LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

Bulletin

Volume 33, Issue 1 | Editor: John W. Snead, M.D. | April 2009

2009 Meetings and Events

No Meeting in April

LCMS General Meeting
Thursday, May 21, 2009
6:30 p.m. Social Time
7:00 p.m. Dinner

Royal Palm Yacht Club
2360 West First Street
Fort Myers, FL 33901

Speaker:
Peter Dans, M.D.

Topic:
"Doctors In The Movies"
Hollywood's portrayal of doctors from 1931 to the present. Invite your spouse to attend with you.

One Hour CME Credit

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

Inserts

- Office Building For Lease Advertisement
- May Meeting Notice

Inside this issue:

President's Message

E.H.R.

Larry Hobbs, M.D.

E.H.R., electronic health records, is the new politically correct label for electronic medical records. This article's intent is only to introduce you to what has been transpiring over the last few weeks. Further discussions and expert evaluation will be needed to fully understand and implement this technology. Presently, only about 13 -17% of the nation's physicians possess a form of E.H.R. technology. Recently, President Obama signed a stimulus bill called the American Recovery & Reinvestment Act (ARRA) into law. Part of that bill appropriated $19.2 billion as the HITECH Act (Health Information Technology for Economic and Clinical Health). The goal of this legislation is to incentivize health care providers to use qualified E.H.R.s by 2015. These incentives will be tied to Medicare and Medicaid reimbursements. Starting in 2011, physicians using a qualified E.H.R., will be eligible for $44,000 to $64,000 and hospitals for up to $11 million. To qualify for these incentives the physician must use a certified E.H.R. product with e-Prescribing capability, have connectivity to other providers and have the capability to report on their use of this technology to H.H.S. Physicians and hospitals that choose not to implement E.H.R.s by 2014 will face a loss in Medicare revenue.

The question we all have now is why do we need this? Some, including the Obama administration, have stated that E.H.R.s will improve quality of care by eliminating medical errors. It has also been touted as helping reduce health care costs by reducing duplication of services if properly implemented. Others have questioned these benefits. Dr. Steve West, FMA president, has stated in a recent editorial in a Tallahassee newspaper the "HIT has little to no impact on the cost or quality of care without the detrimental tool of rationing. Government and insurance company bureaucrats know that HIT can be used to determine what medical care a patient is allowed to receive." A recent article by Nathan Cohen of Sg2, a health care intelligence company, stated that the largest expense to the health care system is people, not errors. And that in other industries the power of IT has been primarily in productivity not quality. He feels the HITECH Act's priority is not meant to incentivize productivity. Mr. Cohen goes on to say that the HITECH incentives would put additional pressures toward physician practice consolidation with larger practices extracting more "profit" from the stimulus than smaller practices.

So what does this mean for Lee County physicians? Our local response should not be confused with federal government policy. It is obvious that discussing all options and implementing a workable and acceptable system is in all of our interests. The flow of medical information from the physician's office to the hospital-based physicians and back would greatly enhance the patient's medical experience. Discussions have begun with physicians within our community on how to best implement a countywide transfer of medical information. The Independent Physician Association of Lee County (IPALC) recently surveyed its membership. Out of 46 medical groups that responded, 26 with a total of 220 physicians reported as using some type of E.M.R. This percentage is much higher than the national average. Mike Smith, the Chief Information Officer at LMHS has stated, "When properly developed and implemented, E.H.R.s are a tremendous tool for the health care provider. But, if E.H.R. is not designed well or supported properly, the results are wasteful and can be harmful." Mr. Smith and LMHS would like to work with all the community physicians in providing safe, two way E.H.R. communications between the hospitals and physicians.

Questions have been and will continue to be raised. Many office based E.M.R. systems are integrated with practice management software. How safe is a physician's business practice from this transfer of patient medical records? Is it possible to collate all the data from other outpatient sources such as radiology and laboratory results? Can we access out-of-town records on the part-time residents we all care for during season? Is a collaborative organization of physician and hospital the best way to facilitate interoperable E.H.R. systems? Should some large IPA be the facilitator or should the hospital carry the burden? The fact is that E.H.R.s are useful at providing continuity of care for patients. And regardless of controversies of the stated political goals of E.H.R.s, by 2015 we will all need to be involved in their implementation. The Lee County Medical Society can provide the forum to promote hospital-physician dialog about E.H.R.s and their implementation. Keep in touch with your Medical Society for updates and physician forums that may be scheduled.

I want to thank Steve West, MD, James Penuel, MD and the IPALC, and Mike Smith, CIO for LMHS for their insight and work on this subject. Dr. Penuel asked all to access his website, IPALC.org, for ongoing links and information on E.H.R.s and as a repository that physicians might find useful.

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

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

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

EDITORIAL BOARD PRESIDENT
Larry Hobbs, M.D.

PRESIDENT ELECT
Craig Sweet, M.D.

SECRETARY
Shahid Sultan, M.D.

TREASURER
Cherrie Morris, M.D.

PAST PRESIDENT
Dean Traiger, M.D.

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

MANAGING EDITOR
Ann Wilke, 936-1645

PRINTERS
Insta Print

Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meeting minutes are available for all members to review.

Membership Activity

New Satellite Office
Robert Martinez, MD
RM Orthopedics
13731 Metropolis Avenue
Fort Myers, FL 33912
Phone: 368-5777

Ankush Gulati, M.D
Lee Kidney Center
1560 Matthew Drive, Ste G
Fort Myers, FL 33907
Phone: 303-2820

Moved out of Area
Lance Hall, MD

New Address
Mazen Daoud, MD
Advanced Dermatology Specialties
12580 University Drive
Fort Myers, FL 33907
Phone: 274-0005

Marilyn Kole, MD
LMHS Administration
13681 Doctors Way
Fort Myers, FL 33912
Phone: 343-0787

William Wittenborn, MD
Wittenborn Plastic Surgery
14131 Metropolis Ave #105
Fort Myers, FL 33912
Phone: 561-2313

Southwest Florida Emergency Physicians
John Bellew, DO
Larry Hobbs, MD
Thomas Johnson, MD
Dwight Phelps, MD
Thomas Schaar, MD
Robert Sharkey, MD
Walter Simmons, DO
13681 Doctor's Way
Fort Myers, FL 33912
Phone: 343-1000

New Members
Janet Cheng, MD - Dermatology
Advanced Dermatology Specialties - 549-0837

Jose Colon, MD - Pediatric Neurology
Pediatric Neurology & Sleep Medicine - 985-3600

Scott Crater, MD - Dermatology
Associates in Dermatology - 936-5425

Adam Heller, MD - Neurology
Florida Neurology Group - 936-3554

Jeffrey Laoang, MD - Emergency Medicine
Lee Memorial Health System ER

Michelle Mon, MD - General Surgery
Assoc in General & Vascular Surgery - 939-2616

Robert Perez, MD - Diagnostic Radiology
Radiology Regional Center - 936-2316

David Sudderth, MD - Neurology/Headache Med
Florida Spine & Brain, LLC - 275-6690

Robert Tomas, DO - General Surgery
Robert Tomas, DO - 424-1616

Harry Turner, MD - Diagnostic Radiology
Radiology Regional Center - 936-2316

Sergio Vignali, MD - Obstetrics/Gynecology
Femme Care - 344-9911

Corrections
In the March 2009 Bulletin under the Out and About section we attributed Dr. Larry and Mrs. Debra Hobbs picture to the wrong doctor and spouse. We would like to apologize to Dr. and Mrs. Hobbs and Dr. and Mrs. Hoffman for this mistake.

Members in the News

James H. Rubenstein, MD and his wife Betty

The American College of Radiation Oncology (ACRO) bestowed its highest honor, the College Gold Medal Award, to ***James H. Rubenstein, MD***, for his outstanding service to the specialty and the organization. Dr. Rubenstein has served on the ACRO board for many years, holding the position of Chair, Treasurer and President. He is also the Immediate Past President of the FMA PAC and practices radiation oncology in Fort Myers.

As I Recall...

Roger D. Scott, M.D.

Jones Walker Hospital - Part II

There maybe those who decry that Jones Walker was a bad hospital but I disagree because it was a clean hospital with good caring nurses and technicians and especially good southern food. Unfortunately it was necessary to transport the patients by ambulance (Sears and Baker were the two colored funeral homes that used hearses as ambulances.) to and return from Lee Memorial for x-rays and any specialized tests. Margaret Grattic (black laboratory technician) did simple blood counts and urinalysis; but blood for other studies was sent to Lee Memorial. When Jones Walker closed, Margaret went to work for Doctors Bryan, Rawl, Gore, Butler, Agnew, and O'Bryan for some years. It was indeed unfortunate and an inconvenience for the physicians to have to attend a separate hospital and especially so for the surgeons who had to make three trips for emergency surgeries and in addition to make rounds at a second hospital sometimes even twice a day. It was the beginning of better days for us all when about 1964 or 65 Dr. Laurent ("Larry") Radkins (Ob/Gyn) had the ambulance take a black female patient to Lee Memorial for a hysterectomy, but with immediate return to Jones Walker for recovery and convalescence. This was the first time a black patient had been operated on at Lee Memorial but from that time on we were able to continue doing this for big cases. In about late 1965, some patients were admitted to Lee Memorial instead of Jones Walker, but there had previously been one patient admitted to Lee Memorial under unusual circumstances. In about 1956 a black man was burning trash somewhere around Bonita or Estero and his clothes caught on fire resulting in extensive third-degree burns of his body. A northern tourist brought the man to the emergency room of Lee Memorial as it was on US 41 (Cleveland Ave). I believe Dr. Jack C. W. Warnock was covering the emergency room that day, and he was admitted to Lee Memorial as he was too severely burned to be transported to Jones Walker. There was a big hullabaloo in Fort Myers (a segregated community) about this admission. John Gadd (Hospital Administrator) and Dr. Warnock felt that the patient was terminal and should not be transferred despite community protest, and; therefore he was treated at Lee Memorial until he promptly expired from the terribly extensive burns. I am not sure, but I think Larry Radkins was the second doctor to admit a black patient.

I had always wanted to do missionary work but never had time to leave my practice here. Many of the Jones Walker patients were on an extremely low economic scale and were unable to pay. Much of the work was free and so I considered much of my work at Jones Walker as missionary years. These were the early days of medical insurance and few patients had insurance and many of the patients were unable to pay part or any of their bills.

The supervisor of the hospital was always a registered nurse, and the first one I can remember was Gladys Frazier (It was a rarity as there were very few black RNs in the U.S.) a really good nurse who handled many minor emergency problems rather than call the doctor. (This was a "no-no" in those days.) She had terrible arthritic deformities and soon retired after I came to town. There were a number of other nurses that worked at Jones Walker over the years. The black nurses were Doris Gallman R.N. and Doretha Stevens,? R.N. or LPN and the white nurses were Mrs. Vickers, R.N., Betty Wight RN, and Clara Ogle R.N. There were several LPN's: Betty Hart Walker (later became an RN at Lee Memorial), and Mary Bellamy. Pearl Wiley was one of several aides and she obtained an LPN status at Lee Memorial later. Pauline (Polly) Stevenson, LPN was working there, but left to be my wonderful first office nurse for many years. Jodie Kinzie, R.N. was the last supervisor working for several years until 1966 when Jones Walker closed. Betty Carr was an aide, and Rayfield Newton was the orderly. Rayfield continued as an orderly at Lee Memorial for several years and then joined the Fort Myers Police Department and retired after many years with them. Lee Memorial was good to offer employment to those who were losing their jobs due to the closure of Jones Walker. In addition many black workers were employed by Lee over the years and many advanced their training. Sorry I can't remember more of the names of the people who worked there and their titles, but its been a long time since all this happened.

John Gadd told me that the federal government did not state that Jones Walker had to close, but it did have to show an equitable mix of black and white patients if it was to be approved eligible for Medicare and Medicaid payments. John said he was given an ultimatum by the federal administrators that he must advise anyone regardless of race, creed, color or sex that they could be admitted to either Jones Walker or Lee Memorial Hospitals, and the census must show an equal distribution of blacks and whites. One of my post-operative patients (Eileen) in early 1966 was in a private room at Lee and stated that in the middle of the night all the lights came on in her room and she was awakened by several well-dressed black persons in her room. She questioned what they were doing, and they said they were from Washington and were checking the census of the hospital. As it was impossible to comply with the federal regulations regarding a 50-50 black-white census, Jones Walker in 1966 became the last segregated hospital in the U.S. to close.

Please remember that 50 plus years ago medicine was not advanced as it is today and customs in this community were different unfortunately, but this was history. We were fortunate to have hospitals here as my hometown did not have any closer than 90 miles away.

After Jones Walker Hospital was demolished a housing project, Jones Walker Gardens, was built on some of the property (There was a great deal of property around the old building). I am not sure what all is present in this area now.

I will always treasure the memories of my patient Silas Alexander (a 95-year-old black man) who was born in slavery, but during his life became educated and wrote many fluent letters about various subjects to the editor of the Ft. Myers News-Press. Monetarily he was poor, but rich in mind and spirit.

Again if there is any offense created with my statements it is certainly regrettable and unintentional and I apologize. It is good that we are now all integrated Americans with equal rights and opportunities with hope and justice for all.

Many thanks to Ms. Pearl Wiley, LPN retired for confirming, adding, and sorting some names to assist in this article.

PART I ERRATUM

Well, I finally made a mistake! Carey Barry & Tom Wiley are still alive and worked at Jones Walker Hospital more than eight years. Tom should be especially remembered as the founding editor of the Lee County Medical Society Bulletin.

LCMS…The Caring Continues

volunteer healthcare CONNECTIONS
SPECIALTY CARE FROM SPECIAL PEOPLE

Volunteer Healthcare Connections, the Lee County volunteer physicians' referral program, is continuing its recruitment of specialty physicians during April. Have you signed up yet?

The referral network is actively seeking a full range of medical and surgical specialists to help with 'pro bono' care for uninsured, low-income Lee adults. Can you see one patient a month?

President Larry Hobbs in his front-page March *Bulletin* message put it well: *Let's show the community that even though physicians are also suffering, we will continue to give back to our community during these tough times.*

A first group of LCMS members stepped forward last month, but many more are needed to make a "fair share" rotation work. By joining, you will be building a true component to Lee County's healthcare safety net. Seeing charity-care patients through *Volunteer Healthcare Connections* benefits underserved men and women needing your skills. And it offers a vehicle to recognize and quantify across the county the costs of charity care you already may be providing. The referrals will be tailored to your practice.

To enroll and join as a volunteer specialty-care physician, LCMS members should contact: Kristin Ritts, coordinator for *Volunteer Healthcare Connections*, at kgritts@unitedwaylee.org, by phone 433-2000, or by fax 433-5692.

And a special thanks to those who've answered "yes" to Dr. Hobbs.

Movie Trivia for May Meeting

Can you guess what decade these doctors movies were released? Answer will be disclosed at the LCMS General Meeting in May.

1) The Country Doctor
2) Dr. Bull
3) Of Human Bondage
4) Meet Dr. Christian
5) Men in White
6) Society Doctor
7) Internes Can't Take Money
8) Young Dr. Kildare
9) Doctor X
10) Arrowsmith
11) Dr. Jekyll and Mr. Hyde
12) The Story of Louis Pasteur
13) Mary Stevens, M.D.
14) Dr. Monica
15) Woman Doctor
16) The Citadel
17) Symphony of Six Million
18) The Green Light
19) Magnificent Obsession

Dr. West's Letter to Congress

Editor's Note: This letter was sent to all our congressional delegation and on March 11, 2009 the FMA Delegation visited our legislators in Washington, DC to carry this message on health care.

Dear Legislator :

As a member of the 111th Congress, a historic opportunity to enact health system reform lays before you. To achieve positive change, the Florida Medical Association believes it is critical to transform our nation's health system into one that ensures **access**, **affordability**, **choice** and **accountability** for Americans while **strengthening the safety net** that serves low income Americans.

It is increasingly difficult for Americans to afford health care services. This problem has arisen from a financing system that is dominated by third-party payers and a lack of direct consumer involvement in health care decisions. Attempts to lower health care costs through alterations of this same system have not been successful. This is because a lack of direct spending by individuals removes the very consumer control that drives down costs and drives up quality in other sectors of the American economy.

We recognize that Congress has already set forth health system reforms that further expand the reach of third-party payers. Yet there is still room for policies that will empower American consumers, especially in the Medicare program. There are two important reforms Congress can achieve in this area:

(1) Congress must prevent the proposed 21 percent cut to Medicare physician payment rates based on an adjustment of the Sustainable Growth Rate (SGR). There is already an acute shortage of physicians participating in Medicare, and it has been demonstrated that when rates are cut, more physicians decline to participate. Last year, in an anticipation of a 10 percent cut, nearly a quarter of physicians reduced their Medicare practice. A 21 percent cut could have an even more dramatic impact on patient access to care.

(2) Congress must restore Americans' right to privately contract for healthcare. Currently, Congress denies the right of a Medicare patient to pay more to see a doctor of their choice. This right was lost in the late 1980s through Congressional action and can be restored today. Americans in Medicare and in private insurance should have the right to arrange contracts with their physicians to gain access to their time and care, and should have the right to purchase an insurance product to cover additional expenses not covered by the government or their private plan. Similar arrangements exist in Europe, and permit patients to seek medical care outside that which is provided through publicly financed programs. We believe the best way to accomplish this goal is through implementation of 22 lines of legislation contained in HR4736 (110th Congress), which would re-establish the right of private contract that is the basis of our free society.

As health system reform unfolds, we ask that you do everything possible to ensure the survival of the American right of private contracting, and to strengthen the patient-physician relationship.

The FMA stands ready to meet with you and provide further insight into these principles on health system reform, and we are eager to explore various policy proposals as they emerge. We are confident that you and your staff will direct great thought and time to this matter.

Sincerely,
Steven R. West, M.D.
President, Florida Medical Association

Quote of the Month:

"Our lives begin to end the day we become silent about things that matter."

- Martin Luther King, Jr.

American Recovery and Reinvestment Act of 2009 (ARRA)

H.R. 1 (Conference Agreement enacted on 2/17/09) Summary of Major Health Care Provisions

American Medical Association - Legislation and Advocacy

Status

The House of Representatives and Senate passed ARRA on February 13th (House vote of 246-183, with no Republican support and 7 Democrats voting no; Senate vote of 60-38, with 3 Republicans voting yes (Senators Collins, Snowe, and Specter). President Obama signed the bill on February 17, 2009.

COBRA

- Sixty-five percent temporary COBRA premium subsidy for workers who have been involuntarily terminated between Sept. 1, 2008, and Dec. 31, 2009.
- Subsidy available for up to 9 months.
- Subsidy would not be considered income for purposes of other federal/state program eligibility.
- To be eligible for the subsidy, an individual must have a modified adjusted gross income below $145,000 (or $290,000 for joint filers); if the taxpayer's income exceeds this threshold, then the premium subsidy must be repaid. For taxpayers with AGI between $125,000 and $145,000 ($250,000 and $290,000 for joint filers), the amount of the premium subsidy that must be repaid is reduced proportionately.

Medicaid

$87 billion in additional federal matching funds is provided (from Oct. 1, 2008-Dec. 31, 2010).

- Increases FMAP (Federal Medicaid Assistance Percentages) for all states by 6.2%.
- Holds states harmless against a drop in their FMAPs for FYs 2009, 2010, and first quarter of FY 2011 (e.g., if 2008 FMAP is higher than 2009, the state gets the higher 2008 rate).
- States with large increases in unemployment would receive an additional FMAP increase. It is estimated that the conference agreement would provide about 65% of its spending via the hold harmless agreement and across-the-board increases, and about 35% via the unemployment-related increase.
- FMAP increases would not apply to other parts of state Medicaid programs that are based on enhanced FMAP (e.g., DSH (Disproportionate Share Hospital), TANF (Temporary Aid for Needy Families), SCHIP, child/family services, etc.).
- States cannot use FMAP/high unemployment increases for rainy day/reserve fund.
- States must maintain the same eligibility standards, methodologies, and procedures that were in effect on July 1, 2008, in order to receive FMAP increase.
- States must comply with current Medicaid prompt pay requirements in order to receive FMAP increase.
- Extends through June 30, 2009, the current moratorium on 4 Medicaid regulations relating to provider taxes, targeted case management services, school-based services, and outpatient hospital services; states the sense of the Congress that the HHS Secretary should not promulgate as final the proposed regulations relating to cost limits on public providers, GME payments, and rehabilitative services.
- Provides for a temporary increase in state DSH allotments for FY 2009 and 2010.

Health Information Technology (HIT)

Provides approximately $19 billion for Medicare and Medicaid HIT incentives over five years.

- Officially establishes the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS to promote the development of a nationwide interoperable HIT infrastructure; President Bush already created ONCHIT by Executive Order in 2004.
- Establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for electronic exchange and use of health information.
- HHS would adopt through the rule-making process an initial set of standards, implementation specifications, and certification criteria by December 31, 2009.
- ONCHIT would be authorized to make available an HIT system to providers for a nominal fee.
- Provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way (as defined by the Secretary and may include reporting quality measures). Authorizes ONCHIT to provide competitive grants to states for loans to providers.
- Medicare incentive payments would be based on an amount equal to 75% of the Secretary's estimate of allowable charges, up to $15,000 for the first payment year. Incentive payments would be reduced in subsequent years: $12,000, $8,000, $4,000, and $2000, after 2015. Physicians who report using an EHR that is also capable of e-prescribing would be eligible for EHR incentives only.
- Early adopters, whose first payment year is 2011 or 2012, would be eligible for an initial incentive payment up to $18,000. In 2014, the payment limit would equal $12,000. Adopters, whose first payment year is 2015, would receive $0 payment for 2015 and any subsequent year.
- For eligible professionals in a rural health professional shortage area, the incentive payment amounts would be increased by 10 percent.
- Incentives under the Medicaid program are also available for physicians, hospitals, federally-qualified health centers, rural health clinics, and other providers; however, physicians cannot take advantage of the incentive payment programs under both the Medicare and Medicaid programs. Eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to $42,500, and other physicians (non -hospital based), with at least 30 percent Medicaid patient volume, could receive up to $63,750, over a six-year period.
- Physicians who do not adopt/use a certified HIT system would face reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. E-prescribing penalties would sunset after 2014.
- Allows HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions would be made on a case-by-case basis for significant hardships (e.g., rural areas without sufficient Internet access).

Privacy

- Federal privacy/security laws (HIPAA) are expanded to protect patient health information.
- HIPAA privacy and security laws would apply directly to business associates of covered entities.
- Defines actions that constitute a breach of patient health information (including inadvertent disclosures) and requires notification to patients if their health information is breached.
- Allows patients to pay out of pocket for a health care item or service in full and to request that the claim not be submitted to the health plan.
- Requires physicians to provide patients, upon request, an accounting of disclosures of health information made through the use of an EHR.
- Prohibits the sale of a patient's health information without the patient's written authorization, except in limited circumstances involving research or public health activities.
- Prohibits covered entities from being paid to use patients' health information for marketing purposes without patient authorization, except limited communication to a patient about a drug or biologic that the patient is currently being prescribed.
- Requires personal health record (PHR) vendors to notify individuals of a breach of patient health information.
- Non-covered HIPAA entities such as Health Information Exchanges, Regional Health Information Organizations, e-Prescribing Gateways, and PHR vendors are required to have business associate agreements with covered entities for the electronic exchange of patient health information.
- Authorizes increased civil monetary penalties for HIPAA violations.
- Grants enforcement authority to state attorneys general to enforce HIPAA.

Comparative Effectiveness Research (CER)

The government will increase funding for CER by $1.1 billion.

- Establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER), an advisory board that will be comprised of up to 15 representatives of federal agencies—at least half will be physicians or other experts with clinical expertise.
- The FCC-CER will coordinate CER to reduce duplication of efforts and encourage coordinated and complementary uses of resources, coordinate related health services research, and make recommendations to the President and Congress on CER infrastructure needs.
- Both the Report on the Conference Agreement and that actual ARRA language provide that the FCC-CER will not mandate coverage, reimbursement, or other policies of public or private payers.
- CER will not include national clinical guidelines or coverage determinations as ARRA incorporates by reference the provisions in the Medicare Modernization Act of 2003 that explicitly preclude this.
- The Agency for Healthcare Research and Quality (AHRQ) will receive $700 million for CER; AHRQ must transfer $400 million to NIH to conduct or support CER.
- The Secretary of HHS will have the discretion to allocate the remaining $400 million for CER to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies.

The Secretary of HHS will also be obligated to meet several requirements, including: contract with the IOM to produce and submit a report to Congress and the Secretary by June 30, 2009, that includes recommendations on the national priorities for CER; consider any recommendations of the FCC-CER; publish information on grants and contracts awarded with the funds within a reasonable time of the obligation of funds for such grants and contracts and disseminate research findings from such grants and contracts to clinicians, patients, and the general public, as appropriate; ensure that the recipients of the funds offer an opportunity for public comment on the research; and annually report on the research conducted or supported through the funds.

Repeal Of The 3 Percent Withholding Tax

The conference agreement delays, from December 31, 2010, to December 31, 2011, implementation of the 3 percent withholding tax on government contractors (including Medicare providers) that was enacted under section 511 of the Tax Prevention and Reconciliation Act of 2005. Section 511, which was intended to ensure that government contractors file their tax returns properly and promptly, would be tremendously burdensome on physician practices with their relatively small operating margins and the AMA has been working actively in a coalition effort to promote its repeal.

Medicare Improvement Fund Modifications

The conference agreement clarifies that the Medicare Improvement Fund can be used to increase the physician conversion factor to address any projected shortfall in 2014 relative to the 2008 conversion factor and to adjust Medicare payments for Parts A and B items and services. It would also require, in 2020 and beyond, that any savings from HIT penalties be applied to the Medicare Improvement Fund.

Other Appropriations

- **Prevention and Wellness**: $1 billion in funding for wellness and prevention programs, including $300 million for the section 317 immunization program; $50 million for state health-associated infections reduction strategies; and $650 million for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes addressing chronic disease rates.
- **Community Health Centers**: $1.5 billion for construction, renovation, and equipment, and for the acquisition of HIT systems, for community health centers, and $500 million for services.
- **Training Primary Care Providers**: $500 million to address shortages by training primary health care providers, under Titles VII and VIII of the Public Health Service Act, including physicians, dentists, and nurses as well as helping pay medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps.
- **Indian Health Service Facilities**: $415 million to modernize aging hospitals and clinics and make health care technology upgrades to improve care.
- **NIH Research and Facilities**: $10 billion in funding for NIH for new research grants and renovations and construction at the NIH's campuses.

What's New with the Board of Medicine

Medical Records

Part two in the Top 10 Tips to Avoid Problems with Your License series is about relocating your practice. However, we cannot talk about relocating your practice without talking about medical records, which is tip number 4.

General information

All too often the Board sees physicians facing disciplinary action because the patient record does not adequately reflect what care was actually provided and why it was provided. Here is a SECRET: in deciding disciplinary cases, the Board of Medicine relies in large part on independent, credentialed experts in a variety of specialties to provide standard-of-care opinions. That expert opinion relies in large part on the clarity and detail of the patient record. To best protect your patient and yourself, look at the record you are preparing and ask yourself: would another Florida physician in my specialty have enough information to decide whether appropriate care was provided to this patient?

Retention of medical records

Physicians are responsible for maintaining the medical records of their patients. These records must remain confidential and whether the records are kept in the physician's office file cabinet, a clinic's record room, or in electronic format in a computer data storage bank, the prudent physician will follow policies, standards and procedures to ensure the confidentiality of the medical records.

A common call to the Board Office involves who is responsible for records after the physician leaves the practice or the practice suddenly closes and the owners are not there to provide patients with copies of their records. The best way to ensure that the patient records are maintained by an appropriate custodian is to make very clear, in writing, who the custodian is if the practice/clinic is closed or the licensee leaves the group/practice/clinic. The custodian of records is covered in 456.057 and bears a careful review by practitioners. Physicians who are part of an HMO or group practice should carefully consider who to designate, in the employer contract with said entities, as the records owner.

Timing is everything: medical records must be maintained at least five (5) years from the date of last contact with the patient. Failing to comply with this requirement could result in disciplinary action pursuant to section 458.331(1)(m), Florida Statutes.

Furthermore, the requirement to maintain medical records for five (5) years may be less than what is necessary to protect the physician. The physician should contact his/her medical malpractice carrier for their retention requirements.

Release of Medical Records & Relocation/ closing practice

If a physician is relocating or terminating practice and is no longer available to patients, the physician must complete the following steps:

- Publish a notice in a newspaper in the area of the physician's practice with the greatest circulation.
- The notice must contain the date the office is closing and the address at which patients may receive copies of their medical records
- The notice must run at least one day per week for four (4) weeks
- Submit a copy of the notice to the Board of Medicine within 1 month of the closing date

A physician may also place a sign at the practice and/or send individual letters to the patients with the notice information.

If a physician closes his/her practice and would like to appoint someone as custodian of the records, the appointee must be an allopathic or osteopathic physician.

Costs for reproducing medical records

Medical records should only be provided in response to a written request from the patient or the patient's legal guardian and/ or legal representative.

The Board would encourage physicians to provide their patients with at least one (1) copy of their medical record for no fee. However, a physician may charge the following fees for reproducing medical records:

- For the first 25 pages, $1.00 per page
- For the subsequent pages (after 25), $0.25 per page
- For other types of records, such as X-rays, the actual cost of reproduction including materials, supplies, labor costs and overhead costs associated with reproduction.

Certain confidential records are very sensitive and must only be provided upon written request and only to certain entities. These records include HIV/AIDS records, sexually transmitted disease records, alcohol and drug abuse records, and psychiatric and psychotherapeutic records. For example, psychiatrists may provide a report in lieu of copies of the psychiatric medical record. However, if the patient is seeing a new treatment provider, the psychiatrist should forward copies of the entire medical record directly to the new psychiatrist.

Furnishing of reports or copies of medical records shall not be conditioned upon payment of a fee for services. However, furnishing of the report or medical records may be conditioned upon receipt of the payment for reproduction of the records.

Additional information regarding medical records can be found, but is not limited to the following laws and rules:

- Rule 64B8-10 – Medical Records Retention, Disposition, Reproduction – Florida Administrative Code
- Section 456.057, Florida Statutes
- Section 458.331(1)(m), Florida Statutes

Medical records are governed by both state and federal laws. If you have any specific questions or are unsure about medical records, you should contact your legal representative.

Electronic medical records

If a physician has elected to maintain electronic medical records, the same principals of content, confidentiality, retention, and release apply. In addition, physicians need to ensure they have a backup of their electronic medical records and have accounted for the confidentiality of these records as well. Remember the SECRET above regarding the role of experts in your specialty… well that applies here too. If an electronically stored patient record is erased or lost, that expert in your specialty would be asked if the steps you took to safeguard the electronic records were appropriate.

The Board of Medicine's Web Forum system has been taken down from our web site. In order to continue receiving information directly from the Board, you will need to sign up at http://flems.doh.state.fl.us/mailman/listinfo/boardofmedicine. You are able to subscribe and unsubscribe any time that you want and you can also subscribe multiple email addresses. So be sure to sign up!

Lee County Medical Society General Meeting

The Lee County Medical Society met for our General Membership Meeting on March 19, 2009 at Fine Mark Bank. Michael Tanner from the Cato Institute spoke to 67 physicians, spouses and guests.

FineMark Bank sponsored our dinner meeting and we would like to thank Joe Catti and his staff for their support. Chef Michael Gavala and his staff provided a wonderful menu, especially the chocolate dessert.

Mr. Jeffrey Moes of FineMark
Dr. John Fenning
Mr. Joe Catti, Pres & CEO FineMark

Dr. Craig Sweet, Mr. Michael Tanner & Dr. Larry Hobbs

Drs. Shari Skinner and new member Scott Crater

Drs. Judith Hartner & Mary Charlton

Dr. John & Mrs. Ernestine Bruno

Drs. Paul Joslyn & Brian Krivisky

Drs. Roger Scott & Shahid Sultan

Opinion

The Healthcare Debate- Local and National

Raymond W. Kordonowy MD

On November 18, 2008 FGCU sponsored a forum to discuss local healthcare delivery. A broad panel of people were on the board, including my esteemed colleague Steve Zellner MD. There was a lot of discussion about national healthcare that kept coming up during that forum.

The topic of health care reform seems to be a popular buzzword. I believe none of us are clear on what we mean when we use this phrase. If by health care reform, we mean how to create incentives to provide competent, efficient health care delivery, I agree. We can start by having all the well intentioned but misinformed social engineers get out of the business of criticizing and regulating physicians and their work. We are under constant barrage to provide "proof of quality", mostly by payers who insist the patient is somehow being gypped and unable to tell quality when they experience it.

Our profession engages in peer review through mutual patient management on a daily basis. We are involved in rigorous continuing medical education as well as board recertification to maintain and update our knowledge and skill level. If we have loyal, paying patient customers that too is an indication of quality. "Proof of quality" infrastructure is just taking dollar resources from actual patient care and giving it to other 3rd party profiteers of such an agenda? Consumers can pay for outside newsletters or rating agencies to provide data should they care to research health care quality. We don't need more regulations and unfunded mandates from our government.

One panelist indicated that health care reform for him means a universal financing system. Currently the majority of health care dollars are under control of a 3rd party payer. This 3rd party payer presently is either the Medicare and Medicaid system or private insurance. As citizens we are paying an inordinate amount of money for the delivery of healthcare. That money isn't being used efficiently to actually deliver health care. This present system of payment is what the local health care market is responding to. Lee Memorial has effectively eliminated its prior competing hospital and now is looking for other revenue sources. It is a promised reduced level of payment under the current system which has our local hospital system priming itself to compete with private practice physicians - thus our local dilemma/debate.

Perhaps some wish for us to allow the already large health insurance monopolies to be in control of the money. We already see where that leads us- to steadily rising health insurance premiums that exceed the cost of living inflation index by leaps and bounds. This system also promotes ferreting out the unprofitable patients via exclusionary policies, etc. The current system rewards short term capital gains/surpluses. The incentive to spend money on prevention is counter-intuitive to the model due to limited time contract terms and the for-profit motive. Because of poor reimbursement to primary care services, access to outpatient care is unable to meet demand. The emergency room has become the medical home for a large number of non-emergency patients. I can't think of a more expensive place to get your health care. The 3rd party payer system also promotes price favoritism in some instances while also creating artificially low price ceilings in others. In my estimation the favoritism is for institutions and surgery centers while short changing physician services reimbursement.

The current prevalent premise that we need to universally provide first dollar heath insurance to all citizens is an incorrect one. What we need is fair market pricing for health care services. We need a safety net for the unemployed and the impoverished. We need individual choice not cheap networks engineered by insurance companies. We need value not just the lowest price or fixed prices that are creating supply shortages.

The current rate of health care utilization, misaligned reimbursement and inadequate government sponsorship of residency funding, has resulted in a significant physician shortage. Medicare is going to have to limit what is covered or greatly increase it's budget. **This is the uncomfortable conversation that no one wants to have.** I would suggest **the universal payer is the individual** whether we recognize this or not. The two choices assumed are to mandate health insurance for everyone or to tax all of us for a national health care system. Quite frankly, mandated health insurance is un-American and taxes are always fine as long as someone else is the person being taxed. A third viable choice would be a partially subsidized, free market .

When patients and providers are cushioned from the actual dollar exchange when care is provided, we don't feel the direct effect of services rendered or utilization decisions made. This facilitates over utilization as well as price inflation (i.e. "the insurance is covering this"). The direct impact of prices and services are "shielded" at the exit window by "filing with the insurance". Having to pay at the time of service or arrange financing for high dollar items would greatly change patient and physician behavior and price.

To address the safety net issue, I would recommend that the government agree to provide a price floor which would allow those unable to pay for their care access to hospitals and physicians. We would need to establish formulas that correctly determine who actually should benefit from government sponsorship. We could start with Medicaid and the truly poor Medicare beneficiaries. The providers should then be allowed to charge fees above the price floor to provide profitability to their operation. This form of balance billing was how Medicare services were handled until the Omnibus Healthcare Act of 1996 eliminated this practice. Since that enactment the government has made it illegal for physician's to charge Medicare beneficiaries more than the current price ceiling they have mandated. This pricing situation has held or reduced payment to physician providers for over a decade.

Insurance companies could also provide similar price structuring. They could list covered services by plan and region with the amount of money they will pay to the service provider item by item. Individuals would then shop for various plans based upon their needs and prices. Service providers would then compete in a "partially subsidized" free market. Some providers would provide a Cadillac model and charge a higher premium for services while other providers may find they can be profitable at the subsidized rate. This model of payment would promote innovative, rapid, efficient health care with more choices (if the market wished it). Catastrophic insurance (which now somehow mysteriously doesn't exist in the present market) would likely be the option a large portion of Americans would choose- much to the chagrin of our current insurance providers. True not-for-profit insurance models could be developed that (for instance) could allow the individual enrollees dividend payments if the participates of their particular co-operative had retained revenues at the end of the year's experience.

Physicians and hospitals would have a responsibility to be viable, efficient enterprises. By allowing us to charge fair market values for services we would be able to provide the lower paying subsidized care in a proportionate, shared and fair manner. Hospitals might chose not to expand if they new they were meeting their obligations to the local community of patients and physicians and were allowed to remain "whole" financially.

Odds and Ends

McCourt Scholarship Fund

The LCMS still has more scholarships to give to kids with Diabetes. If you know a child (8-18) that is having a hard time dealing with diabetes, please let the Medical Society know. We are providing scholarships to the Florida Camp for Children and Youth with Diabetes. Please contact the Lee County Medical Society office—936-1645.

LCMS Pictorial Directory

Time is running out. Please update your information with the Medical Society Office so that we can include the correct information in the 2009-2010 Pictorial Directory

FPIC Rate Decrease

First Professionals Insurance Company has once again filed for a rate **DECREASE**. That's right, decrease. They have filed for a base rate decrease of 5.53% to be effective July 1, 2009. Remember a base rate decrease of 6% was also filed effective December 1, 2008. All current FPIC insureds will be eligible for the rate decrease upon renewal of their policy. All policyholders that renew between July 1, 2009 and November 31, 2009 will receive the cumulative impact of both rate decreases at once and will see their premiums decrease by 11.2%. Please contact me FPIC with any questions 1-800-741-3742.

Benefits of the LCMS

- **Malpractice Insurance Discount**—LCMS members are eligible for a 5% discount on malpractice insurance premiums through FPIC. The payback on this discount alone pays for your membership dues and puts money in your pocket! Call the LCMS Office for more information.
- **Workers' Compensation Insurance**—Workers Compensation Insurance offered by OptaComp and marketed through Professional Benefits. Participating members received a 24.8% return on insurance premiums in 2006.
- **Representation in the Legislature**—LCMS joins with the FMA to effectively lobby the legislature and offer testimony before legislators on issues including managed care, licensing and regulations, medical liability reform and health care access, cost containment and other healthcare topics.
- **Legislative and Regulatory Updates**—Working with the FMA, LCMS provides member physicians with up-to-date information on legislative and regulatory issues concerning doctors via broadcast faxes and emails.
- **Directory and Website**—The LCMS publishes a phone/fax directory for physicians and their staff and a Pictorial Directory that is available at no cost to physicians, healthcare organizations and patients. The LCMS website leecountymedicalsociety.org offers information to patients and physicians. Your link can be added to our website.
- **Patient Referral**—the LCMS receives hundreds of phone calls from individuals seeking physicians. We provide referrals only to LCMS members.
- **Physician information Service**—The Society is pleased to answer the numerous inquiries from the public about member physician's medical backgrounds, board certifications and fellowship training. A wide variety of other patient questions are also answered on a daily basis. The office also assists with questions from members' office personnel.
- **Communications**—LCMS works to keep you informed via our Bulletin, broadcast faxes and emails
- **CME**—Members can enjoy continuing medical education seminars.
- **Networking**—The LCMS hosts 5 membership meetings/ dinners and the Annual Holiday Party. The LCMS and Alliance host a monthly *Meet and Greet* at area restaurants.
- **Volunteer Healthcare Connections**—Is the indigent care program l Physicians donate their services to those who have no other means of accessing medical care.

Lee County Medical Society

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

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

CHANGE SERVICE REQUESTED