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Five Things I Wish I Had Known as a Young Doctor

Dr Robin Youngson offers advice to his younger self, after more than thirty years of medical practice.

Five Things I Wish I Had Known as a Young Doctor

When beginning my medical career, I guess there were three main things I wanted: To provide the best possible care to individual patients; to make a difference in the world beyond caring for my own patients; and to have a happy and satisfying career. Now, at sixty-two, I can look back at a varied career and ask myself, did I achieve those goals? Are there things I know now, that I wish I had known when I was starting out? Before I go further I want to acknowledge a debt of gratitude to my wife Meredith, who partners with me in our Hearts in Healthcare work. I originally titled this article, 'Advice to a young doctor', after the famous book by Peter Medawar, 'Advice to a Young Scientist'. Meredith asked me a question: 'Wouldn't it be so much more meaningful and touching if you wrote the advice to your younger self?' She has a gift for great questions. When I reflect on the lessons I share in my advice to the young Dr Robin, I see so much of her wisdom and guidance.

Looking back on my career, I can say I chose the right profession. To work as a doctor is a great privilege. Each and every day I get deep satisfaction from my work, I take joy from my practice, I enjoy interesting and engaging challenges, and I have made a difference in the world: I have no regrets. Yet had I known in the beginning, what I know now, my career would have taken a very different trajectory. What changed? I answer that question from a broad perspective. I came into medicine late, having first begun a career in engineering and oil exploration, where I survived many hair-raising adventures in different parts of the world. My medical career has been wide in scope. I trained as an anesthesiologist and I’ve done highly specialized practice in the biggest teaching hospital in New Zealand and a broad range of care in smaller hospitals.

I have enjoyed many health leadership roles: on hospital executive teams, as an advisor to the NZ government, and working with the World Health Organization on strategies for people-centered health care and patient safety. For more than a decade, I have led an international movement for the humanization of healthcare and I’m a published author and well-known speaker. I still practice half-time clinical anesthesia, which keeps me honest and grounded.

The things I have learned in later years will be surprising to most young doctors. Although they make an astonishing difference to patient care, and to the satisfaction and wellbeing of doctors, they are rarely taught at medical school, and they are largely absent from medical journals or textbooks. Here are the five things I could share with the young Dr Robin:

Real patients are nothing like the mechanistic models suggested by your studies in anatomy, physiology and pathology! With each new patient I met as a young doctor, my finely honed instinct was to focus rapidly on the clinical problems and the underlying pathology. At medical school, we are taught a mechanistic view of the human being. We are steeped in anatomy and physiology, right down to a molecular level. What’s missing from all the literature is that our patients are conscious – they are highly dynamic, mind-body beings utterly unlike the materialistic version of the science we are all taught. Here’s some random illustrations:

I now know that one episode of exercise changes our gene expression; that nine weeks of mind-body training for patients with inflammatory bowel disease not only improves symptoms but also changes the expression of more than a thousand genes associated with cell reproduction, immune function and inflammatory responses. Psychotherapy can change gene expression, increase levels of brain growth factors, structurally change the brain and cure mental illness. Pessimists are three times more likely than optimists to develop clinical influenza when exposed to live influenza virus. Trauma patients who rate their surgeon as ‘high empathy’ have better outcomes of surgery.

In contrast to the ideal of clinical detachment I was taught at medical school, I discover that human beings are intimately connected. Mirror neurons give us the basis of empathy, which allow us to intuitively understand other peoples’ feelings and intentions. When two humans stand close
together, their hearts and brains are literally coupled together by the electromagnetic field of the heartbeat. Some of my patient's neurons fire in synchrony with my heart beat, and visa versa – truly a 'heart-felt' connection.

If the physician is calm and centered, it directly affects the physiology of the patient and reduces their heart rate, blood pressure, and cortisol. These connections allow our compassionate care to deeply touch our patients and to improve their clinical outcomes in very important ways.

As an anesthesiologist I was astounded to discover some randomized, controlled trials showing that patients who have a warm, empathetic, and supportive pre-operative consultation (compared to those simply offered standard information) need only half the dose of morphine after surgery, have better objective wound healing, better surgical outcomes, they mobilize earlier, have fewer side effects, and have shorter hospital stays.

Many studies show striking results for empathetic and compassionate care. The effect size on clinical outcomes is of a similar magnitude to many of the drugs we use. Compassionate caring improves patients outcomes, reduces patient demand, dramatically reduces interventions and costs, and prolongs survival time in cancer patients. It's great medicine, yet is rarely taught.

I would teach all this to the young Dr Robin. I would say that even though you struggle with feelings of incompetence and inexperience, you have a fully formed heart. Even if you are lacking in medical knowledge and technical skills, your compassion and caring can make a powerful difference to the outcomes of your patients. It will also give you the joy of human connection, a warm feeling in your heart, and it will protect you from burnout.

You don't have to be the hero
As a young doctor, I hid my feelings of insecurity and put on a brave front of cool clinical detachment. I pretended to be competent many times when I felt out of my depth. I believed I had to always be the expert in front of my patients, I never admitted ignorance. I wish now that I had been more honest with my patients.

What I know now is that patients have no way to judge your clinical competence. What they do judge is whether you care. When you show kindness, compassion, and an honest desire to help your patients, they will forgive almost anything. I have learned now to be the patients' friend and advocate. I do many things to help patients that are nothing to do with my technical role as an anesthesiologist.

If I am uncertain about how to manage a condition or perform a procedure, I tell my patient. I explain that I will seek help from a colleague or look up the information I need. If I'm on the learning curve for a procedure, at least I will do it in a way that is safe and kind to the patient, checking as I go along that the patient is doing OK. I will explain the end result that I’m aiming for and how I know it has been a success. I will have a back-up plan. All these things build the patient's confidence and trust, even if I am not the expert.

It's easy for me to say this from a position of seniority and experience – I now have a lot of confidence. But I also commend the strategy to the young Dr Robin.

Several years ago, I recall watching a television documentary about first-year doctors working in a major hospital. It was a very candid portrayal, plainly exposing the fears and challenges of being a new doctor. One doctor stood out. He had a wonderful way of empathizing with patient and showed especial kindness and consideration. He was much more honest than his colleagues in admitting to patients his lack of experience. He simply promised each patient he would do the best he could, and call for help if he was struggling. All his patient loved him. His intention to be kind and caring, his integrity, and lack of pretense actually heightened his success rate in procedures.

I'd say to the young Dr Robin that I learned that patients also care for their doctors, as much as we care for our patients. A compassionate relationship is a two-way street. I learned that patients were forgiving when I was honest about mistakes. Some of my patients became my greatest teachers.

I'd say to the young Dr Robin, you don't have to be the hero to your colleagues either. Hiding our feelings and never admitting to vulnerability perpetuates a culture in which doctors never seek help, battle on alone, and suffer high rates of depression, stress, burnout, and suicide.

I now choose to expose my vulnerabilities to my colleagues and to talk openly about cases that upset me or frighten me. I reach out to support other doctors. I try to role-model a healthy approach to my own emotional and psychological wellbeing. Some years ago, when confronted by the sudden death of a young mother in my care, I took two weeks of stress leave. I admitted to myself and to my colleagues that I wasn't in a fit state to be caring for patients and I took time to work through my own grief and loss. I’m deeply grateful to my wife Meredith for showing me it was safe to be vulnerable.

I now seek professional supervision and counselling to help me deal with the challenges of patient care and my own emotional vulnerabilities. My marriage has benefited greatly. As a doctor, I am more balanced, grounded, mindful and compassionate. I am also a better husband. Acknowledging my own struggles allows me to understand my patients better. A few weeks ago, the World Medical Association voted to amend the Declaration of Geneva, which lays out the professional and ethical duties of doctors. There is a new duty of doctors – to look after their own health. I didn't begin to attend to these issues until I was in my fifties.
If I was a mentor to the young Dr Robin, I would be saying, 'Start now.' Your first duty of patient care is self care.

**Patients heal themselves**
I always thought that it was my treatment that made patients better, or not. I placed great store on the success of my care. I felt myself responsible for each problem the patient brought to my door and soon began to feel overwhelmed.

In modern times, health services are overwhelmed by the endless demands for patient care. We simply don't have enough doctors, nurses, clinic appointments, hospital beds, and procedure lists to cope with the tsunami of patient demand. The endless demand leads to overwork and fatigue. Fifty percent of young doctors have symptoms of burnout: emotional exhaustion, cynicism, depersonalization, and a lack of job satisfaction. With the rise of consumerism, it seems that every patient expects an instant cure or a pill to make them feel better.

The reality is that patients have remarkable capacity for self-healing and that our medical treatments often do little more than support the natural process of recovery. We forget that broken bones heal themselves, that a lung rendered solid with pneumonia restores its own normal anatomy, that our immune system takes care of hundreds of potential infections and cancers. We forget that conditions like hypertension, depression, diabetes, heart disease and most cancers are not part of the natural human condition.

As I have gotten older I have become more humble about my medical practice. I have witnessed miracles completely unexplainable by medical science. There is mystery and awe in medical practice. It's well documented that patients can have 'spontaneous remission' and cure themselves of terminal cancer. I've seen elderly patients fully recover a day after prolonged cardiac arrest, when they should be brain dead. Other patients have turned their face to the wall and died within days, through sheer force of will.

Here's what I'd like to tell the young Dr Robin:
Do your best for each patient but have less attachment to the outcomes; whether your patient lives, or dies, has causes far beyond the limited influence of your medical care. Care deeply about your patients, bring your heart to work, but let go of striving to save everyone.

Don't see patients as a burden of demand, try to see each patient as the most abundant resource of health, healing and wellbeing. Have faith in your patients, explore their strengths, be positive and encouraging, expect miracles. Admire your patient's courage, resilience, wisdom and good humor in the face of serious illness or injury. Be grateful for every patient you meet – it's a privilege to journey alongside them.

**Even doctors make mistakes**
Did I tell you about the time I did an arm block in the wrong arm of a patient so he ended up with one painful arm in a plaster cast and the other arm numb and useless? Or the time I gave another dose of muscle paralyzing drug at the end of an anesthetic, instead of the reversal drug? Or the time I took a blood sample from completely the wrong patient – who had the same name, the same diagnosis and was on the same ward as the correct patient? Or the time I shocked a patient in Ventricular Tachycardia (VT) without first synchronizing the defibrillator, so the patient went into VF?

The last accident didn't happen to a real patient – it was a high-fidelity emergency simulation demonstrating that all human beings make mistakes when stressed, and that outcomes depend much more on teamwork, situational awareness, and good communication, than your skill as an individual.

It's a sobering experience to watch the video replay of your actions in the simulation. In that scenario, we were caring for a patient with multiple medical problems having a major abdominal procedure, when complications started to develop. The simulation involved three very senior and experienced anesthesiologists all trying to solve the problem as the patient rapidly deteriorated. In the confusion of the emergency, not one of us remembered to synchronize the defibrillator, even though we have all done it before many times before.

Every single doctor put on the simulator makes mistakes – everyone! The science of 'human factors' says the mistakes are predictable: the result of intense stress, information overload, task overload, and extreme urgency. The only way to avoid such errors is to train as a team, in high-fidelity simulation, and to learn and rehearse carefully-designed emergency responses that keep you out of trouble. That's what airline pilots do.

So here's what I'd like to tell the young Dr Robin:
No matter how careful and skillful you are, you will make mistakes and some of them will harm your patients. My advice is that you should always be honest with your patient. Sincerely apologize, explain how the error occurred and what the consequences are. Demonstrate to the patient that you care for them very much and that you will do everything in your power to help them recover. Also that you have learned from your mistake and that you will take steps to prevent the same error from happening to others.

If you do all these things, the patient will likely forgive you. Their forgiveness is truly humbling. If you do all these things you dramatically reduce the risk of being sued or having a formal complaint registered against you. I have not received a formal patient complaint since 1990, when I was a resident, and I seriously mishandled the relationship with a patient and her husband at a time of great stress.

Early in your career, learn about human factors. Become aware
of the circumstance when you are likely to make errors and invite others to warn you of a potential mistake – regardless of their rank or title. One month ago, a nurse in the OR saved me from a potentially life-threatening mistake because I made it safe in my team for anyone to speak up. Anytime I make a mistake, I tell everyone in the team. If an unexpected complication or emergency starts to develop, I alert my teammates and call for help early. Take the opportunity to train on the simulator; you will be shocked at the mistakes you make and you will learn skills that will save a life.

You have great power to change the world
As a medical student or junior doctor, it’s easy to feel powerless especially in a hierarchical medical system that too often teaches by humiliation, punishes those who question the status quo, and grinds people down through overwork and inhume working conditions.

Our sense of powerlessness stems from accepting our perception of the harsh world, which we see as a concrete reality ‘out there’. What I have learned is that much of the reality ‘out there’ is actually our own creation and we therefore have great power to change the world.

Here’s an example: Early in my hospital career, I made a curious observation. One of the nurses working in the OR had a very bubbly, affectionate and flirtatious character. She gave lots of people hugs and always had a cheery smile. Especially at that time, I was personally very reserved and socially awkward. But with this nurse, I was outgoing and even flirtatious!

I began to watch her interactions and every single person she met was cheerful and outgoing – even the workers who were normally grumpy. I began to imagine what it must be like to live in her world. Conversely, another nurse was always gloomy and complaining; her attitude was contagious too. I realized that these two nurses had radically different experiences of the same workplace.

When I began to change my attitude, I noticed the world changing around me. I tried experiments. One day I decided to make the assumption that ‘difficult’ patients don’t exist, that if a consultation was going badly the problem was a ‘difficult’ doctor, not a difficult patient. My job was to listen better and to try to understand the patient’s perspective. I guess I dropped my judgmental attitude to challenging patients, and they sensed a difference. The result was a near miracle: most of my ‘difficult’ patients melted away and I began to enjoy my consultations much more.

I’ve found that any problem can be reframed and made easier if you are willing to examine and change your own attitudes, to take responsibility for your side of the interaction. The result can be life-changing. I did a TEDx talk on the subject, showing how a change of attitude transformed my effectiveness as a leader in compassionate healthcare.

So here’s my advice to the young Dr Robin who is, to be honest, something of a righteous troublemaker in challenging the hierarchy: Think about your attitude. What judgments are you making about others and could a different approach work better? If you dropped your need to be right all the time, could you build more collaborative relationships? What mood do you bring to work? Are you relaxed, easy-going, cheerful and appreciative, or grumpy all the time? Could you choose to love your work, rather than dwell on the dissatisfactions?

Go kindly, there is already too much trouble in the world. Be appreciative, kind, generous, and practice gratitude. The world will become more joyful, loving and generous to you.

If I began my career again, where would I focus?
It’s hard to predict the future of medicine; all I can say is that it is very likely to change profoundly before you even finish your training. Advances in artificial intelligence, diagnostic methods, gene therapy and robotics will displace many of the conventional roles of doctors.

In reflecting on all my efforts to change healthcare, I’ve come to realize that we don’t actually have a health system at all, it would be truer to say we have a ‘medicated sickness’ system. It is uncommon for me to meet any patient in their fifties who is not already on life-long medications for high cholesterol, hypertension, diabetes, depression, or gastro-oesophageal reflux. Today I met a 78 year old patient who takes no medication and is in robust good health. Why can’t that be the norm?

Modern medicine is astonishingly good at treating acute illness and injury but is a disaster when it comes to managing chronic illness. Almost all of the patients we treat in hospital have disease that is preventable. However, the pharmaceutical and technology companies have a strong incentive to make money from maintaining chronic illness and there is very little curiosity or research funding to investigate what keeps people well.

If I began my career again, that would be my focus: I’d devote a lifetime of effort to changing our sickness system into a true health system. I’d work in primary care and in community. Many of the determinants of chronic disease are in our society. It’s time for physicians to become community leaders helping to change the way we lead our lives. It’s time for us to be champions of medical research into what keeps us well, rather than investigating yet another new and expensive treatment for illness.

I would take joy in caring for people, not just treating disease. I’d know that even though the challenge of expert medical care can eventually become routine, there is boundless satisfaction and interest in caring for my patients as unique individuals. I would know that every one of the five lessons I shared with the young Dr Robin will be as valid and relevant in another thirty years.
Independent physicians who want to stay that way have been fighting an uphill battle for years against powerful healthcare trends.

The bad news: It's going to get worse before it gets better.

The good news: Proactive physicians can (and must) utilize strategies to remain independent, competitive and viable.

There is still – and hopefully always will be – a place in the healthcare delivery system for independent physicians, but it's shrinking rapidly and only the best and smartest are likely to remain independent.

Moving Target: The Shifting Playing Field – and Players – in Healthcare Delivery

Before we review possible solutions for remaining independent, we need to be crystal clear on the healthcare trends that represent serious problems affecting independent physicians and their patients.

As in many other industries, the delivery of and payment for healthcare in the U.S. has been increasingly controlled by fewer, larger companies. Needless to say, that makes it tough for the “little guys” to survive.

Are you old enough to remember when independent pharmacies, hardware stores, jewelry stores, small bookstores, neighborhood grocery stores and local travel agents were a thing?

Do you remember what the local retail business environment was like before Amazon?

The same thing is happening to the healthcare industry. Hospitals and formerly independent physician practices have merged into health systems and those health systems are now merging into even larger (and fewer) health systems.

CVS, which already operates MinuteClinic walk-in clinics in its stores in 33 states, is now acquiring Aetna unless the deal is blocked by the Department of Justice – which is unlikely.

Walmart is likely to make a play soon to buy Humana, which would also get Walmart into home health care based on Humana’s plan to acquire a 40% stake in Kindred Healthcare’s home division.

Walmart may also soon acquire online pharmacy PillPack. UnitedHealthcare already partners with Walgreens for Medicare Part D prescription coverage through its OptumRx division.

More recently, United Health Group's MedExpress urgent care centers are connected to Walgreens drugstores in 16 locations across six states as part of a new pilot program.

UnitedHealthcare’s Optum delivery unit already includes ambulatory surgery centers, physician practices and locally based community health clinics that they have acquired.

Now, Optum is buying DaVita Medical Group and its 300 primary care and specialist medical clinics as well as its 35 urgent care centers and six outpatient surgery centers.

How can independent physicians possibly compete with these behemoths?

Must-Do Strategy #1 – Get Bigger (or Smaller) FAST

Bigger OR smaller?? Yes, both are viable options.

Get Bigger

If you intend to remain competitive and viable in the traditional insurance-based healthcare delivery model, you need to get bigger. Smaller independent, insurance-based practices just don't have enough leverage to compete against the powerful healthcare trends that are stacked up against them.

Whether it's contracting with health plans, purchasing power for equipment and supplies, increasingly demanding reporting requirements or health benefits for employees, smaller insurance-based practices are the odd man out in this game of musical chairs. (Anyone remember musical chairs?)

Options for getting bigger

1. Mergers

Independent practices are merging with other practices to increase size and leverage. This includes primary care, single-
specialty groups and multispecialty groups.

2. IPAs
Independent Physician Associations are organized and owned by physicians to help smaller practices remain independent by creating leverage for negotiations with insurers and reducing costs through group purchasing discounts and various types of administrative support. Some IPAs are more effective for their members than others, so research on services and track record of the IPA is important. This research includes interviewing other physicians in the IPA regarding their perceptions and experiences.

3. ACOs
Accountable Care Organizations are networks of doctors, hospitals and other healthcare providers organized around the treatment of Medicare beneficiaries.

Participation is voluntary but it also includes shared savings or shared losses so it's vital that physicians research financial history of an ACO they plan to join.

ACOs help physicians gain more control of the care of their patients because they have to reduce costs by emphasizing the quality of care instead of volume.

ACOS also provide access to advanced technologies that independent physicians could not afford to acquire on their own.

4. MSOs
Managed Services Organizations are partnerships that offer a range of practice management and support services to independent physicians and other providers of ancillary services.

Like IPAs, MSOs help physicians remain independent through more powerful vendor negotiations and other group purchasing discounts, but MSOs are much more actively involved in administrative support for physicians. The MSO model allows physicians to dramatically reduce their administrative time demands so they can focus on patient care while increasing their profitability and retaining their independence.

Get Smaller
An increasing number of primary care physicians are opting to buck negative healthcare trends by converting their practices to a membership fee model that allows the provider to see fewer patients for longer, more thorough appointments.

Options for getting smaller
1. Concierge Practice
Most concierge medicine practices charge in the ballpark of $150 – $200 per month for their membership fees. The membership fee covers increased access to the physician including more of the physician's time, attention and advice.

Concierge medicine practices generally also bill the patient's insurance plan. Because these practices are still participating with health insurance plans and Medicare, they are subject to the same regulations as traditional insurance-based practices.

Concierge medicine is best suited for physicians who practice in more urban and affluent communities where there are enough residents who are able and willing to pay more for a more personal and attentive experience and relationship with their doctor.

2. Direct Primary Care (DPC)
Direct Primary Care practices typically opt out of the health insurance model entirely. The patient pays a monthly membership fee that ranges from as low as $10 per month to as high as $100 per month. The typical DPC practice averages $50-60 per month in membership fees.

Patients may still have a traditional health insurance plan to which they can submit claims for certain treatments but the DPC office does not bill or collect fees from the insurance company.

The DPC practice provides most of the needed primary care services within the scope of the membership fee and there are no copays for the patient. DPC practices often provide wholesale reduced or even "at cost" pricing for lab testing and imaging services as well as "wholesale" pricing for common medications.

More employers (both self-insured and not) are including DPC among their paid benefits for employees because it encourages more proactive care that heads off avoidable health problems and saves the employer money on healthcare costs and lost productivity costs.

Concierge and DPC practices generally max out their patient panels at roughly 600 patients (compared to 2,500 patients for a typical, insurance-based primary care practice).

Next Steps
If you are not getting bigger or getting smaller strategically to stay viable in the face of daunting healthcare trends, you are more vulnerable every month than the month before to being permanently sidelined by corporate healthcare or becoming employed by them.

If you don't mind or prefer being an employed physician, you probably didn't get this far in reading this article. If you read this all the way through, it's time to do something proactive – and FAST.

Lonnie Hirsch, Founder and CEO of Hirsch Healthcare Consulting is one of the premier consultants and strategists for helping medical practices and hospitals across the U.S. and in other countries achieve profitable top line and bottom line growth. Over a career spanning thirty years, Lonnie has worked with thousands of medical practices as well as hospitals, health systems, medical device companies, medical software companies and other healthcare businesses.
The past year was an interesting one for fans of everyday tech and gadgets, with plenty of new developments and features appearing within the spaces of smartphones, computers, cars, and other everyday technology.

Some of these were completely new innovations (such as the under-display fingerprint scanner on the OnePlus 6T), others upgrades of things that already exist, but for certain most of these have changed how consumers look at and consume technology, and a good chunk have also set precedents for things to come in the future.

So looking ahead to 2019, we decided to take a stab the prediction game once more and place our bets for what's to come in the next year.

1. Watch Out for The Smartwatch

This year saw some encouraging signs for the smartwatch segment, with sales figures encouraging in the second half of 2018 and manufacturers striving to innovate in what is still a relatively nascent market.

The Galaxy Watch was a great entry in a large offering of smartwatches in 2018. We saw options that catered to many niches, some purely for lifestyle, some for getting fit, and others even pandering to the extreme adrenaline junkie.

In 2019, we expect the smartwatch segment to see more in terms of sales and consumer options, with even more brands to enter the segment to see if they can steal a share of the Apple-dominated pie.

2. Goodbye, Notch

When Apple first introduced it with the iPhone X, it was the subject of derision, and then it become a smartphone mainstay accepted by consumers everywhere, albeit begrudgingly.

Left, right, and center, the notch has been integrated into smartphones of all price points from all manufacturers save Samsung, who have refused to budge on their no-notch policy.

But those with an understanding of the smartphone industry will know that the end goal among manufacturers is a smartphone with an end-to-end display that is truly functional on a daily level.

The Oppo Find X was one of the first smartphones to introduce a completely notchless yet bezel-free display. True enough, we've already seen companies like Oppo, Vivo, and Honor all try their hand at crafting devices that allow for displays without bezels, and we're hearing of tech that will eventually allow front cameras to sit underneath screens without sacrificing photo or display quality. So in 2019, we fully expect these developments to spell the death knell for the notch, which will no doubt please more than a few.

3. More Triple Cameras for Everyone

The double camera lens setup has been a commonplace smartphone feature for a while now, with nearly every high-end flagship hopping on the bandwagon to stay relevant.

The Samsung Galaxy A7 came with three rear cameras and only cost RM1,299. Case in point, this year saw the arrival of phones with more than two cameras. The Samsung Galaxy A7 and A9, and the Huawei P20 Pro and Mate 20 Pro all came with camera setups that promised the world in regards to camera capability, and the public ate them up gleefully.

But as with most tech trends, performance and numbers are loathe to remain the same—processors will always demand more output despite having smaller footprints, screens will always get sharper resolutions, so on and so forth.

The Samsung Galaxy A7 came with three rear cameras and only cost RM1,299. Case in point, this year saw the arrival of phones with more than two cameras. The Samsung Galaxy A7 and A9, and the Huawei P20 Pro and Mate 20 Pro all came with camera setups that promised the world in regards to camera capability, and the public ate them up gleefully.
Also, there were the leaked images of an upcoming Nokia device with five rear cameras and reports of LG's new patent for a phone with 16 cameras. Make of them what you will.

So in 2019, we expect phones with triple cameras—or quadruple cameras even—to become something of a standard. Consumers are constantly demanding more from their devices, and manufacturers would be foolish to ignore them.

One maker has been consistently bucking that trend though: the Google Pixel 3 is still a single-lens camera for the back. They chose to put the dual camera on the front instead, to allow wide angle selfies. 2019 will tell us if they choose to add more to the back, but we predict that at most, it will be an additional single wide-angle lens to match the one on the front.

4. Camera: Software or Hardware?
This one comes as a bit of an antithesis to the previous point, but thanks to Google and the amazing Night Sight feature on their latest Pixel devices, there's also a case to be made that camera quality is just as dependent on software as it is on hardware.

Stubbornly refusing to adapt to the multiple-lens trend as previously mentioned, Google has emphatically proven over and over that with an amazing software suite, one lens is as good (or even better than) a camera setup with multiple lenses.

While most manufacturers today are still focusing on camera hardware, expect more of them to follow Google's lead in 2019 and begin chasing better camera software suites. Want proof this will happen? OnePlus have also tried their hand at beefing up the software on their camera instead of purely touting hardware specs. While it's not Google-levels of impressive, it's a start.

5. Mid-Range Is the New Flagship
It's hard to argue that 2018 was definitely the year of the mid-range smartphone. Sure, there were plenty of interesting entries in the flagship category, but you'd be crazy to dismiss just how strongly in demand the more affordable models were.

Thanks to devices like Xiaomi's Poco F1, the OnePlus 6T, and the Honor Play, the mid-range category was completely turned on its head, proving to consumers that you don't need to shell out a fortune in order to get class-topping performance.

In 2019, we expect more of the same or better, and we predict that phones providing more value for money will eventually begin to see the inclusion of features that you'd normally only see in devices with exorbitant prices. For proof, just look at the previously mentioned Samsung Galaxy A9, a mid-to-upper-range phone costing just under RM2,000 with four lenses in its rear camera setup—a first in any device. As for flagship devices themselves, we feel they'll do okay, but we also expect them to come with more cutting-edge features that fit particular niches, for example, the stylus on the Galaxy Note 9.

6. The Huawei-Samsung Grand Prix
If 2018 proved anything, it was the fact that Chinese smartphone manufacturers were out for blood. Once dubbed a region full of copycats and uninteresting cheap gizmos, Asia's largest economic force has now drawn level with the best tech innovators in the world and have put out a serious number of inventive and class-leading devices in 2018 alone.

Proving the point, Huawei in August leapfrogged Apple in global market shares and now sits second behind Samsung. But judging from the trajectory they're on, we don't expect them to stay there either. In 2019, we predict that Huawei will do just enough to edge out Samsung and end the year as the world's leading smartphone manufacturer.

7. SEA Hello to Electric Vehicles
While the USA, China, and Europe have enjoyed the widespread availability of electric vehicles for approximately two years now, the rest of the world—including Southeast Asia—are still yet to see many of them on public roads, with petrol and diesel engines still the mot du jour.

In 2019, all that should change, with many SEA countries racing to make battery-only EVs more widespread in the coming year. This will no doubt be helped by manufacturers such as Nissan and even Dyson ramping up production within the region, and with administrations making an effort to transition the public to greener automotive options in the future.
CONFERENCE TOPICS

Profiling the needs of the position
Developing the traits you need for the culture of your business or practice
Understanding what you must screen for in filling the position
Creating the characteristic profile for the position that will be your hiring blueprint

Why you should not just hire someone because you like them
Understanding that the hiring process is one of elimination
Creative methods to target and find the right candidates
Which Web-based recruiting sites are most effective for attracting quality health care candidates

Why you must screen by telephone before you invest your time for an interview
How to eliminate based on response to your postings
The screening checklist
Questions you need to ask to match your business culture
Questions you need to ask to match the candidate to the position
How to use a candidate's previous behavior to know how they will perform for you

The keys to a successful interview
Setting up “live” scenarios to check the candidate's judgement
Listening and watching the candidate as your most important functions
Why the match of expectations will be the key determining factor in your success
Presenting the position and the tasks of the position with clarity
How to avoid hiring a person only to find that their “evil twin” show up to work
Using social media and other methods to check out a candidate
The final steps to completing the successful hire

Fee to participate is $129.00 per person (includes materials, luncheon and beverages throughout the day).
Reservations taken on a first come basis. The conferences will commence at 9 am and conclude at 4 pm with a lunch break.

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PROFESSIONAL CLAIMS LINK
Established in 1998 as a medical billing company and has grown into a full-service medical practice management and consulting company. The firm offers medical billing, contracting and credentialing, auditing, staff training and new practice setup services for all specialties.

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PCL has also developed relationships with key insurance personnel throughout Florida’s healthcare industry. The professional contacts we’ve made provide our staff with support for problem claims adjudication and keep us informed of procedural changes within each insurance company. Billing to specific insurance carrier’s requirements is essential in moving your healthcare claims quickly through the system.

PCL offers several services to assist physicians in running a successful practice:

- Insurance Billing and Coding
- Patient Collections
- Insurance Receivables Auditing
- New Practice Setup
- Medical Practice Staff Training
- Medical Insurance Contracting and Credentialing
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“We feel very fortunate to have been introduced to Professional Claims Link. Since September of 1998, this team of professionals have impressed us with their dedication, knowledge base, consistently outstanding service and persistence in getting the proper reimbursement from third parties. They have made a big difference in our bottom line.”

-Daniel C. McDyer, M.D., Obstetrician and Gynecologist

MEDICAL SALES AND SOLUTIONS, LLC
Established in 2017, MSS is a medical device sales company focusing on new technologies that will allow physicians better solutions to diagnostics. MSS is featuring the U-Lite Exp, an ultraportable full HD ultrasound system. U-Lite is manufactured by Sonoscanner, located in Paris, France. Sonoscanner is the leader in portable ultrasound technology and has won numerous awards. Although U-Lite is in 50 different countries, it is just making its debut in the United States.

The U-Lite EXP is the first ultraportable HD ultrasound unit in the world incorporating all of the functionalities of a complete ultrasound device in the palm of your hand. Its eco-conception brings you the lowest energy consumption levels on the market without loss of resolution. U-Lite is the only ultrasound scanner to have a complete set of lightweight broadband multifrequency transducers that deliver superior image quality and doppler sensitivity in a wide range of clinical settings.

The U-Lite is widely used in Europe and most recently the country of Sweden awarded Sonoscanner placement of these machines in all of its hospitals, outperforming the competitors in three different medical fields: emergency medicine, medical imaging consultations and interventional procedures. The French Army granted the military contract to Sonoscanner for the U-Lite over the G.E. Vscan and Philips Lumify.

“Point-of-care ultrasound (POCUS) is the biggest advance in bedside diagnosis since the advent of the stethoscope 200 years ago.”

“Sonoscanner leads in hand-held ultrasound equipment & received the New Product Innovation Award for U-Lite.”

Frost&Sullivan
As we raise glasses and turn gazes toward 2019, everyone at VinePair HQ is debating what we will see, think, and drink in the coming year. Will the bar industry successfully take on sustainability? Can craft beer weather a volatile economic forecast? How will somms stay relevant on and off the floor? We’re calling it: 2019 will be a great year for beer, wine, and spirits. Here are eight top trends to watch.

Zero-waste cocktail lists will make us think outside of the straw.

Last summer, plastic straw bans proliferated at bars, restaurants, and coffee shops nationwide. Several hospitality professionals told VinePair the outrage might be part of a continuum: Straws were an accessible entry point to a larger, more meaningful conversation about conscientious consumption.

Sheesh, were they right. The James Beard Foundation has since launched its Waste Not initiative, a campaign and cookbook to help chefs and home cooks reduce food waste. Joseph Boroski created a “No Impact” bar program at NYC’s 18th Room, and Shawn Chen reuses citrus zest and coffee grounds at RedFarm in Manhattan.

“Sustainability in beverage is undoubtedly in the cards for bars everywhere,” Boroski said in an interview with Fortune. “I only see this movement getting more popular as consumers become more aware of how their choices collectively make a difference.”

Beer will continue its food waste efforts, too, with brands like Toast Ale, Crumbs Brewing, and Been a Slice expanding offerings brewed with surplus bread; and companies like Rise Products making flour out of spent grain.

Sour beers will get the subcategorization they need and deserve. A diverse portfolio of beers currently resides under the catchall term “sour.” As kettle sours, fruited sours, spontaneously fermented wild ales, goses, and Solera beers continue to proliferate, how we talk about and categorize these beers will mature. After all, we don’t call all pilsners “crisps.” Beyond that, not all beers that are “funky” are sour.

Consumers might not immediately start using all the Brewers Association’s style names in casual conversation (“Pick me up a Leipzig-style gose, would you?”). But those in the industry will incorporate more geographic associations, as well as production methods. Just as retailers differentiate between West Coast and New England-style IPAs, and milk versus bourbon-barrel-aged adjunct stouts, we will start separating our Berliner weisses from our American wild ales.

This is already happening at breweries, taprooms, and restaurants like The Farm at Adderley in Brooklyn and The Dabney in Washington D.C. We expect to see it at Whole Foods, Wawas, and Krogers next.

Only the logical hybrids will survive.

From bourbon-barrel-aged wine, to breweries aging ales on grape must, to spiked seltzers, to CBD cocktails, hybridization is happening in every corner of the drinks industry. It makes a lot of sense: Contemporary consumers love customization, hate being pigeonholed, and, statistically, purchase beer, wine, and spirits interchangeably.

Of course, some of these crossovers are better conceived than others. In 2019 the market will correct itself. Rosé sour beers, for example, by brewers like Crooked Stave, will continue to thrive. Big Beer investors are rolling out boozy sparkling water brands left and right. CBD cocktails, especially prepackaged ones, will evolve and elevate. Bourbon-barrel-aged wine will continue to sell, whether we want it to or not; and so sommeliers and retailers need to rethink how to market to the predominantly young, male consumers buying these bottles.

That goes for genre-bending spaces, too.

The smartest hybrids in the business are neither canned nor bottled. Wine shops like The Royce in Detroit are transforming into drinking destinations, offering stylish bars where guests sip cocktails and vino by the glass. Brewpubs and honky-tonks are helmed by sommeliers with Michelin-starred résumés. Excellent wine bars, like High Treason in San Francisco, serve a full list of beer, cider, and sake alongside vino. In 2019, sommelier or cicerone certification will be less important than finding beverage directors who can think across categories and speak to all consumers.

Sommeliers will be everywhere.

As wine professionals become household names, we will see more brand extensions. Patrick Cappiello, Jeff Porter, Thomas Pastuszak, Bobby Stuckey, and Ryan Arnold have already created their own wine labels.
In February, Stuckey started selecting wines for American Airlines, joining such high-flying somms as Andrea Robinson, who works with Delta, and Doug Frost with United. “I think the wine industry is in front of more people than it used to be,” Stuckey said.

More somms will follow suit in 2019. Look for top wine pros’ branding on everything from wine labels to clubs to education to entertainment.

If the economy turns, craft breweries will be in trouble.
The Federal Reserve forecasts less economic growth and more uncertainty in America in 2019, and predicts higher rates of unemployment come 2020 and 2021. In addition to wreaking havoc on financial markets in the short term, this could devastate the already perilous state of craft breweries in the year to come.

The majority of America’s 7,000-and-counting breweries have only existed in a booming economy. “Between 2008 and 2016, the number of brewery establishments expanded by a factor of six, and the number of brewery workers grew by 120 percent,” Derek Thompson wrote in The Atlantic in January 2018. “The source of these new jobs and new establishments is no mystery to beer fans. It’s the craft-beer revolution.”

Now, however, craft growth is slowing. If met with the predicted economic downturn, it could devastate a still-maturing industry.

This might explain why so many craft breweries have partnered with major food conglomerates in 2018. Recent odd couples include 2SP Brewing with Wawa, Blue Point with Taco Bell, and Harpoon with Dunkin’ Donuts. Expect to see more partnerships like these in the coming year.

Low- and no-proof cocktail lists will go national.
Wellness and aperitif cultures rose in tandem in 2018, and so the spritz was an exceedingly popular cocktail. (A multi-tiered marketing push from Gruppo Camparididn’t hurt its cause, either.) Low- and no-proof cocktails are the natural next step.

Younger consumers reportedly drink less than their preceding generations, and smart bars and restaurants that want to keep those dollars are allocating resources to creating low- and no-proof cocktails. We have already seen this happening at cutting-edge destinations like Polite Provisions in San Diego and Katana Kitten in NYC. Zero-proof bottled cocktails and non-alcoholic spirits like Seedlip are nationally available. In 2019, bartenders nationwide will put just as much effort into low- and no-proof cocktails as their full-strength equivalents.
Get a second opinion on your financial health

Investors have survived market swings and correction before, but uncertainty may have you wondering if you should get another opinion to confirm if your wealth is in the right place. Maybe you just want to know if you’re really on track for retirement or if your investments could be better aligned to your goals. Or in the process of working hard for your money, you worry you’ve overlooked some steps to transfer your wealth.

Whatever’s on your mind, I’m here to listen and help evaluate your plan. Then you can decide if your wealth is getting the care it deserves.

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• CME: Out with the Old and In with the New: The Next Accreditation System
Congratulations to Dr. Ruple Galani, 2019 DCMS President!
Securing Your Greatest Economic Asset

By Zachary Cohen, Financial Advisor

It’s disconcerting to think over one in four of today’s twenty-year olds will become disabled before they retire. Did you know that most physicians don’t have enough emergency funds to cover 35 months, which is the average duration of a long-term disability claim? Most people don’t appreciate the commitment and perseverance physicians demonstrate throughout their academic and working careers. Working endless hours for years and earning a minimal salary while stacking up student loan debt at close to 7% in medical school, makes everyone wonder, “was it even worth it?” Then you sit back and think about the income potential, a physician’s cumulative earnings over their career, it makes the sacrifice a little easier to swallow.

A disruption of cash flow as a result of a disability will lessen the likelihood of someone being able to justify the time, student loans and sacrifice they’ve made for the future. Disability income insurance is a protection plan every medical student, resident, fellow or physician should own to know their sacrifice was always worth it. It’s obvious this is something all professionals should have in place, but how easy is it to qualify for disability insurance and what’s the process? What other options are out there? Every sales person has a pitch and they all sound believable.

When you think about the causes for disability, usually accidents are not the culprit, but back injuries, cancer, heart diseases, and mental/nervous disorders, are the main reasons physicians lose their ability to earn a future income, with musculoskeletal disorders being the number one cause (disabilitycanhappen.org). The insurance companies know the risk to their bottom line, and are laser focused on the risk of covering your future income potential.

The cumulative benefit payout on a long-term disability policy is often around four to seven million. When you understand the risk to the insurance company, you can clearly see why the disability underwriting process can be stringent and intrusive and why disability plans can be so expensive. Although the price tag can be steep, this is the best option to protect someone’s future earnings ability. Unfortunately, physicians can’t rely on the social security disability program. In fact, for 2018, if you’re making over $1,500 per month, your payment would be reduced to zero (Dr. David A Morton III 2018).

What about your group disability offered through your employer? Many of us believe group disability is a sufficient option. Yes, it’s cheap and easy. However, group disability leaves a significant gap in coverage taking into account the taxability of benefits, caps on monthly benefits, limited definitions and portability issues. Most claims are not work related, and therefore not covered by worker’s compensation. Knowing your greatest economic asset in life is your ability to earn your future income potential, the only way to protect it is by owning the right individual disability policy for your specialty. An individual disability policy affords you the time necessary to recuperate before returning to work while replacing a greater percentage of income in the event you are unable to work due to an injury or illness.

I’m sure we would all like to avoid intrusive medical exams, bothersome insurance agents and the time-consuming underwriting process involved with obtaining an individual disability policy. There is a way! All employers should be aware of a program called Guaranteed Standard Issue or GSI. These programs avoid detailed medical underwriting, financial documentation and, more importantly, can protect those physicians with health issues from being limited or denied the ability to protect themselves adequately. The underlying product is an individual policy that’s individually owned and portable, meaning employees are in control of policy decisions and can take the policy with them if they leave their employer.

Given today’s competitive employment environment, employers are regularly looking for valuable benefits to attract and retain employees. What if there was a solution that could protect employees along with the future earnings trajectory of the business while providing potential tax benefits? By implementing a Guaranteed Standard Issue Plan, employers can also enjoy a year after year, annual tax deduction.

We understand there’s a real urgency to get the appropriate protection plan in place for your greatest economic asset, it’s important to be aware of all the options. Buyers beware of those insurance agents contracted to sell proprietary products for one institution. As an independent financial planning firm, we’d be honored to review your disability plan. We’ll provide a comparative analysis for the best available options depending on your state and medical specialty. There are various ways to structure a disability program, make sure you’re working with an advisor who can help you understand how these contracts work while providing you with the most suitable options available. St. Johns Asset Management is proud of our partnership with the DCMS. Through this partnership we are able to offer a permanent discount and streamlined underwriting, potentially avoiding the need for a medical exam for all members, including residents.

For eight years, Zach Cohen has specifically worked with doctors and healthcare executives in sculpting custom disability insurance plans. You can reach him at his Jacksonville office at 904-644-7803.

Out with the Old and In with the New: The Next Accreditation System

**Background:**
The Duval County Medical Society (DCMS) is proud to provide its members with free continuing medical education (CME) opportunities in subject areas mandated and suggested by the State of Florida Board of Medicine to obtain and retain medical licensure. The DCMS would like to thank the St. Vincent’s Healthcare Committee on CME for reviewing and accrediting this activity in compliance with the Accreditation Council on Continuing Medical Education (ACCME).

This issue of *Northeast Florida Medicine* includes an article, “Out with the Old and In with the New: The Next Accreditation System” authored by Leslie Caulder, BAS, C-TAGME, Jennifer Hamilton, BA, C-TAGME, Danielle Palmer, BAA, Denise West, MA, and Linda R. Edwards, MD, which has been approved for 1 AMA PRA Category 1 credit.™ For a full description of CME requirements for Florida physicians, please visit [www.dcmsonline.org](http://www.dcmsonline.org).

**Faculty/Credentials:**
Leslie Caulder, BAS, C-TAGME, Assistant Director, Education and Training Programs, Jennifer Hamilton, BA, C-TAGME, Residency & Fellowship Coordinator II, Danielle Palmer, BAA, GME Accreditation Administrator, and Denise West, MA, GME Accreditation Administrator, are with the Office of Educational Affairs, University of Florida College of Medicine-Jacksonville. Linda R. Edwards, MD, is the Senior Associate Dean and DIO at University of Florida College of Medicine-Jacksonville.

**Objectives:**
1. Identify the differences between the ACGME’s current Next Accreditation System (NAS) and the pre-NAS process
2. Understand the purpose of the Annual Program Evaluation and Self-Study
3. Be able to recognize the ACGME’s Milestones

**Date of release: Jan. 1, 2019    Date Credit Expires: Jan. 1, 2021    Estimated Completion Time: 1 hour**

**How to Earn this CME Credit:**
1) Read the “Out with the Old and In with the New: The Next Accreditation System” article.
2) Complete the posttest. Scan and email your test to Kristy Williford at kristy@dcmsonline.org.
3) You can also go to [www.dcmsonline.org/NEFMCME](http://www.dcmsonline.org/NEFMCME) to read the article and take the CME test online.
4) All non-members must submit payment for their CME before their test can be graded.

**CME Credit Eligibility:**
A minimum passing grade of 70% must be achieved. Only one re-take opportunity will be granted. If you take your test online, a certificate of credit/completion will be automatically downloaded to your DCMS member profile. If you submit your test by mail, a certificate of credit/completion will be emailed within four weeks of submission. If you have any questions, please contact Kristy Williford at 904-355-6561 or kristy@dcmsonline.org.

**Faculty Disclosure:**
Leslie Caulder, BAS, C-TAGME, Jennifer Hamilton, BA, C-TAGME, Danielle Palmer, BAA, Denise West, MA, and Linda R. Edwards, MD report no significant relations to disclose, financial or otherwise with any commercial supporter or product manufacturer associated with this activity.

**Disclosure of Conflicts of Interest:**
St. Vincent’s Healthcare (SVHC) requires speakers, faculty, CME Committee and other individuals who are in a position to control the content of this educational activity to disclose any real or apparent conflict of interest they may have as related to the content of this activity. All identified conflicts of interest are thoroughly evaluated by SVHC for fair balance, scientific objectivity of studies mentioned in the presentation and educational materials used as basis for content, and appropriateness of patient care recommendations.

**Joint Sponsorship Accreditation Statement**
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of St. Vincent’s Healthcare and the Duval County Medical Society. St. Vincent’s Healthcare designates this educational activity for a maximum of 1 AMA PRA Category 1 credit.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.
Abstract

Understanding and adhering to the Accreditation Council for Graduate Medical Education (ACGME) program requirements is essential for programs seeking initial accreditation or for those wishing to maintain accreditation. ACGME’s implementation of the Next Accreditation System (NAS) dramatically changed the way the organization accredits programs. This system has moved from a cyclical accreditation review process to a continuous accreditation model. The University of Florida College of Medicine-Jacksonville has implemented several processes, allowing institutional oversight of program accreditation to mirror the NAS process.

Introduction

The Accreditation Council for Graduate Medical Education (ACGME), founded in 1981, brought much needed organizational structure and educational standards to graduate medical education (GME) programs in the United States.1 In 2017-2018, the ACGME had at least 8212 sponsoring institutions and 11,140 residency and fellowship programs, with 136,828 housestaff receiving specialty specific training in those programs.3 Through the use of specialty Review Committee(s) (RC), the Council started on a journey to standardize educational practices, foster public confidence, and document physician competence.1 Physicians who completed an ACGME-accredited residency or fellowship program would have achieved specialty specific competence. Over the years, the ACGME has launched several influential initiatives to foster and encourage physicians to broaden their learning beyond the textbook. According to Nasca et al in the article, The next GME accreditation system: rationale and benefits, “The aims of the Next Accreditation System (NAS) are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME’s movement towards accreditation on the basis of educational outcomes and to reduce the burden associated with the current structure and process-based approach.”1 The purpose of this article is to review the changes in the accreditation process and share how the University of Florida College of Medicine-Jacksonville (UFCOM-J) and its accredited residencies and fellowships have moved from the standard accreditation model to the Next Accreditation System (NAS), which launched in July 2013.1

The Accreditation Process

In the NAS, initial accreditation has remained remarkably similar to the pre-NAS process. First, the application is submitted to the ACGME. The review committee either does a paper review or schedules a pre-accreditation site visit. Following the paper review or Site Visit (SV), the RC makes the accreditation status decision and approved programs receive initial accreditation.4 However, the process in the NAS has changed the continued accreditation flow. At the conclusion of the initial accreditation period, the ACGME awards one of four accreditation statuses: Continued Accreditation, Accreditation with Warning, Probationary Accreditation, or Accreditation Withdrawn.4 Prior to the implementation of the NAS, the ACGME determined a program’s accreditation status based upon data provided to the RC through submission of the Program Information Form (PIF) and the associated SV. Programs began preparing nine months to a year before the anticipated SV date. The program submitted the PIF to the site visit or approximately ten to fifteen days before the scheduled visit. After the visit, the SV team submitted their report to the RC for consideration at their next meeting. During the
Review Committee meeting, members evaluated the materials and determined the accreditation status based on the information from the PIF and the Site Visit Report. Programs received notification of the committee’s accreditation decision eight to ten months after the SV PIF submission. Continued accreditation statuses were set for periods between two and five years. Programs on probation could expect to have another SV within 15 months. Review committees made accreditation decisions based on a snapshot in time, or a biopsy, of the program’s adherence to the RC standards (Figure 1). The NAS has dramatically changed this process by replacing cyclical reviews with annual reviews.

During the pre-NAS cyclical accreditation process, institutions were required to perform a programmatic Internal Review (IR) at the mid-point of the accreditation cycle. The institutional requirements did not specify how this internal review was to be conducted, only that it would occur. At UFCOM-J, the process included a panel review and interview session. The panel consisted of the Designated Institutional Official (DIO), who was also the Senior Associate Dean for Educational Affairs, the Associate Dean for Educational Affairs, two or more program directors and/or associate program directors, a hospital administrator, and a resident/fellow from another program. The program director was required to complete an internal review form addressing citations, attrition, board certification, in-service examinations, and program requirements. In addition, the program’s residents/fellows and faculty completed an anonymous survey assessing the program. The panel reviewed the completed PIF and survey results prior to a scheduled IR meeting. The meeting included separate group interviews with the faculty and trainees to discuss any issues identified on the survey and the program as a whole, as well as an interview with the program director and coordinator. An internal review report was provided to the Graduate Medical Education Committee for review and approval. The internal review report identified issues and assisted the program director with the development of solutions prior to the next ACGME Site Visit. Post-NAS, the ACGME no longer requires internal reviews. The UFCOM-J continues to conduct IRs of all programs in the initial accreditation phase to ensure that new programs remain in substantial compliance with the ACGME common and program specific requirements.

Annual Program Evaluation (APE)

As a part of the new Common Program Requirements (CPRs) implemented through NAS, all programs are required to complete an Annual Program Evaluation (APE). The APE is a self-assessment that mirrors information requested annually by the ACGME through the Accreditation Data System (ADS). Even though the institution is no longer required to complete internal reviews, programs in continued accreditation status complete the annual review process using the institution’s Annual Program Evaluation Review (APER) form.

Again, the institutional requirements do not specify how to accomplish the annual review. To accomplish this requirement, the UFCOM-J established a Committee for Annual Program Evaluation and Review (CAPER), a subcommittee of the Graduate Medical Education Committee (GMEC), charged with reviewing each program’s self-assessment/APE for compliance with ACGME program standards. Table 1 lists the key focus areas for CAPER participants. The program director and coordinator complete a UFCOM-J standardized Annual Program Evaluation and Review

Figure 1
(APER) form and provide supporting data, which is then reviewed/evaluated by faculty and residents during their Program Evaluation Committee (PEC) meeting. During the PEC meeting, the program develops action items and timelines for improvements in the following areas, as applicable: 1) self-identified areas of weakness; 2) citations or areas of concern in the ACGME’s most recent Accreditation Letter; and, 3) items marked as non-compliant or needs improvement during the previous year’s APE review.

A primary and secondary reviewer analyze the submission, comparing the program’s data with the RC’s requirements. The reviewers share their analysis at the CAPER meeting, where the committee mutually decides the recommended final statuses: continued annual review, follow-up review/progress report, or special review. The committee chair provides the GMEC with an executive summary of each program and recommended status for the GMEC’s final approval. The CAPER’s detailed review provides timely identification of areas of concern or potential non-compliance.

The CAPER provides the DIO with data across all programs, allowing the institution to examine trends and to identify areas of improvement needed on the program and/or institutional level. The trends sheet (“dashboard”) provides a visualization tool of each focus area to create action items for possible implementation during the next academic year. The Office of Educational Affairs (OEA) identifies trends through data analysis of the focus areas. The trends sheet in Table 2 lists the programs across the top and key areas from the APER form on the left side.

### Self-Study and Programmatic Site Visit

To bolster this new era of program introspection, the ACGME also implemented the Self-Study (SS). The programs self-assessment through the APE provides the foundation for the Self-Study. According to the ACGME, “The Self-Study is an objective, comprehensive evaluation of the residency or fellowship program, with the aim of improving it. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment, facilitated through sequential annual program evaluations that focus on the required components, with an emphasis on program strengths and ‘self-identified’ areas for improvement.”

The Self-Study is an eight-step process: 1) Assemble the Self-Study group, 2) Engage program leaders and constituents in a discussion of program aims, 3) Aggregate and analyze data from the program’s APE and the Self-Study to create a longitudinal assessment of program strengths and areas for improvement, 4) Examine the program’s environment for opportunities and threats, 5) Obtain stakeholder input on strengths, areas for improvement, opportunities, and threats to prioritize actions, 6) Interpret the data and aggregate the self-study findings, 7) Discuss and validate the findings with stakeholders, 8) Develop a Self-Study document for use in further program improvement as the

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<th>Table 1: CAPER Key Focus Areas:</th>
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<tr>
<td><strong>Annual Program Evaluation/ Program Evaluation Committee (PEC)</strong></td>
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<tr>
<td>Faculty:</td>
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<td>- Survey Results- Assess results, identify areas of concern, develop a plan to improve</td>
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<td>- Board Certification</td>
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<td>- In-training Exam</td>
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<td>Scholarly Activity</td>
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<td>- Clinical Measures- Based on data from chosen key clinical indicators</td>
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<td>- Patient Safety</td>
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<td>- Quality Improvement and Work in Inter-professional Teams</td>
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<td>- Supervision</td>
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<td>- Professionalism (includes code of conduct violations, warnings and disciplinary actions)</td>
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<td>- Faculty Development (individual faculty participation in faculty development activities in education)</td>
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<td>Didactic Curriculum</td>
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<td>- Milestones- Assess trends in aggregated resident/fellow performance on milestones to affect curricular change</td>
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<td>- Rotation Review- Identify changes and improvements that need to be made to the curriculum (adding or removing rotations or sites and adding improvements to specific rotations)</td>
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<td>- Case Logs</td>
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<td>- Goals and Objectives</td>
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<td>- Clinical Competency Committee (CCC)</td>
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<td>- Evaluations</td>
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<td>- Transitions of Care</td>
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Fall in Love with Laid-Back Luxury in Aspen

7 great reasons why you’ll love a winter vacation in this extremely stylish Rocky Mountain town

BY JENNY CAHILL-JONES

Well known as a mountain retreat for America’s rich and famous—movie stars (Goldie Hawn, Kevin Costner) and business moguls alike (Michael Eisner) flock here—Aspen has the skiing chops to balance its reputation as a mini mountain Tinseltown. If you love to ski, you’ll find endless enjoyment across the four mountains that make up the resort.

However, the proximity of so many well-heeled individuals means that unlike many American resort towns, Aspen has a whole lot to offer off the slopes as well as on. It might be one of the best ski resorts in Colorado, but for those days when your legs need a break, or if skiing is just not really your thing, here are 7 great reasons why you’ll love a winter vacation in this extremely stylish Rocky Mountain town.

1. Chic Mountain Shopping
Aspen takes its shopping so seriously that the downtown sidewalks are heated to ensure no amount of snow and ice will stand in the way of you and your retail therapy. Label lovers should head straight for Galena street—where you’ll find all the major names, from Prada to Ralph Lauren, to chic ski wear brands like Moncler.

When you need a break, head for some of the best coffee in town at SO cafe in Aspen Art Museum, located right downtown. After your coffee break, enjoy the revolving exhibits of work by contemporary artists at the museum.

2. Five-Star Dining
With an emphasis on local ingredients and farm-to-table dining, Aspen has been a leading light on Colorado’s culinary scene for decades, and there are seriously tasty options for every meal of the day.

For an early morning coffee fix, locals swear by Peach’s Corner Cafe—you’re likely to meet a local cop stopping in on their way to the station. However, this is Aspen, and even in cozy corner cafes the oatmeal is organic and steel cut and poached eggs come served over herb roasted vegetables with pistachio sausage.

Lunch is all about fresh ingredients sandwiched between pieces of delicious bread—or so say the owners of the ever popular White House Tavern. Try the classic French Dip: prime rib piled on a homemade roll, or the Crispy Chicken Sandwich, served on homemade torta with spicy slaw.

Dinner is a chance to try one of Aspen’s top fine dining restaurants, Element 47 at the most celeb-friendly hotel in town, The Little Nell. Named for the town’s silver mining heritage (silver is element number 47 on the periodic table), the restaurant is sleek and chic – a mixture of grey banquettes and slate blue chairs, low lighting and an illuminated, glass-walled wine cellar that takes up an entire wall – and the food is exemplary.

3. Indulgent Spa Treatments
Treat yourself to a day of pure pampering at one of Aspen’s bliss-inducing spas. Remede, at the St Regis resort, promises to transport you into a world of relaxation, with indulgent treatments like the Remede Customized Bath—a 30-minute soak in an oversized tub scented with aromatherapy oils, juniper and honey—or an award-winning facial. We can’t
think of a better way to escape from winter temperatures. Once you’re suitably warmed up, you can enjoy a champagne afternoon tea by the fireside while the snow falls gently outside. How’s that for a winter wonderland?

4. Ice skating Under the Stars
At the base of Aspen Mountain, the Silver Circle outdoor rink, lit by flickering fairy lights, is the perfect way to round off a day in the mountains. OK so the rink is not huge, but a few turns around with the object of your affection and you’ll have stars in your eyes. Round off the romance with a hot chocolate (rum-spiked if you choose) at The Living Room at Hotel Jerome, where the Hot Mama is a very grown-up version of the sweet treat. The living room has one of the best apres-ski scenes in Aspen, so you’ll be in good company.

5. Snowshoe Trails
Even if you don’t ski, you’ll still want to get outside in all that beautiful snow once you arrive in Aspen. The good news is there are plenty of ways to enjoy the great winter outdoors without boots and poles. First up is snowshoeing, for which all you need is a pair of rackets and a sense of adventure. One of the most popular snowshoe trails is the easy, under 4 mile Tom Blake trail, through the aspen tree groves in Snowmass. The former mining outpost (now a ghost town) of Ashcroft is another popular spot with over 20 miles of groomed trails to explore, and a great spot to stop for lunch, the Pine Creek Cookhouse. For trail maps, the Aspen Nordic Center is a great resource—and your Luxury Retreats concierge can organize equipment rental and guided hikes to make the most of your surroundings.

6. Dog-Sled Adventures
To get your adrenaline pumping, try a dog-sled ride through the snow-covered forest, a truly exhilarating experience. Snuggled under a blanket (each sled takes up to two adults and a small child) with a team of Alaskan huskies in front of you, it’s like going back in time to the days of Wild West exploration. For added romance, set out at twilight and watch the sun go down over the mountains as you race through the pristine snow.

Experienced dog sled outfitters Krabloonik offer a twilight ride that starts off just before sunset, takes in a campfire stop halfway through so you can warm your hands under the stars, and finishes with refreshments in their own mountain restaurant. A good night’s sleep is guaranteed!

7. A Night at the Opera
Aspen might be a former mining outpost in the mountains, but the influx of influential residents has brought world-class music and arts performances to the town, which even has its own opera house, the Wheeler. The theater puts on a wide variety of shows throughout the year – from opera performances (and showings of Live at the Met) to comedians and pop music shows, so no matter when you’re
Delegation
Effectively managing a team involves properly delegating tasks, since no one has the knowledge and expertise to manage everything on their own. Create an atmosphere of problem-solving and empower others to always work at the top of their licensure.

When non-clinical issues arise, they shouldn’t always be a physician’s responsibility. Hiring an office manager to coordinate administrative issues allows physicians to focus on patients, rather than micromanaging staff.

Strategic Planning
Strong leaders strategize with their team to set actionable goals for future success. Implement monthly or bi-monthly staff meetings to coordinate with your medical practice employees. Always set an agenda for meetings to avoid unfocused discussion and wasted time. Review updates since the last meeting, compliment office successes, share results of patient surveys, and note areas of improvement. Then, address staff questions and concerns, and reiterate your practice’s upcoming goals to inspire staff and conclude the meeting.

Listening
Running any business involves listening and responding to feedback. Since patients experience every aspect of your medical practice, use patient surveys to identify areas of weakness and improvement. Share the positive accolades your staff receives from patients, and then build on useful feedback to implement changes.

Additionally, listen to feedback from current employees. If a staff member chooses to leave your practice, ask about their experience and reasons for leaving. Always treat departing staff with respect, and keep their responses confidential. This feedback is critical to identifying problems, decreasing employee turnover, and improving morale for your employees.

Cooperation
To foster an atmosphere of cooperation, a successful leader builds a team of friendly, hardworking, goal-oriented employees:

- Hire effective team members
  When hiring a new staff member, always conduct thorough interviews and background checks. Ensure the candidate has a strong work ethic and exemplary people skills, since staff members help to build positive relationships with your patients.

- Train staff to be courteous and friendly
  Your medical office provides a customer-facing service, so staff must be courteous and helpful during every interaction with patients. Train staff to smile in the office and also when speaking on the phone. Smiling and positive body language improve telephone calls for both patients and employees.

- Implement FAQ scripts and office workflows
  To streamline office communications and routines, implement Frequently Asked Questions (FAQ) scripts and office workflows. FAQ scripts should include answers to questions that staff often receive. The script then acts as a template for employee responses to ensure all patients receive accurate, consistent answers.

  Team workflows for staff, nurses, and physicians outline employees’ roles, responsibilities and specific processes. Workflows guarantee that every team member follows the same procedures, to avoid oversights and misunderstandings, while increasing efficiency.

- Communication
  An effective physician leader uses his or her communication skills to inspire, motivate, and manage staff. For your practice to run smoothly, communicate with every staff member, nurse, and physician to outline his or her job expectations. Then, use constructive criticism to compliment areas where an employee succeeds, before giving helpful suggestions on areas of improvement.

Running a medical office requires strong leadership skills, but this may not come naturally to every physician. Improve your medical practice for your staff, patients, and yourself, by taking steps to strengthen your leadership skills. Look for new chances every day to:

1. Motivate staff by praising their hard work
2. Relinquish some authority and control to properly delegate tasks
3. And ask for feedback from patients and employees to find ongoing opportunities for improvement.

5 Traits of Successful Physician Leaders
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As always, when we get ready to do a list of the best fill-in-the-blank food in Jacksonville, we prepare by making a list of every restaurant we will need to visit. Then we hit up our followers on social media and ask for their input. We compare lists and add to ours if need be, making sure to give every restaurant a fair shake. Then we organize the list in a geographical order and head out to start eating. The plan is always to hit every restaurant on the list within two consecutive days so that each entry is fresh enough in our minds to compare. Sometimes that bleeds over into an extra day or two due to closed restaurants or unforeseen issues.

We always lay out parameters for our Best Of food treks. For fried chicken, the requirement was the restaurant had to serve bone in fried chicken as a meal on their regular menu. Any restaurant that served only certain parts of the chicken, or chicken and waffles, or any form of fried chicken that wasn't a traditional bone in fried chicken, or only had fried chicken some days as a special did not qualify to be a part of this Fried Chicken Quest.

After eating chicken all over this city, we give you the Top Five Fried Chicken Spots in Jax:

#5: The Potter’s House Soul Food Bistro
Soul Food Bistro has long been a favorite of Jacksonville fried chicken lovers. Their sides are wonderful and their oxtail wontons are magical. On a good day their fried chicken is just the right amount of salty crunchy and juicy. If you asked 100 Jacksonville diners where the best fried chicken in Jax is I would wager that Soul Food Bistro is the answer you’d hear more than any other restaurant on the list. One the day where we drove the whole city to rank fried chicken spots the fried chicken we were served had very obviously been sitting for quite some time and was very dry. Had this been our first time trying Soul Food Bistro they wouldn’t have made the list at all. Since we’ve had numerous visits to the restaurant where their fried chicken was fantastic we decided to include them at #5. We’d expect to see them move up next year.

#4: Hangar Bay
Hangar Bay combines two distinctly different kinds of soul food into one restaurant to offer diners a unique kind of treat. Ramen represents Japanese soul food on the menu and fried chicken of course represents American soul food. Their fried chicken is tasty and we expect you’ll enjoy it.

#3: Soul Food Express
This little spot on the Eastside of Jacksonville is very easy to pass by and never notice. Located in a brick building with a small awning that says Soul Food Express on East 21st Street is where you’ll find this hidden gem. Soul Food express offers all the traditional soul food you’d find in any great deep south soul food joint. You can get your fix of Chitlings, liver, gizzards, and so much more. Their fried chicken has a unique breading that you won’t find on fried chicken anywhere else in town. I struggle to find the words to describe it so I’ll simply tell you that it’s worth going out of your way to head down to the Eastside to try it. On our visit to Soul Food Express the folks running the restaurant seemed to know every single person found in the steady stream of people flowing through the door. This is one of those classic neighborhood spots that are so important to the fabric of a city’s food scene.


**Fried Chicken – Soul Food Express**

#2: Coop 303

Coop 303 is one of Jacksonville's newest additions to Jacksonville's food scene. This new 2 story building occupies the space previously filled by Al's Pizza in Atlantic Beach. The building itself is gorgeous and full of playful odes with art and southern cuisine. Coop 303's most popular entrees are the fried chicken and the peaches and cream (a fun presentation of fried green tomatoes topped with burrata and peach jam). On our first visit Coop 303 stumbled a bit served us a badly prepared and over-salted version of their signature fried chicken. On the day where we travelled the city of Jacksonville to try every relevant fried chicken in town the fried chicken was absolutely incredible. It was every bit of the juiciness and flavor you dream about when you dream whimsical dreams of biting into incredible fried chicken. The only reason these guys weren't number 1 is the lack of consistency. We fully expect them to contend for the title next year.

**Fried Chicken – Coop 303**

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**#1: Shut Em Down**

This soul food spot located in an old Famous Amos building is no frills and all great food. Shut Em Down keeps things simple serving up fried chicken befitting your grandmother's table. They don't do anything crazy or out of the ordinary they simply execute an excellent fried chicken recipe “to a T” every single time they serve it (or at least every one of the many times we’ve visited). The consistency with which they put out amazing fried chicken is remarkable. It's fried fresh when you order it so there may be a short wait. We'd rather have quality than speed. If you want the fried chicken you’ll find to consistently be the best in Jacksonville this is the spot. If you need a place to unwind and simply be around positive people who love what they do then Shut Em Down is the spot for that as well.

**Fried Chicken – Shut Em Down Authentic Southern Restaurant**

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**Dont be so poor that all you have is money**
Three years ago, I had a massive, life-changing event. It passed with little notice; it was beyond banal and happened while eating sushi with a colleague in a landlocked state.

Here I am with a young patient at the direct primary care practice I opened in Kansas City, Kansas, after residency.

We were in our last year of residency (he in internal medicine, myself in family medicine) and had realized that we wanted something more from the health care system, not only for ourselves and our careers but also for our patients. We ranted and complained over our sashimi, and as the evening unfolded, we found ourselves developing the dream that changed the trajectory of my career forever: We decided to open a clinic in the direct primary care model, and ceremoniously put pen to paper to jot down a few first steps to get the journey started.

What we didn't realize (and couldn't have realized) at that moment was that we both signed up to be entrepreneurs. We put one foot into the world of small business ownership. We crept out of the world of salaries and benefits and guaranteed success. Unless we defied the odds, we had set a course that, for the majority of people, leads to failure at best and bankruptcy at worst.

We had barely come up with a name and founding documents when my partner stepped out of the business. He had genuinely good reasons for leaving and was beyond gracious and caring in his exit, but in the conversation where we planned his exit—and planned my future—I firmly planted my second foot in the world of entrepreneurship.

It took me another year and a half to realize that I was an entrepreneur; I had become a small business owner. I had developed the type of business that adds character to a community. And I was solving problems that were so pervasive that people were using our services despite my poor efforts at marketing. We didn't even have a sign. We weren't paying for advertising.

For the first 18 months, we saw week-over-week growth in patient numbers. People were so in need of health care without the hassle of insurance that they were—quite literally—Googling us, calling us and trusting that we were a legitimate physician's office.

(That trust thing was huge. On more than one occasion, callers only wanted to make sure that I was a “real” physician because I wasn't affiliated with one of the large, corporate hospitals in town.)

Once I began to identify as an entrepreneur, a whole world of resources, networks, books, literature, and ways of thinking opened to me. And a nagging thought took hold: If we want to make health care better as an industry, we need more physician entrepreneurs. Or physician business owners. Or whatever you want to call it.

This doesn't mean I think we need more physician administrators — far from it. We need physicians who take the leap to launch an idea and solve a problem.

And here's why: With no institutional knowledge or expectations to hold them back, entrepreneurs have the freedom to create elegant, simple solutions.

Entrepreneurs, because they're often either working solo or in small groups, have the ability to change and pivot quickly when the climate dictates it.

• Health care has lost sight of the physician-patient relationship. An entrepreneurial endeavor, by necessity, demands that the inventor get down to a personal level and figure out solutions that work.
• Entrepreneurs often make decisions that are motivated by the desire to solve problems rather than the desire to make money. Health care may benefit from more leaders who exhibit this quality.
• Lastly, and most importantly, I'd argue that physicians and entrepreneurs share a central tenet of their being: problem-solving.

Both physicians and entrepreneurs are inherently problem-solvers. And everyone reading this knows that there are major problems to solve in health care.

Health care amounts to almost 18 percent of our gross domestic product (and keeps rising!) yet, somewhat paradoxically, it is an industry that has a huge target on its back. Every person, politician and business owner wants to reduce spending on health care. We want the best care, but we don't want to go into bankruptcy to receive it. We, as a society, have decided to commodify health care yet we are frustrated when patients are turned away. Drug costs are increasing with time rather than decreasing, counter to the trend with any other science and tech industry.
What gives?
Physicians are the cog on which the entire health care system turns. Without our orders, our prescriptions, our decisions, our procedures and our analysis of a patient’s needs, nothing else in the health care system receives business. If the health care system was a widget-making factory, we would be the machines that make the widget. Without us, there is no product and no business.

Several generations ago, physicians were both the widget-makers and the owners of the factory. They had both the burden and the privilege of seeing the product from inception through the machination process and into the consumer’s hands. They helped set prices and had to interact directly with the consumer that paid that price.

As the influence of insurers grew with the creation of Medicaid and Medicare in the 1960s and the growing influence of HMOs in the 1990s, more and more physicians stepped into the role of simply creating widgets. Running the factory was becoming too complex and required a certain administrative skill set — or at least required that the widget-maker focus on making widgets while someone else focused on running the factory.

But what if we all stepped away with our widgets we worked so hard to create and started to make them differently? Or started to sell them in a different way? What if we, as physicians, started to think like entrepreneurs? What problems could we solve?

Maybe it’s our debt coupled with our above-average paychecks that hold us hostage in the system. Or a terribly restrictive employment contract. Or worse yet, perhaps the biggest hurdle is our complacency as physicians. Perhaps we actually are satisfied with and unaware of — or in denial of — the deficiencies of the system in which we operate.

All of which are reasons we need more physician entrepreneurs. We need more widget-makers who see that there’s a better widget — or a better widget-making machine. We took an oath to help, and it just may be that stepping out of the current health care system and thinking like the problem-solvers we are is the best next step.

Allison Edwards is a family physician and founder, Kansas City Direct Primary Care. She can be reached on Twitter @KansasCityDPC. This article originally first appeared in the American Academy of Family Physicians Fresh Perspectives blog.
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