NORTHEAST FLORIDA MEDICINE

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In partnership with the Medical Societies of Duval, Clay & Nassau Counties

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165

Annual Special Edition

YEAR IN REVIEW

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Duval County Medical Society: Moving Forward in 2019

By Ruple Galani, MD, 2018 DCMS President

Over the years, the Duval County Medical Society (DCMS) has continued to transform itself into a powerful advocate for physicians, patients, and community health. As we move forward into the new year, the DCMS will continue its core mission, “Helping physicians care for the health of our community.”

Expanding our membership

The key to our mission is the continued growth, engagement, and dedication of our members. Going into 2019, the DCMS will work hard on reaching out to all physicians, employed, hospital based, private practices, large groups, and even nationally owned groups. With over four thousand physicians in the Duval County area, only about half are current DCMS members. The value of membership in regards to physician wellbeing, advocacy, leadership development, practice enhancement, philanthropy, and more continue to expand as member benefits. The stronger, more diverse, and bigger our membership base, the better DCMS can address the ongoing challenges that are faced in the work and personal lives of physicians.

As part of a membership expansion, there are opportunities to create subdivisions of memberships by practice type, location, and even common ethnic heritage. In doing so, the DCMS can serve as the common bond to help address and bridge issues for all physicians.

Commitment to Community Health and Philanthropy

The core foundation of the DCMS is physicians working every day for the health of our community. With the renewed strength of the DCMS Foundation through the Future of Healthcare Conference, DCMS members can now become community leaders for public health. Physicians can stand on a true non partisan bully pulpit and push for changes that help all Jacksonville residents achieve optimal health regardless of race, gender, zip code, or economic status. The DCMS can serve as the future liaison to help members find opportunities of philanthropy, volunteering, and outreach to promote improved health and welfare of our citizens.

By giving back to our community, the strength of the DCMS will continue to grow.

Physician Wellness

With help from the DCMS Foundation, our Medical Society has become a pioneer and role model for physicians across the nation dealing with work stress, life balance, and physician suicide. Through the LifeBridge Physician Wellness Program, the DCMS has begun to tackle this immense problem. This effort will only grow to make the lives of physicians, our joys, struggles, and challenges real to each other, our patients, and to our community. If physicians are mentally and physically unhealthy, our patients and our community will suffer. Working with our large practices, hospital systems, and all physicians, the DCMS will keep innovating, evolving, and expanding our programs made directly for physicians.

Advocacy

The future of medicine continues to be attacked and eroded by ongoing political debate, unclear and expensive mandates from CMS, and poorly planned policies that have unintended consequences. The DCMS will continue to work with our partners at the Florida Medical Association, American Medical Association, and multiple subspecialty societies to help detangle the web of regulations, policies, and mandates that do nothing but hamper our job as physicians and limit what we can do to care for our patients. The larger our medical society grows, the more voice and clout we have in Tallahassee, and even in Washington to affect positive change for physicians and patients. 2019 promises to be as political as ever, however, the DCMS will continue to guide and lead our local physicians with information, advocacy, and action.

The DCMS will continue to move forward in the years to come. Everything we will do in the future will help physicians, patients, and our community. Our strength will always be in our numbers, passion, and dedication for our profession and our patients.
Helping Physicians Care for the Health of Our Community: A Look Back at 2018

By Kristy Williford, DCMS Director of Communications

The Duval County Medical Society (DCMS) was founded in 1853 as the first medical society in Florida and continues to serve as the voice for organized medicine in Duval County. At that time, 165 years ago, a handful of physicians, ‘disease weary’ because of smallpox, dengue fever and malaria that had taken its toll on the citizens of Northeast Florida, met and formed the DCMS. Those physicians were passionate about caring for the health of this community, and today, well over a century later, our nearly 2,000 physician members continue to carry that passion.

In 2018, we had physicians who lobbied state legislators regarding new rules on prescribing opioids. We had physicians who traveled around the globe to provide medical care to the underprivileged. We had physicians donate time to treat the uninsured here in Jacksonville. We had physicians serving nationwide in roles within organized medicine. Simply put, we have physicians that don’t just ‘say,’ they ‘do.’

Times may have changed. We no longer have to worry about smallpox or dengue fever in Northeast Florida. But what hasn’t changed is the reason you – our physician members – are part of this Society. You care about the people and health of this community and you want to make a difference.

Advocacy

Tackling the opioid epidemic has been and continues to be a major priority for the DCMS. From in-depth discussions at the Future of Healthcare Conference, to sending frequent member communication regarding the new Florida controlled substance prescribing law, to CME events for our membership, we’ve been working hard to keep members abreast on the latest developments.

Two of our members, Dr. Sunil Joshi & Dr. Ferdinand Formoso, have been traveling around the region to provide the new state-mandated 2-hour Controlled Substance Prescribing CME course to hundreds of local physicians. Thanks to a DCMS partnership with Mayo Clinic and the Florida Academy of Family Physicians, these courses were provided at no cost to our members and included information on prescribing guidelines, and how the opioid epidemic is affecting your practices and patients.

Another important part of advocacy for the DCMS is working alongside the Florida Medical Association (FMA) and American Medical Association (AMA). This cooperation only occurs because of the dedication of our members willing to serve in roles both statewide and nationally. In August, more than two dozen of you traveled to Orlando to participate in the FMA House of Delegates. As one of the largest delegations in the state, we are able to ensure the voice of Northeast Florida physicians is heard in all decisions made at the state level of organized medicine.

Leading by example, our very own DCMS Past President Dr. Ashley Booth Norse currently serves as FMA Vice-Speaker. DCMS Past-Presidents Dr. Tra’Chella Johnson Foy and Dr. John Montgomery were elected this year as FMA Delegates to the American Medical Association. Dr. Mark Dobbertien was elected to serve as the FMA Surgical Specialty Board Representative.

At the state level, Dr. Mobeen Rathore currently serves as the District B representative to the FMA and at the national level, DCMS Past-Presidents Drs. W. Alan Harmon and Thomas Peters, and DCMS Treasurer James St. George currently serve as
delegates to the AMA alongside Drs. Montgomery and Johnson Foy.

Developing Leaders

As you can tell by the long list of members currently serving in state and national roles in organized medicine, the DCMS has a long history of physician leaders. From leaders of the Florida Medical Association to the World Medical Association, from those who’ve pioneered private practices and served as hospital executives, the DCMS is committed to ensuring the next generation of physician leaders has a strong Duval County representation.

To continue to develop leaders, we launched the DCMS Leadership Academy in 2016. Now heading into its fourth year and with already more than 60 graduates, this 3-day curriculum-based leadership training program ensures physicians can enhance their skills in the areas of team building, strategic planning, culture change, management styles, and more.

Membership Events

While advocacy and education are vitally important, the DCMS also aspires to build camaraderie among the physicians of Northeast Florida. By hosting a variety of events, our members are able to network and collaborate throughout the year.

The DCMS year essentially kicked off in November 2017 with the 165th Presidential Inaugural Ball and Annual Meeting at The Museum & Gardens. Cardiologist Dr. Ruple Galani was installed as 2018 President, taking the oath of office with help from his wife, Gina. During his inauguration speech, Dr. Galani shared that one of his top priorities for the year was to expand DCMS membership, believing that a larger member base further enhances the medical society’s role as a community leader.

A couple weeks later, dozens of DCMS members gathered at for one of our biggest family events of the year, the Annual Jaguars Tailgate Party. This fun event is an opportunity for physicians to take a break from their day-to-day responsibilities and enjoy some quality time with their colleagues and family members. It’s also a great way to give back to the community: all of the ticket proceeds support the DCMS Foundation!

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The DCMS is also leading the way in community health and wellness through our Future of Healthcare Conference which brings together physicians, healthcare providers, community members, and politicians to address the top health issues facing our region. The 2nd Annual Future of Healthcare Conference in May focused on the opioid crisis, violent crimes with guns, mental health, and physical fitness/obesity and brought together more than 200 people from Northeast Florida.

As physician burnout rates continue to rise nationwide, wellness continues to be a top priority for the DCMS. In July, the DCMS teamed up with Freedom Boat Club to host a no-stress event at the Julington Creek Marina and remind our members...
they need to take some time to unwind. There’s nothing like a relaxing boat ride along the St. Johns River to wash away the stress of the day!

At the Medical Society, we also recognize the importance of celebrating and collaborating with our military colleagues in healthcare. A longtime tradition, the Annual DCMS/Navy Dinner Meeting took place at the NAS Jacksonville Officers’ Club on August 28. Rear Admiral Bruce Gillingham, Deputy Chief of the Bureau of Medicine and Surgery, Readiness & Health, delivered an inspiring address to the more than 80 DCMS members and Naval Hospital physicians and guests who attended.

Supporting Residents & Fellows
The DCMS recognizes that our resident and fellow members have unique needs and, in 2018, continued its tradition of providing educational and social events for the more than 600 local residents and fellows who are members of the Society.

While young physicians are working hard learning to practice medicine, the most common request we hear is for education about what happens after residency. In April, the DCMS hosted the Life After Residency & Fellowship seminar with a focus on showing residents the best way to transition to life and practice when their training program ends. Topics included finding the right job, negotiating the perfect contract and managing student loan debt. This program is made possible through collaboration with the local hospital programs.

Each year, the DCMS also provides opportunities for residents and fellows to showcase their research through a poster presentation at the Future of Healthcare Conference. These young physicians presented on a variety of topics from treatment of diabetic macular edema to using the EHR as an education tool.

Of course, with daunting schedules and long hours at the office, residents and fellows also need time to have some fun! Beers with Peers events give trainees an opportunity to network with physicians from the other local hospitals while learning about the DCMS, our programs, and organized medicine. Three Beers with Peers events were held this year, including an outing to watch the Jacksonville Jumbo Shrimp.

2018 DCMS Officers & Board of Directors:

**Officers:**
- Ruple Galani, MD – President
- Stephen Mandia, MD – President Elect (resigned due to relocation)
- Elizabeth DeVos, MD – Vice President
- James St. George, MD – Treasurer
- Cynthia Anderson, MD – Secretary
- Tra’Chella Johnson Foy, MD – Immediate Past President

**Board of Directors:**
- Ingrid Carlson, MD
- Mark Dobbertien, DO
- Gianrico Farrugia, MD
- Carl Freeman, MD
- Frank Gilberstadt, MD
- Timothy Groover, MD
- Steven Kailes, MD
- Ali Kasradian, MD
- Parveen Khanna, MD
- Yvette McQueen, MD
- William Palmer, MD
- Daniel Thimann, MD

Helping Physicians Care for the Health of our Community

The mission statement of the Duval County Medical Society has and continues to be, “helping physicians care for the health of our community.” Whether it’s through education, advocacy, fellowship, volunteer opportunities, or wellness initiatives, we will continue to support our members each and every day. We know you have a lot on your plate as physicians: electronic medical records, governmental regulations, malpractice concerns, and lower reimbursements to name a few. No matter what you are going through, know that you can always turn to us at the Medical Society for help, advice, or even just a listening ear.
Duval County Medical Society Application

Online application available at www.dcmsonline.org

Please return application and payment to:
Duval County Medical Society
1301 Riverplace Blvd., Suite 1638
Jacksonville, FL 32207

or email to:
marissa@dcmsonline.org

PERSONAL INFORMATION

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MD □ DO □

Last Name
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FL Medical License #
Practice/ Group Name
Cell Phone
Primary Email Address

MEMBERSHIP DUES

Active: $395.00
One-time application fee: $50.00
Total: $445.00

DCMS members abide by the AMA Principle of Medical Ethics. By signing this application, I agree to answer any questions that arise from actions taken against my medical license. Furthermore, I understand that: 1) any false to misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the DCMS; 2) that by providing my fax number and email, I hereby consent to receive faxes and emails sent by or on behalf of the DCMS.

_____________________________________________
Applicant Signature
Date

PAY BY CHECK OR CREDIT CARD

Visa □ MC □ AmEx □ Discover □ Card #: ____________________________________________

Exp. Date: _________ Security Code: _________ Name on Card: _______________________

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QUICK SIGN UP

Please contact my administrator for all additional application information: Yes □ No □
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**WOULD YOU LIKE TO SUBMIT A HEADSHOT FOR THE DCMS WEBSITE ONLINE DIRECTORY?**  
YES □  NO □

Questions about this application? Contact Marissa Saftner at marissa@dcsonline.org or call (904) 355-6561.

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Thank you for joining the Duval County Medical Society!
Looking Ahead: The DCMS Foundation in 2019

By Sunil Joshi, MD, DCMS Foundation President

Growth, development, roaring waterways and a vibrant economy are ways in which one would describe Florida’s First Coast. This community has a lot to be proud of. Unfortunately, as in many similar sized cities, Jacksonville faces a variety of challenges such as crime, gun violence, obesity and an unusually high number of food deserts. The Duval County Medical Society Foundation (DCMSF) recognizes these challenges and is leading several efforts to improve the health of Northeast Florida. We will continue to move forward in the years to come.

Over the next twelve months, the DCMSF will play a huge role in writing public policy to incentivize grocers to enter into areas of town currently considered food deserts. With a goal of having a preliminary draft done by March 2019, this will become a major issue in local city council elections. In order to gain constructive feedback from interested parties, the coalition will hold a conference that will be open and free to public. This will allow for potential adjustments before the policy is brought to the city council for approval. It is very possible that next year at this time, we will have policy in place to eventually eliminate food deserts in Northeast Florida.

Violent crime, in particular gun violence, plays a major negative role in the health of our community. Losing young people to violent acts has become an epidemic throughout the country and is certainly the case in Duval County, as well. The DCMSF is supporting the American Medical Association’s policy of pushing for an elimination of the Dickey Amendment so that public funds can be allocated in order to research every aspect of gun violence. In medicine, we know that no one truly understands what works and what does not work until there is some data. The same is translatable to gun violence. There are a few larger cities that have taken part in a “Cure Violence” program that has made major impacts in those communities. This program looks at violence as a disease and sets up a plan to detect problems, intervene in high-risk situations and change the social culture. This program has the potential to reduce gun violence by between 43 and 71 percent based on its success in cities such as Baltimore and Oakland. Fortunately, partly due to the efforts of the DCMSF, Mayor Lenny Curry’s office is now funding an assessment looking into how this program may work in Jacksonville. Once again, just like with food deserts, the DCMSF will continue to lead local efforts to reduce gun violence and as a result improve the health of the entire region.

As the leaders of the healthcare team, physicians must remain fully committed to the well-being of their patients. This has become exceedingly more challenging in recent years with physician burnout reaching alarmingly high levels. Fortunately, the DCMSF’s LifeBridge Physician Wellness Program has continued to grow. This confidential, non-punitive and non-reportable counselling program is allowing physicians an outlet to obtain help. It has already made a tremendous impact with over 60 sessions paid through the DCMSF. We are also now reaching our colleagues in the neighboring counties of Clay and Nassau, and supporting our Veterinary medicine colleagues in Jacksonville. As the program continues to gain momentum, it will likely become an option for other local health professionals such as physician assistants, nurses and pharmacists for instance. The impact of the wellness program will be felt for years and even generations to come.

As we move into the Holiday Season, great things are expected of the Duval County Medical Society Foundation in 2019. From reducing food deserts and gun violence to promoting physician wellness, this organization will continue to succeed. In the process, the DCMSF will remain a driving force in helping physicians improve the health of our community.

Sunil Joshi, MD
DCMS Foundation President
DCMS Foundation: A Year in Review

The Academy of Medicine – Jacksonville was founded in 1959 as a non-profit institute of science research and learning, dealing primarily with medical science. In 2009, it was renamed The Duval County Medical Society (DCMS) Foundation to more appropriately match the relationship between the DCMS and its philanthropic arm. Today, the Foundation is a nonprofit, charitable 501(c)(3) organization that serves to improve the health of Northeast Florida by furthering community health education, enhancing health safety net organizations and supporting health professionals and their families.

Did You Know?

Did you know that the DCMS Foundation has contributed to the health of our region through a variety of initiatives:

- Founded We Care Jacksonville
- The Jacksonville Health Education Program (JHEP)
- Founding and development of the Borland Medical Library
- County-wide polio and rubella inoculation programs
- Financial and medical supply relief for international disaster victims
- Community education of HIV/AIDS and substance abuse
- Continuing medical education for physicians
- Fifty years of community health studies and research on a variety of illnesses
- Support for the International Health Volunteers Organization
- Partnering with the DCMS to produce the Northeast Florida Medicine journal.
- 904 Mission One Million

Mission First

Throughout its six-decade history, the DCMS Foundation has a history of supporting the DCMS Mission to care for the health of the Duval County community. 2018 was no exception. This year, the Foundation tackled important issues such as the opioid epidemic, gun violence as a public health issue, and physician burnout and suicide.

Future of Healthcare Conference

The flagship program of the DCMS Foundation is the Annual Future of Healthcare Conference. This annual meeting brings together local, state, and national thought leaders in medicine, medical research, business, public policy, technology, and politics to address issues adversely affecting the region. The goal is to encourage strategic thinking in tackling the region’s most pressing health problems.

The opioid discussion covered a wide range of information from data on local overdoses to an in-depth look at the opioid prescribing law that went into effect in July. The author of the legislation, Sen. Lizbeth Benacquisto, attended the conference to share her personal passion for tackling the opioid epidemic. Attendees also heard from a former Jacksonville dentist who bravely shared the devastating impact of losing his son to an opioid addiction.

The goal of the Conference is to not only discuss critical topics impacting healthcare, but to find solutions. Some of the current efforts underway as a result of Future of Healthcare Conferences include a committee working to draft legislation...
for the City of Jacksonville which will encourage the development of supermarkets in areas currently designated as food deserts, and a coalition of local and national leaders committed to reducing barriers to research which could help reduce injury and fatalities associated with gun violence.

As the Foundation looks to the future, there is no better way to do that than through the Future of Healthcare Conference. Work is already underway for the 2019 Conference scheduled to take place on October 7-8, 2019.

**Physician Education**

The DCMS Foundation is committed to the continuing education of its members by providing CME opportunities free of charge to all DCMS members. These opportunities are available through the monthly DCMS medical journal *Northeast Florida Medicine* and through the website at dcmsonline.org/NEFM-CME. The DCMS and DCMS Foundation also organize live CME events throughout the year on topics that are current and relevant to the physician membership.

In 2018, *Northeast Florida Medicine* partnered with MD Life Magazine to take the message and mission of the Foundation to an even greater audience. Now, every physician in Northeast Florida has access to the resources and education of the DCMS Foundation. Of course, DCMS members are still able to access all CME and educational resources for free!

**LifeBridge: Confidential Physician Counseling**

Let that number soak in for a minute. That’s the number of physicians who reported experiencing burnout in a report by The Physicians Foundation in September 2018. That’s basically four out of five physicians. Physician burnout and its complications are the number one threat to a physician’s medical career. This can lead to lower levels of patient care, more medical errors, and higher rates of staff turnover, disruptive behavior, substance abuse, and even suicide.

The Physicians Foundation reports that more than half of physicians are reluctant to seek appropriate mental health care for fear of impact on their medical license, employment contract, or perception in the community.

That’s where the Foundation comes in.

To support members in need, the Foundation has created the LifeBridge Program. Now any DCMS Member has the ability to access a completely confidential helpline, which will arrange a live one-on-one session with a professional counselor within 24 hours. The Foundation pays for your sessions (up to six per calendar year), and most importantly, your name is never shared with the Foundation, the DCMS or your employer. Even more importantly, the program does not create a medical record, so no information will go to your insurance or the Board of Medicine.

LifeBridge is available to provide support and resources for those suffering from burnout, family issues, or other difficulties. In only its second year, this Physician Wellness Program is already recognized by DCMS members as one of the top member benefits. Each member receives six free counseling sessions each calendar year with a certified counselor experienced in coaching healthcare professionals. A 24/7 appointment line is available at (904) 631-1446.

**National Leadership**

The LifeBridge program is receiving nationwide recognition for meeting the growing need of physicians for confidential mental health resources. The DCMS Foundation and several other County Medical Society Foundations from around the country have partnered with The Physicians Foundation to create resources to expand LifeBridge to physicians across the United States. At this time, more than 20 Societies have started LifeBridge programs for their local members. The DCMS Foundation will continue to be a national leader in physician wellness, with the goal of helping to facilitate access to this program for every physician in America.
Foundation - A Year In Review

2018/2019 Foundation

Officers:
President: Sunil Joshi, MD
Secretary/Treasurer: Todd Sack, MD

Board of Directors:
Mr. Doug Baer
Mr. Richard Brock
Ruple Galani, MD
Tra’Chella Johnson Foy, MD
Ms. Mia Jones
Ms. Bonnie Upright
Audrey Wooten, MD

A Campaign for Mission First:

Whether it’s founding We Care Jacksonville, sharing LifeBridge with physicians across the nation, or tackling our largest healthcare problems right at home at The Future of Healthcare Conference, the DCMS Foundation continues to focus on its Mission.

And that Mission is possible thanks to the generosity of the physicians and institutions in North Florida who are also committed to that Mission. However, there’s still a great deal of work to be done. You can be a part of helping us achieve that mission. The DCMS Foundation is a 501©3 organization. Your tax-deductible contribution will help to ensure that we continue to find the most important and impactful ways to care for the health of our community.

You can learn more about making a pledge by contacting Kristy Williford at kristy@dcmsonline.org. Donations can also be made at dcmsonline.org/donations.

Donate To The DCMS Foundation

Suggested Donation:

- $100.00
- $250.00
- $500.00
- $_____.

Other:

- One-Time Donation
- Recurring Monthly Donation (until cancelled)

Name: Email:

Card Number: Expiration Date:

Zip Code: CVV:

Return to marissa@dcmsonline.org or call (904) 355-6561 ext. 2001 to pay by phone
The NCMS has enjoyed some excellent meetings in 2018. We received a stellar presentation in February by Drs. Ricardo Hanel and Mohamed Chmayssani (neurosurgery and neurocritical care, respectively, both with Baptist Health) on their cutting-edge efforts to provide highly coordinated stroke care in the community. Members of the Nassau Alcohol Crime and Drug Abatement Coalition (NA-CDAC) including Dr. Penny Ziegler gave a relevant and extremely informative presentation in March addressing the opioid crisis; its origins, current statistics, and a discussion of efforts in progress at the national, state and local levels to address this critical issue. In April, the NCMS heard a provocative and informative talk from Dr. Scot Ackerman (Ackerman Cancer Center) on HPV-related cancers, and the role of immunization in the prevention of these neoplasms. As usual, Dr. Ackerman was ahead of the curve, with the HPV vaccine just approved this month by the FDA for administration in adults up to age 45. NCMS concluded the first half of the year in June with an on-site presentation and tour of the gorgeous, state-of-the-art facilities at nearby UF Health North.

I have had the privilege in 2018 to engage on behalf of the NCMS with our neighboring northeast Florida medical societies at multiple events. These included attending the thought-provoking Future of Healthcare Conference organized by the Duval County Medical Society (DCMS) and DCMS Foundation in May and serving as the Nassau County delegate to the Florida Medical Association (FMA) at the annual meeting held in Orlando in August. The critical contributions of our Northeast Florida medical community to the readiness of our nation’s active duty service-members was the inspirational focus of the DCMS Navy dinner in late August. I am thankful to have met with Drs. Joe Parra and Ruple Galani (presidents of the Clay County Medical Society [CCMS] and DCMS, respectively) on a number of occasions, in support of strengthening our regional societal coalition.
From the NCMS President’s Desk

This cooperative relationship has resulted in multiple beneficial opportunities for the NCMS membership. These include access to the DCMS-run LifeBridge Physician Wellness Program, a crucial lifeline for physicians struggling with burnout, and the gracious offering of state-mandated CME for controlled substance prescribing free of charge to NCMS members by the CCMS through Orange Park Medical Center.

As we look forward to a fall with more superb dinner meetings – we’ve already enjoyed an expert presentation on thromboembolic disease and anticoagulation given in September by Dr. John Gums, Associate Dean of Clinical & Administrative Affairs in the College of Pharmacy at the University of Florida – a look back at the year wouldn’t be complete without recognition of the energetic work on behalf of NCMS by our staff members Sallie Baumann and Bryan Campbell. Without their expert management, advocacy, and guidance, the NCMS would not thrive as it currently does.

The last I heard, the roadwork on A1A is not slated for completion in 2019. So more caution cones and potholes are in our future, and significant growth in our county looms large on the horizon. But I look forward to the year ahead confident that the NCMS membership will grow and strengthen in the process, just like our noble oaks.

NCMS Past-President Dr. Alan Miller entertains members at the 2017 Holiday Party.

John Gums, Pharm D gave a presentation on extended VTE thromboprophylaxis to NCMS members at the September NCMS meeting.

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Clay County Medical Society Year in Review

By Joseph M. Parra, MD, MBA, CPE, FAAFP, 2018 CCMS President

2018 has been a tremendous year for Clay County and the Clay County Medical Society (CCMS) as we’ve seen tremendous growth both inside and outside of healthcare. Both St. Vincent’s Clay County and Orange Park Medical Center have expanded in facilities and service. There has been great expansion in GME at Orange Park, as well. This year, our membership in the Clay County Medical Society has risen from 160 members in 2017 to a total of 210! We have also seen new physician specialties come to the community.

This year, the CCMS worked hard to advocate on your behalf on issues facing medicine. Our Society was well-represented at the Florida Medical Association (FMA) House of Delegates with CCMS members Drs. David El Hassan, John Zapp, Peter Jansen, and myself all traveling to Orlando to participate. Alongside our contingent from the Duval and Nassau County Medical Societies, we were successful in unifying our “First Coast” voice to work on legislation that will affect all physicians. Going above and beyond, Dr. El Hassan also visited Tallahassee during the Florida Legislative Session to serve as the “Doctor of the Day.”

Outside of our efforts in healthcare, the Society also works hard to better our community. Our CCMS Dr. Masoud Nemati Golf Tournament annually raises funds for local organizations. This year we were able to support a wonderful charity, PACE Center for Girls, that helps at-risk young women in Clay County by providing education and opportunities for a better future. Lastly, the Society worked hard to ensure our members are in compliance with new opioid prescribing law that went into effect in June. On November 7, the CCMS, in conjunction with Orange Park Medical Center, hosted the mandatory 2-hour CME that is now required to prescribe controlled substances for all physicians in Florida.

On a personal note, this past year has been one of great leadership growth for me. We were able to successfully collaborate between the Duval and Nassau County Medical Society’s leadership. We are a stronger voice in the state unified as opposed to separate and have many common issues that affect us in NE Florida. By increasing our collaboration, we can help affect change for the betterment of our physicians on a bigger scale. I am excited for the future of not only Clay County but for all of the First Coast. I am humbled and honored to have served as the CCMS President this past year and look forward to future service.
We know physicians’ impact is felt far beyond the exam room, reaching through local communities, producing a network of jobs and spurring local investment. The 2018 American Medical Association (AMA) Economic Impact Study found that each dollar in direct output applied to physician services supports $2.24 in economic activity in Florida, and physician-driven economic activity is greater than legal services, home health care, higher education, and nursing home and residential care. Specifically, physicians in Florida contribute 673,683 direct and indirect jobs and support $113.8 billion in economic output.

Despite major political headwinds, progress was made this year on many fronts. In the face of renewed vigor surrounding gun violence advocacy, the AMA partnered with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit organization that aims to counter the lack of federal funding for gun violence research by sponsoring research of their own. On the legislative front AMA has pushed for federal funding on gun violence, advocated for the expanding of domestic violence restraining orders to include dating partners, supported an increase in the legal age for purchasing ammunition and firearms from 19 to 21, supported gun buyback programs and commented on proposed regulations issued by the Department of Justice on bump stocks.
Seeing the challenges physicians face in assisting patients with substance use disorders, the AMA has been calling for increased federal funding to combat the opioid epidemic. This year Congress enacted the Consolidated Appropriations Act of 2018 which includes nearly $4 billion for prevention, treatment and law enforcement efforts targeted at addressing the opioid epidemic. An additional agreement was reached on comprehensive legislation, which included many provisions supported by the AMA that will create new programs to prevent substance use disorders while expanding existing ones, increase funding for residential treatment programs for pregnant women, expand the use of telehealth services and authorize CDC grants for improving Prescription Drug Monitoring Programs and implementing evidence-based prevention strategies.

We work in a health care system that is undergoing rapid change and daily confronts new obstacles. Physicians get frustrated when their concerns go unanswered. By participating in medical associations and specialty societies and supporting collective advocacy on behalf of patients and physicians, we can tip the scales back in favor of patient care and improve care delivery and health outcomes for all patient populations.

As a part of an ongoing effort to “right-size” prior authorization programs, in 2017 the AMA established a coalition of organizations and released a set of 21 Prior Authorization and Utilization Management Reform Principles. To date, over 100 provider and patient groups—including Florida Medical Association—have signed on in support of these critical improvements that will minimize care delays and practice burdens. Resulting from the momentum of those principles, the AMA, along with other national health care professional organizations and health plan trade associations, released the Consensus Statement on Improving the Prior Authorization Process in January 2018. This document reflects an agreement between provider and health insurance organizations to pursue prior authorization reform in several key areas. We also have launched a dedicated grassroots website, fixpriorauth.org, where we collect patient and physician testimonials on the impact of prior authorization to help inform our advocacy efforts. Meanwhile, the AMA continues to help enact legislation across the country to improve the efficiency, reduce the patient and physician impact and increase the transparency of utilization management programs.

Thanks to the relentless advocacy efforts of the AMA and our Federation partners, Congress passed the Bipartisan Budget Act of 2018, which repealed the Independent Payment Advisory Board, and extended the Children’s Health Insurance Program (CHIP) for 10 years.

Even with these accomplishments our work is far from done. We must continue working together to protect our patients’ access to care and combat nationwide problems like the opioid epidemic. Your participation in organized medicine ensures that your opinion counts, your voice is heard and your interests are protected.

We appreciate your membership support as the AMA and the DCMS work together to improve care delivery and health outcomes and to support physicians so that they can provide the best possible care to their patients and communities.
A Letter from the FMA President

By Corey L. Howard, MD, Florida Medical Association President

I’m looking forward to joining you at the Duval County Medical Society Annual Meeting in December and wanted to briefly discuss the state of the FMA, and how we can work together to make Florida the best state to practice medicine.

Through the Florida Medical Association, we have the opportunity to work in unison and ignite a new future for healthcare. Now is the time for us to focus on what we have in common, become one voice and create the future we want.

Imagine using your best judgment, education and experience when caring for patients and having the ability to truly practice both the art and science of medicine.

Imagine a world where you are in the driver’s seat. Where we all work together to create the most powerful and unifying voice in medicine. A place where we work together to build trusted relationships with organizations that support and affect our profession. Where excellence in education, lifelong learning and leadership training ensure physician competence and best practices, not some factitious, contrived, antiquated testing system that does not promote lifelong learning and can negatively affect our ability to practice.

Imagine a world where you are valued not only for what you do, but who you are: a true healer. That world and those statements are the foundation of our Florida Medical Association. Your state organization.

That is a world that I want, and it is what we are working toward at the FMA.

In addition, your well-being is one of our top priorities. We are addressing the root causes of physician dissatisfaction and burnout — namely the overwhelming bureaucracy and barriers to our autonomy — so that you are free to help your patients in the best way possible. Your FMA is looking at ways to help you find the real joy in medicine.

Your FMA is looking at the future and working on your behalf so that you can do what you do best: practice medicine. When we work together, anything is possible. We need everyone to be a part of the one organization that represents all physicians in our state.

I challenge each of you to talk to four people and let them know the importance of your Florida Medical Association, what it means to you and what is could mean to them.

Let them know that we are dedicated to making Florida a great place to practice medicine by helping to remove burdensome regulations and other barriers between you and your patients.

Let them know that we are working to improve the economic viability of all types of medical practices in Florida.

Let them know that we are dedicated to promoting public policies that reinforce your role as the leader of the healthcare team and preserve your ability to be independent advocates for your patients.

Let them know that to be a powerful voice of change, we need to unify as physicians so that we can all deliver the highest quality healthcare found anywhere in the United States.

I look forward to working with all of you to become the champions of the FMA and help us grow, help us become better, help us fight the fights worth fighting and, most of all, help us help you practice medicine.
Advocacy In Action

One of the most important jobs of the County Medical Society and the Florida Medical Association is to represent our physicians in Tallahassee and Washington. We take our responsibility to be the voice of physicians very seriously and strive to ensure that you are heard when legislators take on issues that impact the practice of medicine in Florida.

2018 got off to a fast and furious start for the DCMS Legislative Committee. Due to the November 2018 elections, the Florida Legislature moved the start of the Legislative Session to the beginning of January. That meant that even before the New Year’s parties were cleaned up, it was time to head to Tallahassee.

This year, there were three very major issues considered by the Legislature which would dramatically affect your ability to practice medicine: expanded scope of practice for nurse practitioners and pharmacists, the ability to practice direct primary care, and a sweeping change in opioid prescribing regulations.

The DCMS was front and center in each of these issues, working on behalf of Duval County physicians to protect your ability to practice medicine and provide the highest quality care to your patients.

Dr. Ferdinand Formoso was one of several DCMS Members who served as the Doctor of the Day for the Legislature. In this capacity, he served on standby in case there were any medical issues for the Legislature or their staff. He also had the opportunity to sit on the floor of the Legislature during debate and was able to speak one-on-one with several Representatives about the pending opioid bill.

A key part of our ability to be successful in Tallahassee is our continued partnership with the Florida Medical Association. The FMA legislative team is a powerful lobbying force in Tallahassee, and the best part is that their agenda is set by you.

The FMA Legislative Agenda is set by the House of Delegates which meets every summer in Orlando. The DCMS sends the largest delegation to that meeting every year. The DCMS also has a representative to the FMA Board of Governors, Dr. Mobeen Rathore. Additionally, Dr. Ashley Norse serves on the FMA Executive Committee as the Vice-Speaker, and serves as the Vice-chair of the FMA Legislative Committee.

The FMA used its considerable resources to stop scope of practice expansion. The FMA strongly opposed legislation that would have allowed nurse practitioners to practice independently and pharmacists to test, diagnose, and treat influenza and streptococcal pharyngitis. Additionally, the FMA defeated a bill that would have allowed consultant pharmacists to order and evaluate lab tests, conduct patients assessments to evaluate and monitor drug therapy and initiate, modify and discontinue medications.

The FMA promoted a bill that allows Direct Primary Care (DPC). This is a practice model that eliminates third-party payers from the primary care physician-patient relationships and establishes that DPC agreements are NOT insurance. Therefore, they are not subject to regulation under the Florida Insurance Code. This model is anticipated to lower healthcare costs, increase access to primary care services, enhance the physician-patient relationship and reduce physician burnout.

Governor Rick Scott declared a Public Health Emergency on May 3, 2017 in response to the escalating opioid crisis. He made this his priority health care legislation in 2018. This bill limits opioid prescribing, requires mandatory checking of the PDMP, requires a 2-hour CME course for prescribers amongst other provisions. The FMA worked very aggressively on behalf of all physicians to make positive changes to this legislation as originally drafted. Once the Opioid bill passed, the DCMS team went into quick action to ensure that the implications of the rule could be shared with every physician in northeast Florida quickly and efficiently.
Within days of the bill being signed into law by the Governor, the DCMS sent a one-page summary of the bill to every member. This form has been used by practices to inform their staffs and some groups share the sheet with their patients to reinforce that the changes in practice are mandated by the state.

We did not stop there. Thanks to a partnership with The Mayo Clinic and its CEO, Dr. Gianrico Farrugia, a member of the DCMS Board of Directors, we were able to provide the state-mandated two-hour Opioid CME course, for free, to any DCMS Member. We were able to do this not once, but twice. Nearly 700 physicians were able to satisfy their mandatory CME requirement thanks to this generous partnership.

The FMA once again fought for insurance legislation that would have prevented retroactive denials, allowed physicians to override fail first protocols and providers for simpler prior authorization procedures. The bills moved through the Senate and made it through two of three House Committees but failed to move through the last committee in the House with STRONG opposition from the insurance industry. We will continue working these issues next session.

What would your life look like without the FMA/FMA PAC working for you?

- Assignment of benefits would disappear, and checks that should have gone to you from the insurance companies would go directly to the patient.
- Expert witness certificates would no longer be issued. Any physician in any specialty could testify against you in a lawsuit. So, a psychiatrist would be able to tell a general surgeon how to practice medicine.
- The look back period for insurance companies to recoup payments would increase to 30 months instead of 12 months.
- You would be fingerprinted every two years, as some legislators must think that our fingerprints change over time.

Elections have consequences. Florida physicians have spent over twenty years working with the Florida Legislature to pass malpractice tort reform laws only to see all efforts struck down by the Florida Supreme Court. These were 4-3 decisions. The new Governor will appoint new Justices to replace three of the retiring Justices who voted to strike down our legislation. If elected for a second term, the Governor will appoint six of the seven Florida Supreme Court Justices. The average term of a Florida Supreme Court Justice is 17 years and the appointments of the new Governor will impact a generation of physicians. Physicians usually agree that changing the current system and tort reform makes sense. Major roadblocks to any meaningful reform are the state and federal lobbying efforts of the trial and plaintiff attorneys. As a group, the lawyers’ effectiveness in blocking common sense legal reforms far surpasses our efforts to exert political influence. Lawyers gain their influence through large donations, fundraising efforts, being focused on their objectives, and the number of legislators who are also lawyers. In contrast, only one percent of congressional leaders over the past 50 years have been physicians. The plaintiffs’ associations have thousands of members who are willing to write checks for the maximum allowable donation. Congressional campaign contributions by lawyers in the last election cycle far exceeded the total given by physicians.

Elections cost money, lots of money. Influence of those elected (lobbying) costs even more money, lots and lots more money. If you, as a physician, want to have a physician friendly legislature, you should view political contributions as an important and necessary professional overhead expense. This is the perspective of most law firms and individual lawyers. They recognize the return on their investment both professional and individually. The easiest and most influential means of contributing is through the FMA PAC.

FMA PAC-endorsed candidates won in 94 percent of their races. Of the 98 candidates in the 2016 Florida election that the FMA supported, 92 were elected.

This past summer, the DCMS worked together to raise more than $12,000 in contributions to the FMA PAC during the FMA House of Delegates. Duval County brought in more money over that weekend than any other county in the state. This is just one way our DCMS physicians are leading by example.

Your PAC donations ensure that physicians have a voice in the Legislature, which is vital in passing pro-medicine legislation and defeating harmful bills. There are approximately 46,000 licensed practicing physicians in Florida. If just 50 percent made a $250 contribution, the PAC would raise almost $6 million. This would triple the amount of money the PAC currently works very hard to raise and would make Florida physicians a formidable political force. This contribution amounts to only $21/month! Donations can be made easily through the FMA website, flmedical.org/pac. Physicians may participate in politics and, thus, have some effect on medicine’s future, or they may abstain and take the consequences.
The DCMS created a one-page summary of the opioid prescribing bill to share with membership:

The bill was signed into law in April and will go into effect on July 1, 2018. It was created in response to the rising number of opioid-related deaths in Florida. The law is intended to reduce the amount of opioid pills prescribed in Florida while using state dollars to fund addiction recovery and treatment programs.

**3-Day Limit**
- Applies to all acute pain opioid prescriptions
- Does not apply to:
  - Pain related to cancer
  - Terminal conditions
  - Palliative care
  - Certain severe traumas
- 7 day supply allowed if:
  - Script includes "Acute Pain Exception"
  - Reason for exemption documented on chart
- No change for chronic pain patients, but you must maintain patient data including:
  - Complete Medical Record
  - Controlled Substance Agreement
  - Driver’s License

**PDMP**
- The E-FORCSE state Prescription Drug Monitoring Program (PDMP) must be accessed for every Schedule II-V prescription
- Only exception is Schedule V non-opioids
- PDMP may be accessed by designated staff with individual login
- If the PDMP is down at the time of the script, you must document the script, time and reason you are unable to access.

**CME**
- All physicians with a Florida Medical License and a DEA License must complete a two-hour mandatory CME course before January 31, 2019.
- CME must be completed for each subsequent License renewal
- Takes effect beginning with renewals scheduled for January 2019
- By law, the CME course is only accessible from certain state-wide Medical Societies

**July 1, 2018**
Law Takes Effect

For More Information Contact:
Bryan Campbell
Chief Executive Officer
Duval County Medical Society
(904) 353-7536
brcampbell@dcmsonline.org
The mission of the Northeast Florida Medical Group Management Association, Inc. is to improve the effectiveness and skills of those individuals who lead Medical Group Practices in the Northeast Florida area. The Corporation will accomplish this by providing leadership, quality speakers, improved communication, networking opportunities and continued education for its membership.

Members are invited to join together monthly at Epping Forest Yacht & Country Club for a splendid meal, hear great speakers regarding current medical group concerns and networking at its finest.

Active Member Dues are $75.00

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Better Together: DCMS and the local MGMA Chapter (NFMGMA)

Physicians understand the value of belonging to their Medical Society. They know they can turn to their national specialty society to focus on standards of care and Federal reimbursement issues. They know local societies like the Duval County Medical Society are providing connections in the community, providing opportunities to serve the community, and providing access to free state-mandated Continuing Medical Education (CME).

You trust your Practice Manager to be on top of the ever-changing regulations in Washington and Tallahassee, while keeping an eye to the future so that your practice will never be caught off-guard. That’s where the Medical Group Management Association (MGMA) becomes invaluable to your practice.

MGMA is a national, state and local group of Practice Managers who meet regularly to stay up-to-date on practice management trends, evolving technology and regulations. In Northeast Florida, there is an exceptionally strong chapter (NFMGMA), chaired in 2019 by Mischelle Register from North Florida OBGYN.

The partnership between the DCMS and the local MGMA chapter has been beneficial for physicians and their patients across Jacksonville. In February this year, Duval County Medical Society Chief Executive Officer Bryan Campbell met with the NFMGMA members providing a detailed summary of the upcoming opioid prescribing bill that was about to be signed into law. This gave practices with administrators in the group a heads-up on the frantic race to comply with that bill by July 1.

That’s just the most recent example. The Duval County Medical Society and NFMGMA have worked together to share information on ICD-10, MACRA and several other dramatic paradigm shifts in practice management.

Just as the DCMS encourages Northeast Florida Medical Group Management Association members to get involved with the DCMS, the DCMS strongly encourages you to ensure that you have a member of your staff involved in the NFMGMA. Working together, we can continue to reduce the stress and burden of changing regulations on your practice, and let you get back to what you enjoy doing the most, taking care of your patients.

You can apply to join the MGMA by visiting bit.ly/MGMAapp.
The world is going DIGITAL, so should YOUR PRACTICE. Make it SMART & EFFICIENT!

- Expand Outreach
- Increase Revenue & Efficiency
- Decrease No-Shows, Cancellations & Costs
Introducing LifeBridge: Confidential Physician Counseling

By Bryan Campbell, Duval County Medical Society CEO

Physicians have the highest rate of suicide amongst all professions in the United States. It’s important to let that fact be set aside and resonate. How is it that the profession that is dedicated to improving quality of life and saving lives can also be stricken with an epidemic of stress and burnout?

The most recent Medscape Lifestyle Report indicated the following as the most prominent causes for stress amongst physicians:

1. Too many bureaucratic tasks
2. Spending too many hours at work
3. Feeling like just a cog in a wheel
4. Increased computerization of practice
5. Income not high enough

As you can see, all of those top five issues deal with external pressures and changes on the medical field. Physicians love to care for their patients, they don’t love it when a torrent of external factors makes it difficult or impossible to do so in the way they were trained. More than half of all physicians report signs of burnout. That number is growing rapidly, increasing by more than 10% in just four years.

As a result, a number of resources have been created to address physician wellness, including mindfulness seminars, yoga classes, and more. Unfortunately, physicians have been reticent to seek the type of professional care they need to address their signs of stress or burnout.

Until now.

Introducing LifeBridge: Confidential Physician Counseling. LifeBridge is provided to all members of the Duval County Medical Society via the DCMS Foundation. LifeBridge is a safe and confidential program to help get you back to feeling like yourself.

· LifeBridge is like no other physician wellness program out there. The service provides up to six free in-person sessions with a counselor to discuss any issue which is causing you stress or burnout. It doesn’t matter if it’s a troublesome co-worker, marital issues, or difficulty dealing with a bad outcome. You get the help of a licensed professional at no charge to the physician.
· LifeBridge does NOT create a medical record. Unfortunately, physicians have expressed concern that seeking appropriate help from a mental health professional will create a medical record and could impact their licensure.
· LifeBridge has been designed in conjunction with the Florida Board of Medicine specifically to be a pre-clinical program that does not create a medical record.
· LifeBridge is completely confidential. From the moment you call our LifeBridge Hotline, your personal information is protected. Only your counselor will know your personal information, so it can never be reported to the DCMS, your employer, or any other group.
· LifeBridge has a diverse panel of counselors who have committed to making themselves available for an appointment within 24 hours of your call to the wellness line. They are specially trained to work with physicians, and have confidential office space located across the metropolitan area.

LifeBridge is the path to get you back to the life you want to be living. I encourage you to write down the number, even if you don’t need it today. You may have a friend or colleague who needs it now or in the future.
You won’t find a physiatrist in the ER providing chest compressions or in the operating room asking the nurse for a scalpel. But, that’s not to say they don’t do something equally important.

Physiatrists are medical doctors, specialty trained in physical medicine and rehabilitation. They treat a variety of disabling conditions such as stroke, spinal cord injury, brain injury, neurological disorders, musculoskeletal disorders, developmental disorders and chronic pain.

The debilitating damage following a traumatic event can last a lifetime. Physiatrists emphasize long-term quality of life, creating a unique path for each patient based on their functional goals.

There are three ways that physiatrists help patients in their journey.

The first is medical management. Physiatrists are aware of how medical issues affect a patient’s ability and motivation to reach their goals. By having a broad base of training they are able to use this knowledge to help patients hit their physical, emotional, medical and social targets.

Second, they work toward restoring function. Physiatrists lead interdisciplinary teams which often include physical therapists, occupational therapists, speech-language pathologists, nursing staff and physician extenders. In addition to helping patients regain strength, coordination and other functional improvements, physiatrists also work to help people adapt to new ways of doing things.

Finally, physiatrists serve an important role in educating patients and families. They help them understand their injuries and how to provide proper care giving during the recovery process. They provide useful information about what to expect, care giving and support, and how long the recovery might take.

“We understand the impairments associated with illnesses and injuries,” says Kerry Maher, MD, Vice President of PM&R Consulting and Physician Relations. “We recognize the importance of saving of lives in medicine, but we also understand that the quality of that life is really important.”

What is a Physiatrist?

phys·iat·rist
noun | fi-zē-ˈa-trist, fi-ˈzī-ə-trist

Medical Definition:
A medical doctor who has completed training in the specialty of Physical Medicine and Rehabilitation (PM&R) and may be subspecialty certified in brain injury, neuromuscular, pain, pediatric rehabilitation, spinal cord injury or other areas.
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#WeAreBrooks

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**Brooks Rehabilitation Medical Group**

- **Mabel E. Caban, MD**
  Medical Director, Physical Medicine and Rehabilitation
- **Jorge Perez Lopez, MD**
  Staff Physiatrist
- **Parag Shah, MD**
  Medical Director, Stroke Program, Memorial Hospital Consultant Liaison Service
- **Geneva Tonuzi, MD**
  Medical Director, Brooks Spinal Cord Injury Program & Cybernic Treatment Center
- **Charles M. Dempsey, MD**
  Medical Director, Rehabilitation Services at Bartram Crossing
- **Kerry Maher, MD**
  Vice President of PM&R Consulting and Physician Relations
- **Keisha Smith, MD**
  Associate Medical Director, Stroke Program
- **Marla Trapp, MD**
  Medical Director, Bartram Crossing SNF
- **Carolyn Geis, MD**
  Medical Director, Halifax Health | Brooks Rehabilitation Center for Inpatient Rehabilitation
- **Kenneth Ngo, MD**
  Medical Director, Brain Injury Program
- **Sarala H. Srinivasa, MD**
  Staff Physiatrist
- **Howard Weiss, DO**
  Medical Director, Pain Rehabilitation
- **Adria Johnson, MD**
  Staff Physiatrist
- **Trevor Paris, MD**
  Medical Director for Brooks Rehabilitation Hospital, Vice President of Brooks Rehabilitation Medical Group, Medical Director of University Crossing

**BrooksRehab.org**

#WeAreBrooks
We Care Jacksonville: Then and Now

Twenty-five years ago, We Care Jacksonville, Inc. (We Care) was organized as a collaborative effort by George S. Trotter, MD, the Duval County Medical Society, Duval County Health Department, local churches, hospitals, and community organizations to provide donated health care to low-income persons who are uninsured and at or below 200% of the Federal Poverty Level. This community partnership of more than 500 health care professionals, community volunteers and all the major health systems operating in Duval County, donate their time, skills and services to the community to provide medical care to those who either lack access to care or cannot afford health care services. Working through 10 free and charitable clinics in Duval County, We Care assists more than 1,500 unduplicated patients each year with more than 4,000 referrals. While the need is enormous, each of these individual patients receive quality, compassionate care from our network of providers.

Rickey R. is 59 years old and a staunch Raiders fan, former youth baseball coach, family man, and now a cancer survivor. Speaking with Rickey, it quickly becomes apparent that the two topics that create a sense of passion in him are sports and family. These are the two things that helped to motivate and comfort him during his fight with cancer.

Before his cancer diagnosis, Rickey was a patient at one of the area free clinics, where he received help with managing his diabetes and high blood pressure through We Care’s Health and Wellness Program, a collaboration of services with Baptist Beaches Hospital, BEAM (Beaches Emergency Assistance Ministry), I.M. Sulzbacher Beaches Clinic, and Mission House. Through the Program, We Care’s RN Case Manager provides high-impact case management to qualifying chronically ill patients, many of whom habitually use the emergency room for their primary care issues. As part of the Program, Ricky received six months of hands-on nutrition counseling, access to a community food pantry, medications, and the necessary tools for monitoring his blood pressure and glucose levels at home.

At the time of his diagnosis, Ricky’s overall health had been improving. That is, until a bout with pneumonia would not go away. It was discovered that he had cancer in his lungs and that it was spreading to his liver. Poor and without health insurance, Ricky was once again referred to We Care for the care and medical services he needed to fight this disease.

“We Care helped me get started with the treatment for my cancer,” Ricky shared. “They got me hooked up at the hospital, helped me with my disability and emergency Medicaid and they still check in on me.”

Flash forward several months later to a man donning a red muscle tee that has just finished six rounds of chemotherapy. When asked what happens if the cancer comes back, he replies with a committed look on his face is, “It’s just going to be another fight, but one that I can win.”

“About We Care: We Care’s staff of 10 is comprised of dedicated, passionate people, whose tireless efforts on behalf of our patients, offer hope and many times, life. It is estimated that there are between 130,000 and 150,000 uninsured adults in Duval County. Without We Care, these neighbors would be unable to receive the often life-saving care that most of us take for granted. For every $1 donated to We Care, we can leverage it to approximately $30 worth of medical services.”
Mayo Clinic Continues to Transform Health Care in NE Florida

This year has been momentous for Mayo Clinic, which is once again ranked No. 1 in Florida and the Jacksonville metro area in U.S. News & World Report’s annual list of top hospitals. Mayo Clinic contributes roughly $2 billion annually to the Florida economy.

In 2018, Mayo Clinic continued to expand and invest heavily in people, space and technology. Milestones included the opening of Dorothy J. and Harry T. Mangurian Jr. Building, a new 190,000-square-foot destination medical center providing patients with integrated services for complex cancer, as well as neurologic and neurosurgical care. In addition, a state-of-the-art positron emission tomography (PET) radiochemistry facility was unveiled that includes a radiochemistry laboratory and a cyclotron—a particle accelerator important in the production of radiopharmaceuticals. The facility will produce Mayo-developed choline C-11 used in certain PET scans, enabling cancer to be identified more quickly and allowing more effective treatment.

Florida’s Comprehensive Cancer Center became one of the first in the nation to offer CAR T-cell therapy. The treatment is available for patients with relapsed or refractory B-cell non-Hodgkin’s lymphoma or relapsed or refractory B-cell acute lymphoblastic leukemia who previously failed two or more lines of systemic treatment. This cell-based immunotherapy is one of the most promising new areas of cancer treatment. Several patients have successfully undergone this individualized therapy and are now in remission.

Other milestones included the 20th anniversary of the transplant center, which has performed more than 6,000 transplants since its inception, and the expansion of the J. Wayne and Delores Barr Weaver Simulation Center, which offers training and education to staff and the community at large.

Additional campus expansion is underway to further increase clinical space, including new surgical suites and a building dedicated to increasing the volume of lungs available for transplantation. Through collaboration with United Therapeutics, marginal lungs will be preserved and made viable for transplant for patients at Mayo Clinic and other centers around the U.S. The facility, which will also feature space for regenerative medicine research and a bioincubator and accelerator, is set to be completed in 2019.

Many new physicians have joined the staff in Florida, including leading experts in brain tumors, epilepsy and seizure disorders and adult congenital heart disorders. Minimally invasive robotic surgery is now available for brain tumors, spine procedures and urologic issues.

In addition to its clinical growth, Mayo Clinic is committed to advancing research and medical education through reinvestment of $1 billion annually in these areas.

Mayo Clinic is working to create a hub for the development of biomedical technologies to advance research as an economic driver for the region and to bring new solutions to patients worldwide.

“Mayo Clinic is committed to shaping the future of medicine as the premier destination medical center in the Southeast. We aim to meet the growing needs of our patients and advance the discovery, translation and application of innovative solutions to address serious and complex health issues,” says Gianrico Farrugia, M.D., CEO of Mayo Clinic in Florida and president-elect of Mayo Clinic.

The Florida practice, which last year served more than 119,000 patients from all 50 states and more than 80 countries, remains steadfast in its mission to transform health care in Northeast Florida, while staying true to its fundamental principle—providing the highest quality care to every patient.

Dr. Farrugia credits Mayo’s 6,400 employees, which includes 500 physicians and scientists and 300 residents and fellows, for helping to advance Mayo’s reputation as a leader in the diagnosis and treatment of patients in all specialties including surgery, individualized medicine, neurosciences, cancer, solid organ transplantation, digestive diseases and cardiovascular diseases.
University of Florida Health Science Center’s Jacksonville Campus

Jacksonville is home to the regional campus of the University of Florida — the UF Health Science Center Jacksonville. Its facilities intertwined within UF Health Jacksonville’s hospital and outpatient buildings, the Health Science Center includes the UF colleges of Medicine, Nursing and Pharmacy. Similar to its sibling campus in Gainesville, the Health Science Center in Jacksonville also includes a full UF library, dedicated clinical research facilities and a medical simulation laboratory.

Nearly 430 faculty members and 17 clinical departments comprise the UF College of Medicine – Jacksonville. More than 380 UF medical residents and fellows train in Jacksonville in one of 37 accredited programs. Third- and fourth-year medical students from UF’s main campus in Gainesville complete rotations at UF Health facilities in Jacksonville, allowing them to gain hands-on experience in a busy, urban hospital setting.

Research
In addition to patient care and education, research is the third pillar of academic medicine. Physicians and residents at the UF Health Science Center Jacksonville have completed more than 500 clinical research studies, with community-based, patient-centered projects often a major focus. The campus received $26.8 million in research funding in 2017-18, with more than 60 percent of that money from federal sources like the National Institutes of Health.

College of Nursing
The Jacksonville campus of the UF College of Nursing offers an accelerated Bachelor of Science in Nursing for people who already hold a bachelor’s degree in another field. The college has Jacksonville faculty and employs modern communications technology to offer interactive teleconferenced seminars from the Gainesville campus. Differentiating the college from other nursing schools in the area, UF nursing students regularly work alongside pharmacy students and medical residents in simulation scenarios aimed at optimizing patient outcomes by improving communication and inter-professional teamwork skills.

College of Pharmacy
Ranked by U.S. News & World Report as the No. 1 pharmacy college in Florida and in the top 10 nationally, the UF College of Pharmacy has been developing future leaders in pharmacy practice and science for nearly a century.

The college welcomed 275 students into the professional Pharm.D. program in August. Of that group, 49 enrolled at the Jacksonville campus. Students enjoy small class sizes that allow them to build quality relationships with professors and classmates, as well as take advantage of leadership opportunities.

“Renowned faculty physicians and research experts work alongside thousands of employees on our campus,” said Leon L. Haley Jr., MD, MHSA, CPE, FACEP, who serves as dean of the UF College of Medicine – Jacksonville and CEO of UF Health Jacksonville. “While providing exceptional patient care and forging new discovery, they help ensure our trainees and students receive all the support and resources they need and ultimately have an educational experience that is second to none.”
Fake News in the Financial Planning World

By Jim Neshewat, JD

For almost every client of ours at Doctor's Fiduciary Group and St. Johns Asset Management, LLC, talks of differing philosophies of investment, tax, insurance, estate and wealth planning take place. The most prominent of these philosophies is surrounded by investment choices that individuals take into qualified plans through their employers (such as a 401(k) or profit-sharing plan) and debt management. These are the two areas in which we’ve witnessed the highest occurrence of mistakes being made due to what mainstream media (and our President!) has dubbed “Fake News” within the financial planning arena.

Regarding debt management: Just Say No [to refinancing]! Most of our clients have relationships with no fewer than eight banking institutions. Be it student loans, credit cards, mortgages, checking, savings or car loans. The wondrous achievement of completing one’s residency is fully appreciated by only two groups of people: other residents and banks that want to lend you money!

The average medical school graduate owes nearly $280,000 upon completion of residency. The vast majority of these graduates select the Income Based Renewal option while their wages are limited during this period. Few are able to make their full payment as the 25-year payment option at current interest rates is nearly $2,000/month. Most of our clients while entering their first year start to receive numerous ads supporting consolidating into one of the many government-sponsored plans that are administered by Navient, Great Lakes or the other federally approved loan servicers. The most commonly advertised is the PAYE or REPAYE program. This plan is much like an income based but with caps associated with it. A quick glance at one’s Facebook feed will render dozens of student loan consolidation ads, REPAYE being an attractive one with the government’s associated consumer protections.

To opt for the government sponsored plan would be a mistake for physicians in most situations. While these loans are advertised as temporary solutions to cashflow concerns, the ultimate conclusion would be to avoid the non-guaranteed Congress-mandated interest rates that show total interest paid around $300,000 or more depending on the resident’s unique situation. To begin one amortization schedule and end it prior to the maturity of that loan benefits one group more than any other: The Banks! The interest of any loan is paid at the beginning of the schedule. For our average physician, consolidating to the REPAYE program and then to a private institution at current rates (7.15% and 5.25% for government and private loans, respectively) would result in a total of around $15,000 additional interest paid on the first loan – only to necessitate a consolidation some years later. This is a mistake we’ve unfortunately seen occur by many recently graduating doctors due to the advertising and Fake News associated with reviewing these programs. A quick Google of REPAYE Fox News/CNN/MSNBC gives the benefits of this program.

Regarding contributions to qualified plans, addressing Fake News is even more important for physicians both young and experienced. Most doctors are encouraged to take out enormous loans, personal and business, by banks that target their profession for special programs with incentives. This increased debt creates an opportunity cost for our clients when making contributions to their qualified plans. As most physicians make contributions to a 401(k), they should assess several key factors before locking up their money until age 59.5: 1) Will this money be necessary to purchase a home or practice in the near future? 2) Will I be better served paying off debt at high interest rates than trusting market fluctuations? 3) Could I be in a higher tax-bracket in the near future, making it more beneficial to defer at a later time? 4) Is my current cashflow sufficient to meet my immediate lifestyle goals? The reoccurring theme for doctors making these contributions is that they’re always better served maxing out all tax-deferred accounts. However, in our experience, we’ve seen that most physicians can actually earn a higher rate of return by maintaining cash positions to pay off debt in early years and make long-term purchases sooner to avoid costly amortization schedule restarts (as stated above).

Our firm is dedicated to helping individuals make intelligent decisions regarding all facets of their financial plan. Being an independent firm, we aren’t bound to particular investments or insurance products as many captive advisors are. Our philosophy of education and trusted relationships is what led us to become the Premier Partner of the Duval County Medical Society. Our benefits include fee-based financial plans, discounted and simplified issue disability insurance through the state’s best carriers for specialty-specific physicians, business advising and investment advisory services. We look forward to being a resource for you in the future!
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Virtual Reality for Pain Management: An Alternative to Opioids

Miranda Felde, MHA, CPHRM, Vice President, Patient Safety and Risk Management, The Doctors Company

In 2016, the opioid epidemic’s toll hit $95 billion, with healthcare costs concentrated in emergency room visits, hospital admissions, ambulance use, and Naloxone use—the personal costs to those who have lost loved ones are uncountable. The epidemic’s impact is far-reaching and has emotional, physical, and financial implications for our entire society.

Many physicians are exploring VR technologies as an alternative to prescriptions. The Gate Control Theory of pain, proposed by Melzack and Wall, suggests that a person may interpret pain stimuli differently depending upon mental/emotional factors such as attention paid to the pain, emotions associated with the pain, and past experience of the pain. VR addresses both attention paid to pain and the patient’s emotional state.

Getting Started with VR

To explore VR as an alternative therapy, first consider the distinctions between two key terms:

- **Virtual Reality (VR):** Provides an immersive experience via a computer-generated 3D environment for the user to explore. The user may be able to move objects or otherwise change the environment.
- **Augmented Reality (AR):** Adds sounds, videos, and/or graphics to an existing environment, such as an outdoor planetarium where AR viewing glasses show constellations highlighted in the sky.

Then, evaluate VR interfaces that are relevant for patients managing pain, such as:

- **Head-mounted display (HMD):** Like a heavy-duty pair of goggles plus headphones. Completely surrounds the user’s visual field for an immersive experience.
- **Treadmills and haptic gloves:** Allow the user to physically move around in the virtual environment, and to physically move objects within that environment.

And weigh the value of interfaces that are more relevant for physician use, such as:

- **Smart glasses:** May look more like regular eyeglasses or more like safety glasses. May display information or help the physician capture information for the electronic health record (EHR).
- **Desktop VR or Window on a World (WOW):** Uses a desktop or laptop computer to run simulation programs.

Mitigating VR Patient Safety Risks

While therapeutic VR for pain management shows promise, there are patient safety risks. They include:

- **Falls:** Patients wearing a full-surround headset cannot see their real-world environment and may walk into or trip over objects.
- **Motion sickness:** Many people experience some combination of eye strain, headaches, and/or nausea. Patients who are ordinarily prone to any of these symptoms may not be good VR candidates.
- **Psychological effects:** The brain can store VR experiences as memories in almost the same way it stores physical experiences. Young children, especially, may confuse VR experiences with real experiences, especially when remembering them later.
- **The unknown:** VR technology is still in its infancy, and therefore, little is known about the long-term consequences of VR use.

The Future of VR for Pain Management

To reap the potential benefits of VR while mitigating its risks, clinicians could start with a two-part approach: identifying patients with specific clinical indications that would benefit from the use of VR and assessing patients for potential risk factors. Successful implementation of VR for pain management depends on wisely deciding which patients are VR candidates—and which are not.

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

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of the circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

Interprofessional Collaboration in Health Science Education

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, “Interprofessional Collaboration in Health Science Education (To err may be human, but together we can do something about it!)” authored by Thomas Morrissey, MD, PhD, Frank J. Genuardi, MD, MPH, Jane Gannon, DNP, CNM, CNL, Carol Motycka, PharmD, and Eric F. Egelund, PharmD, PhD, 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.

Faculty/Credentials:
Thomas Morrissey, MD, PhD, Clerkship Director, Assistant Program Director, Associate Professor of Emergency Medicine, Frank J. Genuardi, MD, MPH, Associate Dean for Student Affairs and Associate Professor of Pediatrics, Jane Gannon, DNP, CNM, CNL, Director of Simulation-Based Learning, Carol Motycka, PharmD, Clinical Associate Professor, Eric F. Egelund, PharmD, PhD, Clinical Assistant Professor. All are with the University of Florida College of Medicine Jacksonville

Objectives:
1. Describe the impact of communication gaps on patient outcomes
2. Describe strategies for forming an interprofessional collaborative healthcare team
3. Describe the impact of TeamSTEPPS training on attitudes toward teamwork

Date of release: 1, 2018    Date Credit Expires: December 1, 2020    Estimated Completion Time: 1 hour

How to Earn this CME Credit:
1) Read the “Polypharmacy; A Case-based Primer on the Practice in the Geriatric Population” 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/CME 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:
Thomas Morrissey, MD, PhD, Frank J. Genuardi, MD, MPH, Jane Gannon, DNP, CNM, CNL, Carol Motycka, PharmD, and Eric F. Egelund, PharmD, PhD 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.
Interprofessional Collaboration in Health Science Education
(To err may be human, but together we can do something about it!)

By Thomas Morrissey, MD, PhD,1 Frank J. Genuardi, MD, MPH,1 Jane Gannon, DNP, CNM, CNL,2 Carol Motycka, PharmD,3 and Eric F. Egelund, PharmD, PhD3

University of Florida College of Medicine,1 College of Nursing,2 College of Pharmacy,3

Abstract
To prepare tomorrow’s healthcare practitioners for challenges in medicine and to make the healthcare environment safer, the University of Florida Colleges of Medicine, Nursing and Pharmacy have combined forces to develop novel teaching strategies. The institution devised a four-hour series of learning activities designed to heighten awareness of medical errors and patient safety with core sessions involving interprofessional teams composed of students from each discipline. High-fidelity simulation techniques were employed to provide experiential learning and opportunities for self-discovery in a safe training environment. Attitudes, skills and behaviors were assessed and analyzed. Common themes included teamwork, communication and patient-centered care. Preliminary results demonstrated that interprofessional simulation as a training activity among health science students was both well-received and effective. This article discusses the issues and ideology that led to this endeavor as well as future directions.

Introduction
It is critical that all healthcare providers understand the prevalence of medical errors and the dramatic headlines they create.1,2 Errors are not suffered lightly. In 1996, the Institute of Medicine (IOM) launched the first phase of its Quality Chasm series, aimed at documenting the significant toll medical errors placed on human health. Headlines describing how 44,000 to 99,000 die each year from medical errors made for sobering news for both public and health professionals.3 Subsequent phases highlighted actions to take in the practice environment, education reform, changes in nursing practice, and enacting a vision for the future. Despite the focus, medical errors are now the third leading cause of death in hospitals and healthcare facilities2 with estimates of such deaths as high as 400,000 per year.4 The cost of such errors is staggering with a 2010 report estimating $19.5 billion was spent due to medical errors on direct costs5, while a 2012 report estimates lost years of life costs were as high as $187.5 billion to $250 billion.6

Such errors are divided into five categories: diagnostic errors, errors of commission, errors of omission, context, and communication.1 Many sources contribute to such errors, including care complexity, staffing issues, patient acuity and production demands in cost-driven institutions.4 Of the five categories, however, erroneous communication is considered the leading cause of medical errors.2

Communication errors can occur between two or more healthcare providers, or between healthcare providers and the patient. Information transfers are a significant source of communication gaps that lead to errors. These often occur at times of rapid communication (associated with quick judgment calls, prompted by time pressures) and during more formal conversations (shift sign outs, patient hand-offs, consultations, discharge discussions).7,8,9 Compounding this, education is often conducted in “silos” within professional schools with limited contact with students outside the college’s boundaries. Additionally, colleges have separate faculty,
educational levels, and schedules, which foster differing philosophies and approaches to care. Interprofessional training is more often conducted post-graduation, where high levels of cooperation are already required among the disciplines to safely care for patients.

The reality is that healthcare professionals need to be the masters of their domain. It is incumbent on physicians and others in the health care setting to do everything they can to minimize misjudgments, mistakes and errors. While a standard business model would dictate that such professionals should just work harder and be smarter, in healthcare that approach is difficult to implement, and such strategies actually have minimal power to reduce error.\textsuperscript{10} While there are many efforts to make delivery of care more effective, efficient, and safe, achieving those goals requires more than simply working as hard as possible, or being as smart as possible. Consequently, current research is dedicated to elucidating when and where mistakes happen.\textsuperscript{10,11,12,13}

Rapid clinical judgments can be double checked by other members of the care team when those team members are empowered to bring their perspective to the decision-making process. (Think NASA: following the Challenger disaster, decision making became a more collaborative process- anyone can stop the space launch today if they see something concerning). In fact, safety-based process design throughout healthcare today relies heavily on lessons learned in the aviation industry, including crew resource management (CRM) and safety management systems (SMS).\textsuperscript{14}

Information transfers are greatly improved by formal training in the use of structured communication tools including the following:

- \textit{IPASS- Illness severity, Patient summary, Action list, Situation awareness, Contingency planning}\textsuperscript{15}
- \textit{TeamSTEPPS\textsuperscript{\textregistered}- Team Strategies and Tools to Enhance Performance and Patient Safety}\textsuperscript{16, 17}
- \textit{SBAR- Situation, Background, Assessment, Recommendation}\textsuperscript{18}

For instance, SBAR guides the provider to succinctly describe a patient Situation, relevant Background information, focused Assessment data, and Recommendation for what is needed to manage any problem that has arisen. Such strategies help reduce intimidation in the workplace while closing communication gaps to promote not only critical information transfer but timely interventions.\textsuperscript{19} While challenges exist in retraining current healthcare providers across the country, their student counterparts are ripe for indoctrination into these interprofessional communication approaches. Such was the impetus for the University of Florida, College of Medicine to pursue an interprofessional education activity that focused on communication skills in the interest of preventing medical errors.

\section*{Background}

Before a disparate group of siloed faculty members from the colleges of pharmacy, nursing and medicine could bring an understanding of inter-professionalism to the students, the group had to work to understand what they each brought to the table. Beginning in 2014, faculty from the College of Pharmacy wanted to expose their students to inter-professional learning opportunities. Lacking a cohort of similarly prepared students in other healthcare professions on the Jacksonville campus, a faculty member from the College of Nursing was invited to help facilitate a community-based interprofessional health promotion activity. That faculty member was able to bring the nursing perspective to pharmacy students as they worked to design and implement a health promotion activity for an assigned family in the surrounding community. It was during that collaboration that faculty from the two colleges proposed completing a project focused on end-of-life (EOL) care, a growing area of need for pharmacist involvement. Desiring to find a way to provide the activity across all the campuses (Jacksonville, Orlando, Gainesville, and St. Petersburg), the project developed into a comparison of simulated versus paper-based case studies on student attitudes toward EOL care.\textsuperscript{20}

With growth came the need for more faculty; therefore, a PhD prepared pharmacist and a nursing faculty member with simulation experience were integrated into the team. It was during this growth phase that the team ironically developed a keen appreciation for some of the challenges inherent in interprofessional collaboration. Scheduling meetings proved especially difficult as clinician members of the team had patients to see,
faculty members had students to teach, and administrators had conflicting meetings to attend. In addition to being flexible, the team realized it needed to accept a commitment. They decided to meet on Tuesdays at 10 am and with a set day and time, the meetings became sacrosanct. However, other communication challenges arose throughout the process. The team had to maximize the use of tools like “reply all” in emails, or else some of the messages would get lost in the threads. Simple mistakes can cause big setbacks!

Task delegation by the pharmacy leader was key as was playing to each team member’s individual strength. While the simulation expert focused on scenarios, another member keyed in on the budget, and a third arranged space to carry out the simulation. The team members were surprised to learn just what the other profession could offer. From writing skills and data analysis to simulation pedagogy and outcome evaluation, they found the team had a wealth of skills on which to draw. When the day finally came to implement the EOL simulations, they all had trepidation as the experience got underway. Two hours later, with the last post-experience survey completed, the team was excited at the success of the program and already looking forward to the next opportunity to collaborate.

That opportunity included work on a collaborative presentation, publication and two grant writing efforts. They also decided to send an invitation to faculty members from medicine to join the team. The goal was the pursuit of a truly interprofessional simulation effort focused on preventing medication errors. Starting in 2016, faculty members from the colleges of pharmacy, nursing, and medicine (both MD and Physician Assistant (PA) students). The team proposed that being able to foster acceptance and use of these practices at a grassroots level, would sow the seeds of success in tomorrow’s healthcare teams.

**Design**

A pre/post design was used to assess the impact of a teamwork-based education intervention and exposure to team-based simulated scenarios on attitudes toward teamwork. The education intervention was a series of four scenarios involving the medication management process. Within each scenario was a potential medication error that needed to be identified, prevented, and/or mitigated. Scenarios were identified from the literature or were developed by the authors. The focus was on some of the most common types of errors identified in the literature and included errors based on distraction, antibiotic cross reactions, antibiotic resistance, and toxicity.

**Methods**

Students from UF College of Pharmacy, Nursing, and Medicine participated in interprofessional training sessions as part of their senior level clinical experiences. MD and PA students were engaged in their senior year Emergency Medicine rotation at UF Health Jacksonville. Accelerated second degree nursing students were in the third semester of their five-semester program, and pharmacy students were in either their second or third year of their four-year training program. All students were consented. Participation by the medical, PA and pharmacy students was voluntary, but mandatory for the nursing students as it is a component of a clinical course. While participation was required for the nursing students, grades were not otherwise impacted. Students were divided into four-member teams with at least one representative from each specialty.

Each training session consisted of a one-hour large group introduction, including a pre-session survey. Students were provided a description of the learning activity and consented for a survey tool at the start of the activity. The survey tool, the Teamwork Attitudes Questionnaire (T-TAQ) is a 30-item validated tool that assesses changes in attitudes toward five teamwork
constructs (team structure, leadership, situation monitoring, mutual support, and communication).

A brief team building activity (Figure 1) was held with students being divided into teams of four and performing a timed cooperative-task exercise of building construction paper chains with each member using only their non-dominant hand. Despite the hilarity, members began to grasp the importance (and challenges) of clear verbal communication in accomplishing complex team behaviors. This was followed by a 45-minute presentation on TeamSTEPPS® competencies which broached the topic of medical errors and set the tone for the day.

The following two hours consisted of the teams rotating through four separate simulated clinical scenarios (Figures 2a and 2b). Each 30-minute station was designed to highlight a specific aspect/issue in the team approach to medical care. Instructors played roles as patients, family members, or ancillary medical staff. A timekeeper maintained the start and stop time. Following a very brief “setting of the stage,” 15-20 minutes were allotted for the students to be engaged in playing out the simulated scenario. This was followed by a 10-minute debriefing and discussion before moving on to the next station. The debriefing could be modified to focus on aspects that a particular team had either performed especially well or had struggled with. Both self-reflection and instructor-guided analysis was used to direct the discussion and to highlight key points. After rotating through all stations, students returned to the classroom for a large group debriefing, culminating in once again completing the T-TAQ tool.

Pre and post T-TAQ scores were analyzed with descriptive statistics utilizing SAS® v9.3. Comparisons were carried out for the entire T-TAQ questionnaire and at subgroups level. A p-value <.05 on Wilcoxon Rank Sum test was considered statistically significant.

Interestingly, the different types of students (pharmacy, nursing, medicine) demonstrated significant changes in disparate aspects of the T-TAQ instrument (Table 1). For instance, while all three professional student types showed significant improvement in the communication domain, for medical/PA students it was the only domain in which attitudes improved (p<.04). Comparatively, pharmacy students demonstrated significant attitude improvements in the domains of situation monitoring (p<.0003), mutual support (p<.03) and communication (p<.003). For nursing students, the team structure (p<.002) and leadership (p<.005) domains showed the most profound levels of improvement, in addition to those seen in communication (p<.02).

**Results**

Pre-intervention scores on the T-TAQ indicated that while students entered the education session already perceiving teamwork as a positive aspect of safe care delivery, significant improvement in attitudes was seen across all five constructs. The greatest degree of improvement was seen in the Situation Monitoring and Communication domains. This appears especially significant given the role communication gaps play in medication errors.

<table>
<thead>
<tr>
<th>Table 1. Changes in constructs between pre and post T-TAQ surveys.</th>
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</thead>
<tbody>
<tr>
<td>Team Structure</td>
</tr>
<tr>
<td>Medical/PA</td>
</tr>
<tr>
<td>Nursing</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

NS = not significant
Additional information was gleaned from students during the post-session large group debrief. When asked to describe the experience in one word, terms ranged from “humbling,” “scary,” and “overwhelming,” to “enlightening,” “fun,” and “educational.” Commonly expressed feedback during debriefing included a greater understanding of each other’s roles and what each profession brought to the bedside. Medical students identified an unspoken assumption that the leadership role was theirs to assume. A sizeable focus of conversation was on the role pharmacy students played as a vital information resource for the team. Additional take home lessons included:

1) Importance of nonjudgmental (and non-hierarchical) communication in the team approach to issues.
2) Awareness that commonplace mistakes are easily made.
3) Insight into what patients want to know about medical errors and patient safety.

Discussion

The faculty team spent considerable time in the design phase of this project. Having previously conducted a similar End-of-Life simulation for pharmacy and advanced practice nursing students, the team recognized the need for detailed simulation scenario development, a team-based approach to implementation, and a well-structured outcome evaluation plan. Simulation was the pedagogy selected to deliver the scenarios as opposed to paper-based case studies due to its focus on active learning. Simulation offers students the opportunity to “assemble” or organize learned facts and past experiences within the context of the novel problems the scenario offers. Communicating that information with each other helped the team reconfigure the data, use their cognitive power to form logical conclusions, and act on those conclusions to make patient care decisions.

Each student brought something different to the patient’s bedside. The pharmacy students had a particularly focused area of medication knowledge that was critical for nursing and medical students, including medication interactions, interpreting an antibiogram, and recognizing when assessment findings were medication based. Nursing students focused on gathering assessment data and conveying that information to their medical student team member, who saw their role to be interpretation of the data. Team members then had to collaborate in decision-making and formulate a plan of care.

Traditional views of healthcare provider roles likely explain the differences in which constructs of teamwork were most significantly changed for each professional student group. Significant changes in perceptions toward the role that communication played across all three student groups is easily understandable, as that was the major focus of the pre-simulation work. Other explanations may exist for the attitude transformations regarding the other constructs. For medical students, their easy assumption of the leadership role during the simulations perhaps reflects their real-life presumption that they are the leader of the care team in the clinical setting. Their pre and post scores were equally high, hence no significant change occurred. Nursing students however had significantly favorable changes in their perceptions about the leadership construct. This is hopefully due to the opportunities that arose during the scenarios for any of the students to assume the leadership role, which was also emphasized in the pre-simulation activity.

Another interesting finding involved provider perception toward team structure. Nursing students scored highest on the construct “Patients are a critical component on the care team” compared to medical and pharmacy students. Attitude changes in this area are important. Nurses often provide the lion’s share of the face-to-face contact time with the patient. In today’s environment of patient-centered care, a healthy respect for the role the patient plays as a vital team member is a critical. Seeing this belief develop in nursing students was quite rewarding.

The fact that pharmacy students changed their attitude significantly toward support is probably best understood from a performance perspective. Supporting their team members with their ability to look up drug interactions, calculate the creatinine clearance, or find alternative medication choices was the most frequently seen behavior by these students. The fact that they also significantly changed their attitude toward monitoring was an unexpected but welcome observation. Empowering these students to assume a role often taken on by the nurse or physician adds another level of safety and situational awareness. Part of the original impetus to include pharmacy students was the increasing evidence that pharmacists reduce medication errors when they
Finally, the employment of blended scenarios (both manikin and human role playing) provided an uncommonly suitable venue for exploring the hidden curriculum parameters of professionalism and respect. For example, in one scenario that involved the team recognizing failed outpatient antibiotic treatment of cellulitis, the team was reporting to a “supervising physician” who was friendly, supportive and lovable, but also overstepped some professionalism boundaries regarding patient privacy, language choice, etc. The patient was a somewhat irascible, yet not unreasonable fellow, who was a bit fed up with the fact that he wasn’t getting better quickly. Providers face subtle, yet important and ubiquitous, challenges like these daily. Approaches and answers are not found in textbooks, and live clinical scenarios provide very awkward venues to critically assess and teach approaches to these situations. Simulation provides a valuable safe harbor to explore this. Having the opportunity to dissect these situations allowed for student reflection on ways to navigate these minefields and provided mentoring from experienced teachers to help students build and refine their skill sets.

**Conclusion**

The information age has lifted the veil on many of the mysteries of healthcare. Gone are the days of the doctor telling the patient what’s best for him or her and having the patient take that on blind faith. Today’s Internet-informed healthcare consumers have greater agency in all aspects of their healthcare, including not only the “medicine” but also the behaviors of their providers. This is clearly a good thing, but will necessitate changes in how healthcare providers interact with patients (dare we say, consumers?). The savvy physician has evolved beyond the antiquated expectation that pharmacists, nurses, and others should merely be expected to follow orders. Instead, healthcare teams composed of a variety of professionals must cooperate and collaborate to provide safe, high-quality care. The goal of this collaboration was to introduce some of these changes at a grass roots level in order to instill some of these basic tenets at early levels of training, in tomorrow’s healthcare professionals. The project also attempted to develop interactive and experiential techniques to keep learners involved and make the training as lifelike as possible.

**References**

2. Makary MA, Daniel M. Medical error—the third leading cause of death in the US. BMJ. 2016 May 3;353:i2139.
Interprofessional Collaboration in Health Science Education

CME Questions & Answers (circle one answer)/Free to DCMS Members/ $55.00 charge non-members*

(Return by December 1, 2020 BY EMAIL: kristy@dcmsonline.org or ONLINE: www.dcmsonline.org/CME)

1.) A MAJOR goal of interprofessional collaboration is to:
   a. demonstrate that healthcare professionals can cooperate with each other
   b. maintain a hierarchical relationship between the professions
   c. improve revenue for participating healthcare providers
   d. achieve high-quality safe client care

2.) Interprofessional collaboration:
   a. is relevant only in primary care settings
   b. may involve physicians, nurses, pharmacists, patients and anyone else on the healthcare team
   c. generally does not involve patients and their families
   d. is replacing patient-centered care as a care model

3.) Which of the following strategies is most likely to reduce error caused by rapid clinical judgments?
   a. Allow any member of the team to ask for a pause if they have concerns
   b. Designate the most experienced member of the team to make all important decisions
   c. Suspend the use of clinical algorithms when decisions need to be made urgently
   d. Utilize single-profession healthcare teams to ensure their ability to work together

4.) Which of the following is the best approach to improving the quality of medical decision making?
   a. Ask the patient to designate which team member they would like to make important decisions about their care
   b. Ensure that the physician in charge of the patient’s care makes all important decisions
   c. Regularly utilize input from different professions to make important decisions
   d. Rely on the wishes of family members as the primary factor in making important decisions

5.) Which of the following is considered to be the leading cause of medical errors?
   a. Ask the patient to designate which team member they would like to make important decisions about their care
   b. Ensure that the physician in charge of the patient’s care makes all important decisions
   c. Regularly utilize input from different professions to make important decisions
   d. Rely on the wishes of family members as the primary factor in making important decisions

6.) In regards to education of healthcare professionals, which of the following may have the greatest impact in helping reduce medical errors in the long term?
   a. Educating professionals in isolation from other professions in order to enhance focus on that particular profession’s needs
   b. Limiting discussions regarding communication in order to allow health professionals to focus solely on management of the patient
   c. Creating opportunities for professionals from various colleges to collaborate together from an early point in their education
   d. Teach students to work harder and be smarter

7.) Which of the following structured communication tools can improve information transfer?
   a. IPASS
   b. SBAR
   c. TeamSTEPPS
   d. All of the above

8.) Which of the following contributes to communication gaps among healthcare professionals which could lead to errors?
   a. Physicians, pharmacists, and nurses are all trained together prior to graduation
   b. Educational levels are similar between professionals post-graduation
   c. Pre-graduate training is often conducted in “silos”
   d. A shared philosophy in communication among healthcare professionals

9.) Who is in the best position to take the reins in limiting communication-related medical errors?
   a. Healthcare providers, and those who train them
   b. The patients
   c. Hospital administrators
   d. Government agencies and accrediting bodies

10.) Common areas of communication-based medical errors include:
    a. Rapid communication during high-pressure, quickly-changing scenarios
    b. Formalized communications (such as consultations and shift sign-overs)
    c. Discussion between the healthcare team and the patient or family
    d. All of the above

1. What will you do differently as a result of this information? ____________________________________________________________

2. How will you apply what you learned to your practice? ______________________________________________________________

Evaluation questions & CME Credit Information

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The article was appropriate to my practice: 1 2 3 4 5
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**Medicare: Past, Present, and Future Directions**

**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, “Medicare: Past, Present, and Future Directions” authored by Ross Jones, 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:**
Ross Jones, MD, Clinical Assistant Professor, University of Florida College of Medicine – Jacksonville.

**Objectives:**
1. Understand the components of the various parts of Medicare and which parts of Medicare are responsible for which payments.
2. Describe how historical trends and policy changes have resulted in the current state of Medicare programs.
3. List the current challenges to control spending in the Medicare program.

Date of release: December 1, 2018  Date Credit Expires: December 1, 2020  Estimated Completion Time: 1 hour

**How to Earn this CME Credit:**
1) Read the “Medicare: Past, Present, and Future Directions” 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/CME](http://www.dcmsonline.org/CME) to read the article and take the CME test online.
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Medicare: Past, Present, and Future Directions

By Ross Jones, MD, MPH, FAAFP
UF Health Family Medicine and Pediatrics

Address correspondence to:
Ross Jones, MD, MPH, FAAFP
1155 E. 21st Street
Jacksonville, FL 32006
Email: Ross.Jones@jax.ufl.edu

Abstract

The Centers for Medicare and Medicaid Services (CMS), which administers Medicare and Medicaid, is the single largest payor in the U.S. healthcare system. Currently, Medicare is divided into four parts that cover services across the spectrum of care. Medicare was initially created to address the high number of uninsured elderly during the 1930s, 1940s, and 1950s. Since its inception, Medicare has seen changes in eligibility and payment structure. In an attempt to control cost, there have also been changes to the Medicare payment structure. Recently, Medicare has shifted from a traditional fee for service to a payment structure based on value. In the coming years, Medicare will face challenges due to rising costs caused by demographic changes among Medicare beneficiaries and the complexity of Medicare financing. The program will continue to be a focus among policy makers. Potential solutions for the Medicare program range from privatization to simplification of the current program.

Introduction

In 2015, CMS spent $585.7 billion on Medicare beneficiaries.¹ During that year, Medicare was responsible for providing healthcare for over 55 million Americans. That number is expected to grow to over 70 million by 2025 as baby boomers continue to enroll in the program.²

Currently, Medicare is divided into four distinct parts. Part A of Medicare covers inpatient hospital admissions, skilled nursing facility stays, home health, and hospice care. Part B covers outpatient services, preventive services, and home health visits. Part C is responsible for the Medicare advantage programs, which allow Medicare beneficiaries to enroll in private health plans such as health maintenance organization (HMOs) and preferred provider organizations (PPOs). Part D covers outpatient prescription drugs through private plans, either as stand-alone prescription drug plans or as a part of Medicare Advantage drug plans.

History of Medicare

1965 to 1980: Creation of Medicare and Expansion of Eligibility

Medicare was established after President Lyndon B. Johnson signed Title XVIII of the Social Security Act into law in 1965. This legislation was the result of the high number of uninsured elderly patients during the 1930s, 1940s, and 1950s.³ Prior to the initiation of Medicare, over 40 percent of U.S. citizens over the age of 65 did not have healthcare. To address this issue, Medicare was initially designed to provide health insurance to any person over the age of 65 regardless of income or past medical history.

Since the start of its operations, the Medicare program has seen changes in its eligibility criteria, services covered, and payment structure. In the 1970s, Medicare began to include persons with disabilities, in addition to the elderly. The expansion of coverage started in 1972 with the addition of patients with long-term disabilities and end stage renal disease. During the 1970s, Medicare also began to pay for additional services beyond traditional inpatient hospital care and routine office visits, such as physical and speech therapy.

1981 to 2000: Cost Controls and the Rise of Managed Care Plans

During the 1980s, the Medicare program underwent several significant changes. Hospice care became a permanent benefit in 1982. During this decade, the most radical changes were in the payment structure. Prior to the 1980s, Medicare payments were modeled after private insurance companies. Providers and hospitals billed Medicare according to reasonable and customary charges. In 1983, Medicare began paying for hospital admissions based on diagnosis related groups in place of the routine charge-based method. In 1989, Medicare established the Resource Based Relative Value Scale (RBRVS) to replace charge-based payments in both the inpatient...
and outpatient environments. By the end of the decade, RBRVS was the dominant payment model for the healthcare industry and it remains the predominant model for payment in healthcare today.

In the 1990s, the Medicare program shifted focus to controlling costs by starting and codifying a number of initiatives. HMOs were one way to control cost using the capitation model and had been gaining traction in the U.S. healthcare system since their inception in the 1960s. Prior to the 1990s, HMO involvement in the Medicare program was limited to a few demonstration projects. The inclusion of health maintenance organizations in the Medicare program was formalized when President Bill Clinton signed the Balanced Budget Act of 1997. The Balanced Budget Act of 1997 created Part C of Medicare, Part C allowed for the creation of Medicare+Advantage, later renamed Medicare Advantage plans. The Medicare+Advantage programs allowed Medicare beneficiaries to enroll in managed capitated-fee health plans such as HMOs in place of traditional Medicare plans. The Balanced Budget Act of 1997 also created one of the most contentious aspects of Medicare, the sustainable growth rate (SGR).

The SGR tied payment rates to providers to target expenditures in an attempt to ensure that Medicare spending did not exceed growth in the gross domestic product. The SGR adjusted physician payments based on two factors: 1) how total expenditures from the previous year matched cost targets based on the number of Medicare beneficiaries and 2) changes in the real gross domestic product (GDP). The SGR often called for decreased payments to providers as actual costs often exceeded target values. In 2014, the SGR required for Medicare reimbursements to be reduced by 16 percent. Congress was called on numerous occasions to modify or to prevent these cuts in so-called “doc fixes.”

2001 to Current: Efforts to Increase Access and Coverage

In 2003, President George W. Bush spurred the passage of the Medicare Modernization Act of 2003 (MMA) that added prescription drug coverage to Medicare. The MMA allowed Medicare beneficiaries to enroll in private plans for prescription drug coverage. As of 2015, more than 39 million Medicare beneficiaries were enrolled in Medicare Part D prescription drug plans. The passage of the Patient Protection and Affordable Care Act (ACA) in fall of 2015, under President Barack Obama, sought to alter the landscape of healthcare in the U.S. by expanding the number of Americans with healthcare coverage. The ACA and supporting legislation represented the most significant changes in access to healthcare since the creation of Medicare. While leaving the structure of Medicare largely intact, the ACA hoped to increase savings in the Medicare program by reducing the amount of waste and fraud, in the system, along with reduced payments to Medicare advantage plans. The ACA allowed for innovative payment and delivery systems such as accountable care organizations (ACO) and bundled payments. The ACA also expanded coverage for preventive service and increased prescription drug benefits for Medicare beneficiaries.

Building on the ACA’s effort to increase access, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) strengthened access to Medicare by improving physician payments, incentivizing physician participation in risk sharing payments, and by repealing the SGR. The legislation also aimed to improve patient care by moving payment from a fee for service model to one based on value and quality. MACRA combined quality programs within the Medicare program and changed providers’ payments to be based on their relative performance among Medicare providers.

Current Challenges and Potential Solutions

Despite the numerous changes Medicare has undergone since its inception, the program still faces substantial challenges. The primary challenge facing Medicare will be the rising cost to changes in demographics. In the U.S., life expectancy continues to increase. Between 2010 and 2050, the number of people over the age of 80 in the U.S. is expected to triple. It is estimated that 81.8 million people will be eligible for Medicare by the year 2030. According to some projections, Medicare spending will double by the year 2027 to $1.2 trillion in order to provide adequate care for these newly eligible patients.

The disjointed nature of the Medicare program is also a challenge. Each of its four parts is funded by a different source. As a result, the Medicare system can be difficult to navigate for patients and healthcare providers.
providers as each service has different required copays, deductibles, and regulatory requirements. Additionally, many low-income Medicare beneficiaries may forego care, as they cannot afford the various copays and premiums required.

Given the significant amount of federal spending on Medicare, the program will continue to be a focus for consumers, health providers, and policy makers for the near future. Stakeholders will continue to explore methods to improve Medicare. Proposals for potential comprehensive Medicare reform are focused on two models: 1) premium support and 2) restructuring traditional Medicare programs.\(^6\)\(^,\)\(^7\) Advocates of premium support believe that Medicare beneficiaries should be given subsidies to help purchase traditional Medicare plans or private plans with a defined set of benefits. Supporters of this approach think premium support will lower cost due to increased competition among plans, and efficiencies that result from this competition. Some potential drawbacks of this approach are decreased ability of private plans to drive down costs, lack of information about the quality of the plans offered, and decision fatigue among Medicare beneficiaries given the number of choices for healthcare plans.\(^8\)

Others have proposed restructuring traditional Medicare to reduce the complexity and fragmentation of the current program.\(^8\) The various parts of Medicare could be combined into one program with a single set of deductibles, copays, and regulations. Medicare could also reduce the out of pocket cost for services to reduce the burden on low-income beneficiaries. With this option, the program could continue to focus on cost savings by increasing efficiency through value-based reimbursements and risk sharing payment models such as ACOs.

### Conclusion

As Americans continue to live longer, the Medicare program will continue to grow in importance given the number of citizens it covers and its cost. The success of the Medicare program will hinge on the ability of policymakers to contend with changing demographics and increasing expenditures due to the rise in the prevalence of chronic diseases such as diabetes and hypertension. While policymakers contend with these challenges, it is paramount that stakeholders, including physicians and patients, collaborate and add their voices to the discussion to ensure older Americans continue to have access to high value care.

### References


Medicare: Past, Present, and Future Directions

CME Questions & Answers (circle one answer)/Free to DCMS Members/ $55.00 charge non-members

(Return by December 1, 2020 BY EMAIL: kristy@dcmsonline.org or ONLINE: www.dcmsonline.org/CME)

1.) What is the single largest payer in the U.S. healthcare system?
   a. Veteran's Administration
   b. Centers for Medicare and Medicaid Services
   c. Aetna
   d. United Health Group

2.) Medicare consists of how many parts?
   a. 3
   b. 4
   c. 5
   d. 6

3.) Medicare was signed into law by which president?
   a. Harry Truman
   b. Richard Nixon
   c. Lyndon B. Johnson
   d. Dwight D. Eisenhower

4.) Medicare was primarily created to address what issue?
   a. The high number of uninsured elderly during the preceding decades
   b. Lack of parity in payments between inpatient and outpatient procedures
   c. The lack of uptake of scientific advances in medical care
   d. Decreased healthcare spending

5.) Expansion of Medicare coverage started with which group?
   a. Persons with long term disabilities in 1962
   b. Persons over the age of 60 in 1981
   c. Persons with end stage renal disease in 1972
   d. Persons with diabetes in 1983

6.) In 1989, Medicare created which payment system to replace charge based payments?
   a. Diagnosis related groups
   b. Medicare system for payment innovation
   c. Capitation
   d. Resource Based Relative Value Scale

7.) The sustainable growth rate created in 1997 as an attempt to control Medicare spending was based on which factors?
   a. Target expenditures from the previous year
   b. Changes in the real gross domestic product
   c. Both A and B
   d. Neither A or B

8.) President George W. Bush signed the Medicare Modernization Act of 2003, which added prescription drug coverage to Medicare. Which part of Medicare was created as a result of this legislation?
   a. Part A
   b. Part B
   c. Part C
   d. Part D

9.) Given the changing demographics of the U.S. and the increase in chronic diseases, spending on Medicare beneficiaries is expected to exceed what amount by 2027?
   a. $2 Trillion
   b. $1 Trillion
   c. $750 Billion
   d. $500 Billion

10.) True or False: Premium support and restructuring traditional Medicare have both been proposed as methods to reform Medicare.
    a. True
    b. False

1. What will you do differently as a result of this information? __________________________________________________________
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

2. How will you apply what you learned to your practice? __________________________________________________________
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

Evaluation questions & CME Credit Information

(Please evaluate this article. Circle one number using this scale: 1=Strongly Agree to 5=Strongly Disagree)

The article met the stated objectives: 1 2 3 4 5
The article was appropriate to my practice: 1 2 3 4 5
The topic was current and well presented: 1 2 3 4 5

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• Incredible Summer Kitchen Pavilion
• Pool & Spa
• Dock with boatlift
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• MLS# 959419

BEAUCREC | $1,175,000
Hidden Riverfront Treasure
• Riverfront
• High bluff lot
• Custom-built
• Large great room overlooking river
• Bonus room above garage
• Pool, Dock, and Summer Kitchen
• 4 Bedrooms /3.5 Bathrooms/5,044 Sq. Ft.
• MLS# 962984

EPPING FOREST | $2,650,000
Rare Offering
• Riverfront
• Elegant finishes and upgrades
• Gourmet kitchen
• Nanny Suite with private entrance
• Pool and Dock
• 5 Bedrooms/6 Full &2 Half Baths/6,747 Sq. Ft. 
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FORT GEORGE ISLAND | $1,375,000
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