begins when a client in need of specialty care is referred by their primary care physician to the We Care Program. After an intense financial evaluation, if the client is deemed eligible, they are referred to the next specialty physician on a rotation list. The more physicians that participate, the less often each physician will be asked to accept a client. At any time, a physician can accept or refuse a referral.

As benefits for your participation, this program provides you litigation protection through the State of Florida Sovereign Immunity Statute. In addition, the program provides CME credits as well as an opportunity for exemption of biennial medical licensure fees.

In summary, the Escambia We Care Program accepts specialty referrals from community physicians. The program needs physicians in all specialties to provide care for the uninsured adult members of our community.

Sharon Harris, the We Care Program Coordinator, will provide you with an application for sovereign immunity, if you are interested in participating. If you have any questions or concerns, please contact her at 850.595-6500 ext. #1070.

Save the Date!

Bourbon, Beer, & Boil
The Fish House Deck
Thursday, October 19, 2017
Fundraiser to support the ECMS Foundation
The many ways you could be wasting money on your malpractice insurance

Did you know that most doctors unknowingly waste money on malpractice insurance, which is one of the largest expenses in a medical practice each year? One of the most common ways doctors continually spend too much include:

#4. Not considering purchasing as part of a larger group
Purchasing coverage as a small practice is almost never as economical as doing so as part of a purchasing-group program, so find a broker versed in finding you such savings.

Isn’t it time you called Julie Danna, the med mal insurance expert?

Julie@dannagracey.com • 850.995.9119 • www.dannagracey.com

Delray Beach • Jacksonville • Miami • Orlando • Panama City • Pensacola

Quit Your Way with Tobacco Free

Quitting tobacco isn’t easy. Finding help should be. Tobacco Free Florida offers free tools and services to help you get started. Just pick the one that’s right for you and get the support you need to begin your life, tobacco free. No judgments. Just help.

PHONE QUIT
A Quit Coach ® is waiting for your call to help you on your journey to be tobacco free.
• Quit Coach ® 24/7
• 2 weeks nicotine patches or gum
• Custom plan
• 3 calls from Quit Coach ®
• 1-877-U-CAN-NOW
(1-877-822-6669)

GROUP QUIT
Register for a session with trained facilitators along with others who want to quit like you.
• Led by a trained specialist
• 2 to 4 weeks nicotine patches, gum or lozenges
• Convenient times & locations
• Group support
If you are looking for face-to-face help in a group setting, Tobacco Free Florida in Escambia County offers free resources through our Group Quit sessions. The sessions take place every third Thursday of the month at the Florida Department of Health in Escambia County located at 1295 W. Fairfield Drive from 5:00 pm until 7:00 pm CST. To reserve your space, please call 850-682-2552 or 850-595-6500 ext 1830.

WEB QUIT
Try Web Quit. Get access to virtual tools, tips and support that will help you quit tobacco.
• Available 24/7
• 2 weeks nicotine patches or gum
• Track your progress
• Blogs

MORE QUIT TOOLS
But wait, there are more ways to quit!
• Available 24/7
• 2 weeks nicotine patches
• Texting support
• Quit Guide & helpful emails

Call, click or come in. Let us help you quit today.
ANNOUNCING THE 2017 DIVIDEND FOR FLORIDA MEMBERS

The Doctors Company has returned nearly $400 million to our members through our dividend program—and that includes 4% to qualified Florida members. We've always been guided by the belief that the practice of good medicine should be advanced, protected, and rewarded. So when our insured physicians keep patients safe and claims low, we all win. That's malpractice without the mal.

Announcing the 2017 dividend for Florida members

Join us at thedoctors.com

Advancing the practice of good medicine. NOW AND FOREVER.