THE FORUM

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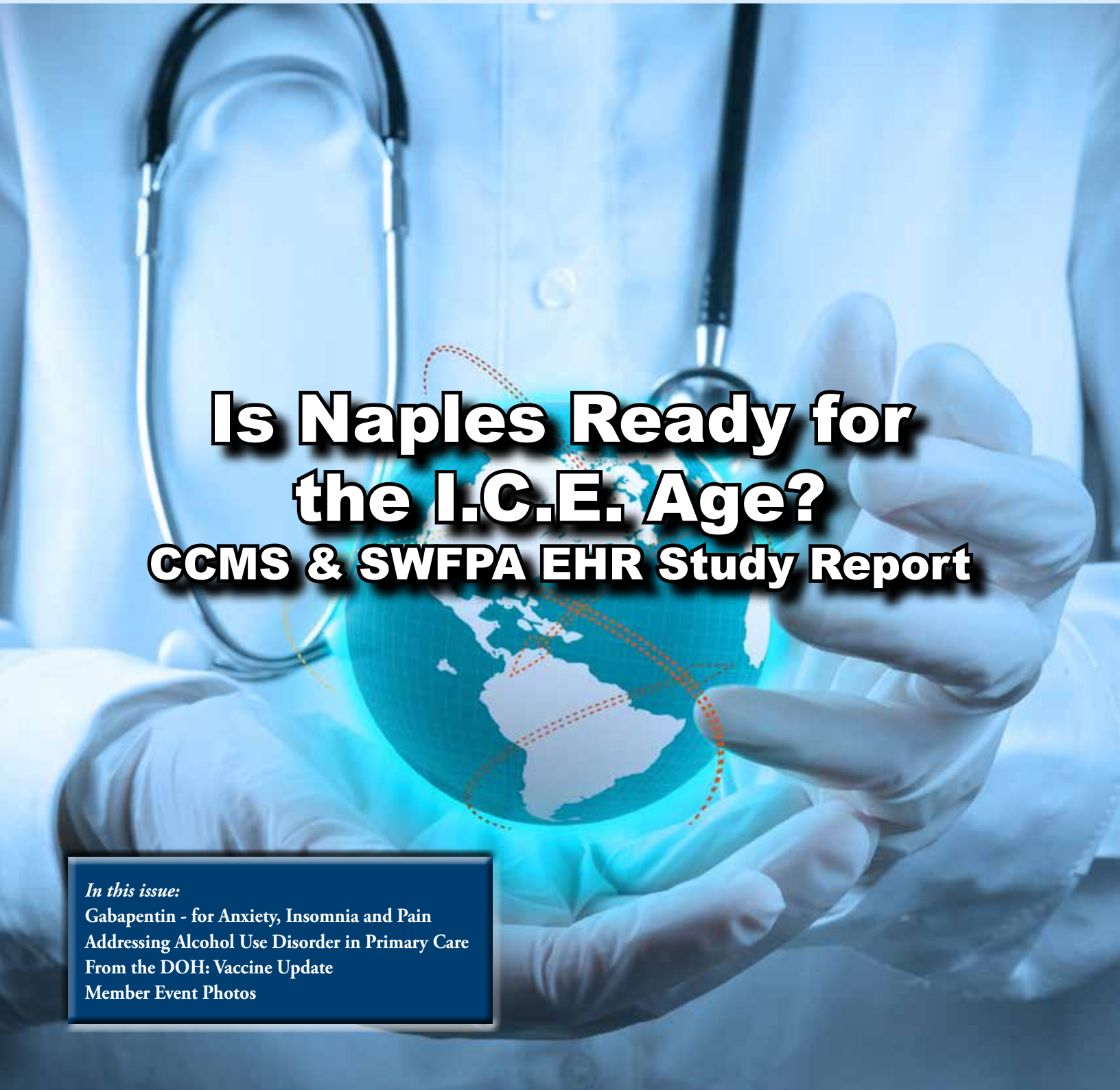

Is Naples Ready for the I.C.E. Age?

CCMS & SWFPA EHR Study Report

In this issue:

CALENDAR OF EVENTS

Unless otherwise noted,
register at www.ccmsonline.org
or call (239) 435-7727

Wednesday, March 19, 6pm
CCMS Spring General Membership Meeting:
"2014 Business & Economic Updates for Physicians"
Wyndemere Country Club
in conjunction with SWFPA

Wednesday, March 26, 6pm
CCMS & VITAS Present: "Advanced Heart Failure:
How Palliative Care and Hospice Can Help"
Hilton Naples
1 CME Credit

Saturday, May 3, 8:30am & 6:30pm
Foundation of CCMS Golf Tournament
& CCMS Annual Meeting
Grey Oaks Country Club
Contact CCMS for sponsor/exhibit opportunities

July 29-August 5, 2014
Gems of Antiquity CME Cruise
Aboard Oceania Cruises "Riviera"

NEW MEMBERS

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Physicians Regional Medical Group
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Naples, FL 34119
Ph: 239-348-4236
Fax: 239-348-4144
Specialty: Neurology

Retired Physician Member:
Bernard Lublin, MD
Board Certified: Orthopaedic Surgery

MEMBER NEWS

Office relocations:
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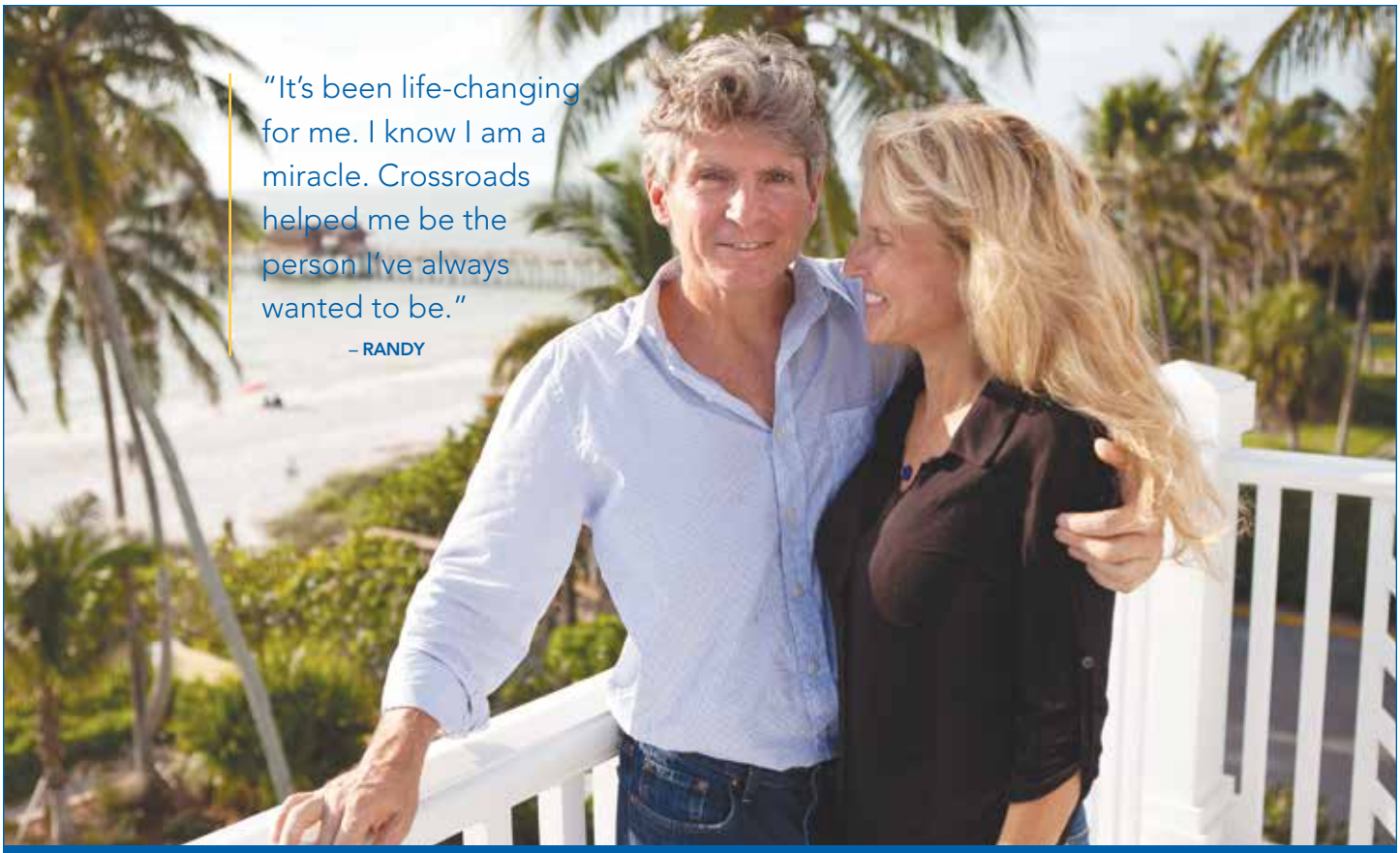
Views and opinions expressed in *The Forum* are those of the authors and are not necessarily those of the Collier County Medical Society's Board of Directors, staff or advertisers. Copy deadline for editorial and advertising submission is the 15th of the month preceding publication. The editorial staff of *The Forum* reserves the right to edit or reject any submission.



His Recovery is *Our* Concern.

CROSSROADS at David Lawrence Center offers a full continuum of co-occurring capable substance abuse services for adults. These services leverage the Southwest Florida-based not-for-profit leading provider of behavioral health services' 40-year history of inspiring life-changing wellness. Crossroads is located on the Center's private, tranquil eight-acre campus and includes refreshing gardens, a fitness court and screened pool.

Crossroads services include a state-of-the-art, 15-bed inpatient detoxification program; a beautifully appointed 18-bed residential treatment program; a flexible, intensive outpatient treatment program; and supportive aftercare services. These services holistically address the wellbeing of the entire individual and feature experiential therapies that focus on the physical, emotional, social and spiritual needs of each participant.

Let us help your patients become their own miracle by making a commitment to life-lasting wellness and recovery by calling Crossroads today.

CROSSROADS
DAVID LAWRENCE CENTER

6075 BATHEY LANE, NAPLES, FL 34116
239-354-1428
CrossroadsNaples.org

A Message from the President

How Do You Stop A Steamroller?

"Medical decisions have been politicized. What doctor wants a state legislator in his consulting room?" - Garry Trudeau

Richard Pagliara, D.O., President, Collier County Medical Society

Lately, the news has been rife with stories how health care is changing from the implementation of the PPACA: insurers dropping doctors from their networks, patients losing insurance plans and scrambling for new plans and doctors, and patients losing access to specialty care within entire geographic regions. Is there anything we can do?

On a local level, the Committee for Healthcare Workforce and Innovation in our Florida House of Representatives recently proposed a bill to massively expand scope of practice. This proposed bill will: create the "Independent Advance Practice Registered Nurse" (APRN) allowing nurses to practice independently/without physician supervision, allow APRNs to administer, dispense and prescribe controlled substances and narcotics, allow the prescription of treatment regimens WITHOUT physician supervision, and allow CRNAs to administer anesthesia independent of an anesthesiologist. What happened to the tested notion that the ***physician*** is the leader of the medical home? Is this necessary? What is the message to our future physicians? Would this really lead to decreased health care cost, and if so, who's to say this expansion would stop with general practice and anesthesia? A slippery slope for sure.

So how do you stop a steamroller? It won't be quick and easy, but neither was going through medical school, your first night on call, or sitting for your board certification exam. So, I know you all have the ability to sacrifice and work hard to achieve lofty goals. Preventing our profession from being steamrolled is the new lofty goal we need to accomplish. Please support the CCMSPAC, FMA, FMAPAC, and your specialty PACs so that these organizations have the influence to promote physician friendly candidates. Write letters, talk to your patients, and get the word out that these changes are deleterious to your ability to practice, and ultimately limit best patient care.

Finally, I'd like to share with you excerpts from a letter written by Dr. Kristen Held, an ophthalmologist from San Antonio, TX to Mr. Bertolini, Chairman and CEO of Aetna.

Notification of Termination to Aetna
January 30, 2014

Dear Mr. Bertolini,

With a deep sense of sadness, I must inform you that I will no longer serve as a physician for Aetna patients under the terms of our contractual agreement, which you most recently unilaterally changed.

I have been privileged and honored to care for thousands of patients covered by Aetna policies since the 1990's. I have devoted my life to providing the very best, state-of-the-art care to these individuals. We have formed a patient-doctor relationship, which I hope many will chose to continue in spite of my severing ties with Aetna. You see, health insurance has evolved such that insurers and government have inserted themselves smack-dab in the middle of the once sacred patient-doctor relationship. I am called a provider- not a doctor. My patient is now yours- not mine. What I can do as a physician now has strangulating strings and nonsensical numbers attached- to you and government and money-not the best interests of the patients…

… Only by logging in [to the insurance exchange] as a prospective patient did my office manager and I discover that Aetna was selling plans for which I am a provider-effectively selling my services without even asking, much less informing me that my services would be sold on such a site, under the auspices of new terms with which I will not comply.

Then, after the fact, I received a form letter informing me of Aetna's "new allowables". I will not sell my services under such terms. While treated as such, patients and doctors are not commodities worthy of such impersonal, inconsiderate, and cavalier treatment. We choose dignity and personal service over disrespect and form letters.

So here we are, you are getting new business offering health insurance plans featuring my services without my consent under terms which are unacceptable to me. Accept this as my official written notice that the changes that you have unilaterally made to our contract are unacceptable to me and make our contract null and void. You must explain this to your patients. You must tell them that they have purchased a product that was misrepresented to them and that you cannot deliver. It saddens me to think of the decreased access to care from actual physicians and the shockingly increased costs Aetna patients will now experience because of your choice to collude with big government rather than collaborate with patients and physicians.

Kristin S. Held, MD

Thank you, Dr. Held, for sharing this letter with the world. We are ***doctors***, not just providers. I believe your voice is being heard loud and clear and may this inspire our collective voice to be deafening.

Is Naples Ready for the ICE Age?

CCMS & SWFPA EHR Study Report

Mark Anderson, CEO of AC Group, Inc.

As the Naples community moves towards clinical care coordination (Required in Stage 2 MU) and prepares for the roll-out of the Naples community ACO, it is clear that the community will need the ability to connect multiple EHR products with one or both of the two Hospital Health Information (Medicity HIE and the Cerner HIE). The Naples community, through its Hospital HIE partners, has started the process of connecting healthcare providers to enable care coordination. Once completed, the community will be able to ensure that the right patient information is available at the right time to the right person. To accomplish this, Naples needs to get ready for the ICE age – **I**ntegrated **C**ommunity **EHR**s.

Benefits of ICE Age strategies

Within an Integrated Community EHR model, Primary Care Providers and Specialists can view demographics and patient clinical data in one common form no matter where the patient was seen in the community as long as the EHR meets the interoperability standards (Required under Stage 2 MU). Through data integration, patient specific information can flow from one practice's EHR product to another EHR product. This will enable Naples physicians to select the best EHR product for their practice as long as the EHR meets the national standard for interoperability (HITSP C32 v 2.5 CCD Record). The benefits of an Integrated Community EHR model include:

- Data is entered once and can populate multiple practice management systems (PMS) / electronic health records (EHR) databases
- Patient has complete control over disseminating of clinical data following HIPAA rules
- 92% reduction in duplicate data entry.
- 74% reduction in overall data entry time.
- 19% reduction in clinical testing.
- 32% reduction in referral tracking activities
- Reduces uncompensated ER Cost by as much as $500,000 for every 20,000 emergency room visits. Study conducted by AC Group on 3,120 ER visits determined that if clinical data was available to the ER physician at the time of treatment, the ED physician could properly treat the patient faster and with fewer tests.
    - Patient time in the ED was decreased by 26%
    - Test costs were reduced by 31%
    - Cost reduced $500,000 for every 20,000 Emergency Room Visits.

To meet the specific ACO requirements of care coordination, the community requires strong leadership, EHR applications that meet Stage 2 certification for interoperable data exchange, and a wiliness to exchange specific patient data electronic between all providers of care who are treating the same patient. This has been accomplished in multiple communities across the United States. ICE technologies helps identify patients that require specialized care and it stratifies populations at risk. It implements evidence based care protocols and manages care provider teams to support collaboration between multi-disciplinary professionals. Patient care is coordinated across clinical specialties and disciplines through a system of alerts and appropriate notifications, e.g. care providers and care recipients are alerted to key milestones such as blood tests, assessments or visits due, based upon care protocols and care plans. Dashboards in help in the discovery of gaps in care and in compliance of both providers and patients to industry standard quality measures.

Naples Community Practice Survey

So is the Naples community ready for the "ICE Age"? To help answer this question, the Southwest Florida Physician's Association (SWFPA) and the Collier County Medical Society (CCMS) collaborated to conduct an assessment on the EHR and PMS currently used by physicians in our community. This Survey was completed in conjunction with a comparative review of various EHR/PMS software applications based on product capabilities, vendor viability, end-user satisfaction, overall costs, and the vendor's ability to integrate with the NCH Sunshine Connect HIE and/or HMA's Medicity HIE.

One goal of this study was to provide members with the information necessary to make educated decisions regarding ongoing technology investments. The second goal was to assess the community's current ability to exchange patient specific information via practice based PMS/EHR applications. In simple terms, we hoped the survey & comparative analysis would answer the following questions for physician members:

- What are the major systems currently in use in the community?
- How well and at what cost will my system integrate with the Health Information Exchanges (HIEs) currently available in the community?
- What are considered the best PM/EHR systems on the market today?
- How does my current system compare to the others in cost, function and ability to integrate?
- What are the systems' ability to meet future reporting requirements of healthcare (PQRI, meaningful use, managed care/ACO reporting, and ICD-10)?

The member survey was completed by 75 different practices, representing nearly 400 Providers within the community. The number of physicians per practice varied from 1 to over 30 and over 53% of the practices that responded to the survey were in single-physician practices. Of the remaining practices, 32% were in groups of 2 to 5 physicians while 89% were in practices with 10 or less physicians.

The survey indicated the practices were using 36 different PMS applications (registration, scheduling and billing) as well as 28 different Electronic Medical/Health Record software applications for capturing patient clinical information. It was also apparent that no one vendor dominated. In fact 18 of the 75 practices were using a unique PM product that was not used by any other practice while 15 practices were using a unique EHR product that no one else in the community was using.

There are 29 different EHR products in 60 Practices

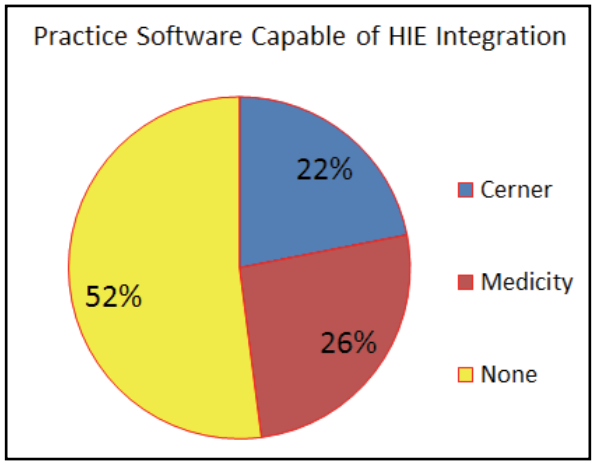
AthenaHealth	10.0%
NextGen	8.3%
Practice Fusion	8.3%
Amazing Charts	6.7%
Vitera/Sage	6.7%
Allscripts - Professional	5.0%
Aprima/iMedica	5.0%
Cerner	5.0%
eClinicalWorks	5.0%
e-MDs	3.3%
NexTech	3.3%
Quest Care360	3.3%
SAMMY USA	3.3%

Vendors with just 1 practice

Acom Solutions, RAPID Documentation
acumen
Advance MD
Allscripts - MyWay
e scripts
MDIntelleSys (Ophthalmology specific program)
MIE
modernizing medicine ema
none-retired
Physician's Solution
Prognocis
PTOS
Soapware
SuccessEHS
TheraOffice by Hands On Technology
TIMS

With so many products being represented within the Naples community, what is the likelihood that Naples can successfully develop and maintain a community Accountable Care Organization (ACO) and meet the new Stage 2 requirements of patient data integration?

We know that there is a desire to improve care, reduce costs, and enhance patient satisfaction. The Naples community has strong leadership and according to the survey, the community has already embraced EHR technologies. In fact, 75% of the responding practices have already implemented a certified EHR application and of those practices, 83% of the physicians are using the EHR for full encounter documentation.



Health Information Exchange Capability

The only factor still missing is the ability to exchange patient specific clinical and demographics data between disparate PMS/EHR applications. Based on the vendor responses, only 4 of the 28 vendors (14%) have already successfully interfaced with both of the Naples Hospital sponsored HIE products (this represents 14.6% of the practices). Overall 22% of the practice software has the capability of connecting to the Cerner HIE and 26% of the practice software has the capability of connecting to the Medicity HIE. However as of December 1, 2013 over 50% of the practice software does not have the capability of connecting to the local HIEs. Therefore, to have a successful ACO which promotes Care Coordination, the physician community will need to push their EHR software vendors to become compliant with the national standard for interoperability and data exchange.

As part of the evaluation, the team also looked at each of the current EHR vendors in the community to determine if the EHR was Certified for Stage 1 and or 2 and, using a 6-Star ranking system, ranked each of the vendors based on their ability to connect with the local HIEs and the company's overall rating on functionality, usability, pricing, company viability, and end-user satisfaction. The data indicated that the majority of the community EHRs have not been certified for Stage 2 Meaningful Use and that overall only 30% of the practices have deployed Stage 2 MU certified products. Additionally, only 10% of the practices have software applications that have successfully implemented data exchange with both Medicity and Cerner HIEs in other communities.

The results of the PMS/EHR vendor technology and company viability survey can be downloaded at www.ccmsonline.org.

Conclusion

To effectively implement Care Coordination and to insure a financially successful ACO, the Naples community must begin the process of moving into the "**ICE Age**". Since the Naples community has already selected their HIE products, the next step is to start integrating the various EHR products. If a practice's EHR is not capable of data integration and data sharing, the practice will not be able to participate in the "ICE AGE". If this occurs, individual practices may have to look for a new software vendor.

Gabapentin - for Anxiety, Insomnia and Pain

D.A. Deutschman MD, DLF APA

All physicians who work directly with patients are called upon to help with anxiety, insomnia and pain. Providing relief with effective, non-addicting agents is a challenge. Gabapentin can be very effective, is well tolerated and non-addicting.

Purpose

Demonstrate the Safety and Efficacy of Gabapentin for Anxiety, Insomnia and Pain; at times doses were well above the FDA recommended ceiling of 3,600mg/d. Document full symptom control following withdrawal of addicting agents once Gabapentin dose has been titrated sufficiently.

Case Series

188 consecutive patients, ages 19 to 93 years on sustained doses of Gabapentin as high as 16,000mg/d (almost five times the FDA suggested maximum). Indications were anxiety, insomnia and pain. Initial side effects were sedation and unsteadiness. These disappeared with reduction of doses or the passage of time (a few days).

- **Brain Receptor Corruption**: Gabapentin dose not "up-regulate," corrupt or perturb brain receptors. Benzodiazepines (Xanax, Klonopin, Ativan), Zdrugs (Ambien, Sonata, Lunesta) and Narcotics do! There is no drug dependency or worsening of original symptoms when Gabapentin is withdrawn!
- **Safety**: No long term issues were seen in tolerability or toxicity. No organ damage was seen. No drug interactions appeared. No withdrawal effects or seizures were seen when doses were decreased or discontinued abruptly (contrary to the warning in the package insert).
- **Efficacy**: Patients experienced good symptom relief, occasionally from the first dose! At other times full relief appeared in a few days.
- **Tachyphylaxis**: Decrease in symptom relief from a continued, stable dose appeared in many patients in a matter of days or weeks. When this occurred, doses were titrated upwards until the full therapeutic effect reappeared. Before long (days to weeks) an enduring, stable dose for complete symptom relief was achieved.
- **Side Effects**: In those patients who experience initial sedation, doses were temporarily decreased or time intervals between doses were increased. Tolerance to side effects (acclimation to the agent) appeared quickly.
- **Addicting Agent Discontinuation**: Addicting agents when present were reduced gradually and discontinued once full symptom relief had been achieved from adequate doses of Gabapentin.

Explanations for Underutilization of Gabapentin

It is communication intensive to initiate. It is not FDA labelled for anxiety and sleep. Its FDA suggested ceiling of 3,600mg/d for pain (1993) is too low to provide full relief for many patients.

Clinical Considerations

- **Gabapentin Titration**: Gabapentin was titrated up gradually, over a 3-4 week period to avoid intense initial sedation and unsteadiness. Starting dose for adults was 300mg one hour before hs. For geriatric patients and patients with renal compromise, starting doses were 100mg. By the end of 7 to 10 days, patients were often on 1,200 to 1,800mg/d (in divided doses) with the largest dose at hs. Doses eventually reached 4,000 to 8,000mg/d by the end of week four. Upward titration was stopped when symptom response was sufficient.
- **Gabapentin Pharmacokinetics**: Absorption was 60 to 120 minutes for full effect. Metabolism was none. Elimination was unchanged via the kidneys; half-life is 5 to 9 hours. Renal Patients require tiny doses, longer intervals, more gradual titrations.
- **Removing Addicting Agents**: Addicting agent dose was not reduced until benefit from Gabapentin appeared. At that point, addicting agents were reduced by 15-20% each week until they could be discontinued. During the downward titration of the addicting agents, Gabapentin doses sometimes had to be increased.

Gabapentin, the molecule

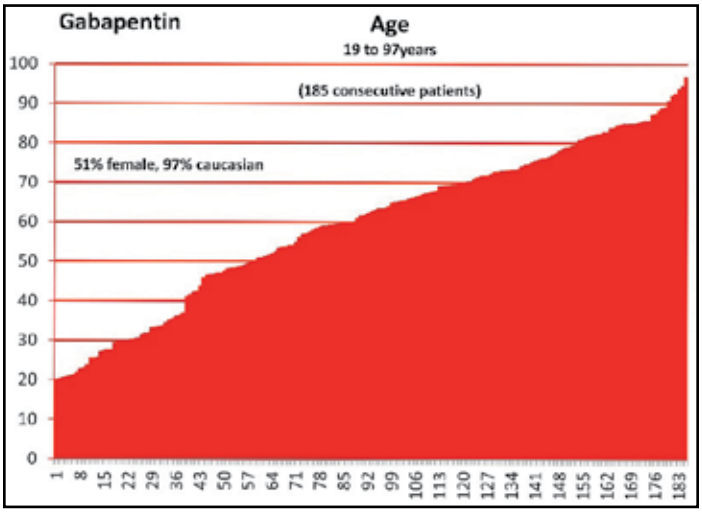
- **FDA approval**: Gabapentin is FDA approved for Partial Seizures in Children and Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia in adults at doses to 3,600mg/d (1993).
- **Pharmacology**: Gabapentin interacts with no medications and damages no organs. It is exclusively excreted by the kidney. It does not cause kidney damage.
- **Discontinuation**: Gabapentin is not habit forming. In our series of 188 consecutive patients there were no discontinuation effects. Patient symptoms returned (as expected) but no flu-like symptoms or seizures were seen even from abrupt discontinuation of very high doses.
- **Safety in Overdose**: The literature reports a suicide attempt with 90,000mg with no significant consequences (patient slept for 36 hours).

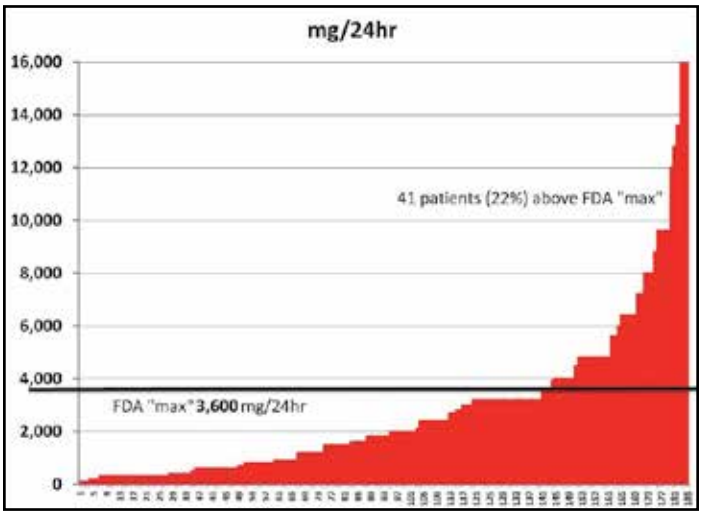
Caveats

Titration is communication intensive. In spite of an initial, extensive discussion, patients need: support and encouragement in getting through some initial sedation and/or dizziness; support to continue to titrate the dose upward for full symptom relief. This could take the form of frequent phone calls to the physician's staff over the first days or weeks.

Justification

The agent can be very effective in relieving anxiety, insomnia and pain. It is safe at all doses and not habit forming. It can be used to eliminate addicting medications.





Addressing Alcohol Use Disorder in Primary Care

Dana Castro, MD, David Lawrence Center Crossroads Addictionologist/Adult Staff Psychiatrist

April is Alcohol Awareness Month

NCADD

ncadd.org

Each April, the National Council on Alcoholism and Drug Dependence, Inc. (NCADD) sponsors Alcohol Awareness Month to increase public awareness and understanding, reduce stigma and encourage local communities to focus on alcoholism and alcohol-related issues.

Behind cigarettes, alcohol is one of the most dangerous substances commonly ingested. The CDC reports that alcohol kills 88,000 people per year in the United States. This is the third most common cause of preventable death, and is almost double the number of US combat deaths in all of the years of the Vietnam War. In 2006 alcohol use was estimated to cost the country 224 billion dollars a year[1] and this is increasing at a rate outpacing inflation. Improved screening and referral for alcohol use disorder by primary care is thus a priority for the future.

Excessive drinking is greater than 7 drinks per week for women and 14 drinks per week for men. [2] However, intermittent binge drinking, defined by the NIH as 5 or more drinks for men and 4 or more for women on one occasion[3] shares in the morbidities and mortalities of daily alcohol consumption. Simply put, an alcohol problem is one that has created significant negative consequences in terms of health, behavior or well being.[4]

Patients rarely spontaneously disclose an alcohol use disorder. History taking may help, but lab studies and physical exam can also uncover alcohol use disorder. Adding a GGT to routine lab screening is cost effective. Both sensitive and specific, GGT will pick up hepatic irritation from alcohol, often when AST and ALT are still negative. Elevated RDW and MCV may occur. By the time Bilirubin is elevated the situation is usually getting bad. In that case an Ammonia level may help quantify how bad things are.

If the presentation raises suspicion the patient can gently be "confronted" with comments such as, "There are some abnormalities that are sometimes seen with alcohol problems; is it possible that that is an issue for you?" When a patient acknowledges a problem, positive support should first be voiced for disclosure.

Then, for a binge pattern a referral to Alcoholics Anonymous is a reasonable first level intervention. Their local telephone number should be provided, which is 239-262-6535.

For daily heavy drinking (about 5-6 drinks a day or more) an inpatient detox should be the first step. Local hospitals can detox, but detox in a facility that also has follow up resources such as residential rehab or outpatient treatment will result in a better outcome. An example of such a facility in this area is the Crossroads program at David Lawrence Center, which may be reached at 239-354-1428.

For a patient reporting recovery, a simple way to monitor this is to include a CDT (carbohydrate deficient transferrin) with other labs, which will reveal significant daily drinking for up to 2-4 weeks. Facility based treatment - as discussed above - should be considered for relapse, or, for signs of sobriety positive support should be provided. Through the four elements of screening, confrontation, referral, and monitoring, Primary Care can make a real difference in addressing this deadly health issue.

Dr. Castro is a full time, board certified Adult Psychiatrist and Addictionologist at the David Lawrence Center Crossroads Program. He earned his bachelor's degree in biology and environmental science and his master's of arts in teaching from the State University of New York at Binghamton. He earned his medical degree from Albany Medical College and completed his psychiatric internship and residency at North Shore University Hospital.

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1. http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
2. http://www.cdc.gov/alcohol/faqs.htm#excessivealcohol
3. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2748736/
4. http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.htm

From the DOH: Vaccine Update

Lisa Karamehmet, RN, MSN and Cindy Whetsell, RN, Nursing Consultants, Department of Health in Collier County

According Community Preventive Services Task Force*, a recommendation by a patient's provider for needed vaccines is a strong predictor of patients receiving recommended vaccines. Your voice, as a respected healthcare provider, is instrumental in keeping not only your own patients' healthy, but when we talk about vaccine, the community healthy. Below are the 2014 Immunization recommendations from the CDC Advisory Committee:

- **Influenza**: Information on the use of the recombinant influenza and inactivated influenza vaccines among egg-allergic patients was added to the footnote and indicates that RIV or IIV can be used among persons with **hives-only allergy to eggs**, as these vaccines contain **no egg protein**.
- **Td/Tdap**: A single dose of Tdap vaccine is recommended for previously unvaccinated persons ages 11 or older, and Td booster should be administered every 10 years thereafter. Pregnant women continue to be recommended to receive a dose of Tdap vaccine during each pregnancy, preferably during 27 to 36 weeks' gestation, regardless of the interval since the prior dose of Tdap or Td vaccination. Tdap is available at the Florida Health Department in Collier County **at no cost for both male and females between the ages of 19-26 (underinsured, no insurance, and Medicaid)**. Vaccines are offered Monday through Friday at both Department of Health locations in Naples and Immokalee.
- **Zoster**: Being a healthcare worker is no longer an indication for vaccination. This change was also made to the HPV vaccine footnote.
- **PCV13**: Because PCV13 is recommended to be administered before PPSV23 among individuals for whom both vaccines are recommended, the PCV13 footnote now precedes the PPSV23 footnote and includes wording to remind providers of the appropriate order of these vaccines when both are indicated.

School age children

it's the time of year when schools are preparing for students to start enrolling for the 2014-15 school year. One of the requirements is for children new to the school system, entering Kindergarten and 7th grade to have up-to-date immunizations for their age, along with a certificate of immunization. To avoid last minute appointments and long wait times in August, now is the time to remind parents of the vaccines their children will need for the next school year. Along with the usual requisite vaccines, this year:

- **Varicella**: all children in Kindergarten through 6th grade will be required to have **2 doses** of Varicella vaccine and all children in 7th through 12th grade are required to have **one dose** of Varicella vaccine.
- **Tdap**: Children in grades 7 through 12 are required to have 1 dose of Tetanus, Diphtheria, and acellular Pertussis (Tdap) vaccine.

Legislation is being introduced in Florida which would require 7th grade students to have meningococcal vaccine. At this time, this legislation has not been approved.

Even though, with the new Affordable Care Act, vaccines are a covered preventative service for children, some families may not have access to the vaccines. Florida Department of Health in Collier County offers immunization services free of charge to all children birth through 18 years of age. Vaccines are offered Monday through Friday at both Department of Health locations in Naples and Immokalee. More information is available on the Department of Health–Collier website at www.floridahealth.gov/chdcollier/immunizations.html#pediatric.

Working together as a community allows us to focus on keeping all of our children and adults healthy and protected from vaccine preventable diseases.

* The Community Guide: Vaccinations to Prevent Diseases: Universally Recommended Vaccinations. Community Preventive Services Task Force. Accessed at www.thecommunityguide.org/vaccines/index.html on 21 November 2013.

HIPAA & False Claims Act Seminar - January 14, 2014
Dermatology CME - February 18, 2014
Women Physicians Luncheon - February 21, 2014

Carrie Pearson and Dr. Julie Carter

Dr. Jose Baez and Marisol Baez

Dr. Gregory Paine, Dr. Zdenko Korunda, Dr. Bruno Dipasquale and Dr. Rafael Haciski

Dr. Charles Camisa and Kathryn Camisa

Dr. Leela Bolla and Dr. Susan Hetman

Jennifer Brewer, Dr. Caroline Cederquist and Dr. Leslie Stapp

Dr. Jamie Weaver and Dr. Lynn Byerly

Dr. Catherine Kowal and Dr. Todd Brodie

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Don't miss the
FCCMS Golf Tourney
& CCMS Annual Meeting
May 3rd
at Grey Oaks Country Club
registration details at
ccmsonline.org