



THE FORUM

September/October 2016 • Volume 15, No. 5 • The Official Magazine of Collier County Medical Society

CCMS Delegates Your Voice at the FMA Annual Meeting



Dr. Alejandro Perez-Trepichio, Dr. David Wilkinson, Dr. Rafael Haciski, Dr. Jose Baez, Dr. Catherine Kowal, Dr. Rebekah Bernard,
Dr. Paul Makhoulouf, Dr. James Talano, April Donahue, and Dr. Cesar De Leon

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CALENDAR OF EVENTS

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

Saturday, September 17, 8:00am
Foundation of CCMS Golf Tournament
Bonita Bay Club Naples

Thursday, September 29, 6:00pm
CCMS Fall General Membership Meeting
“Strategies for Success: MACRA and the Trends
Impacting Clinical Practice”
Hilton Naples

Thursday, October 6, 6:00pm
CCMS After 5 Social
Paradise Wine

Thursday, October 13, 5:30pm
20th Anniversary CCMS & GGN GI Symposium
Kensington Country Club

Friday, October 21, 6:00pm
CCMS After 5 Social
Aesthetic Plastic Surgery & Med Spa of Naples

Friday, November 11, 6:00pm
CCMS New Members Welcome Reception
Wyndemere Country Club

Wednesday, November 16, 6:00pm
**CCMS Seminar: The Role of Physicians
in Death Certification**
Brookdale Naples

Save the Dates!

Saturday, March 4, 2017 8:30am
CCMS Women's Health Forum
St. John the Evangelist Catholic Church

Saturday, May 13, 2017
CCMS Annual Meeting & Installation of Officers
Quail Creek

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Physician Directories:

Each CCMS member and office manager should expect to receive a new 2016-17 CCMS Physician Directory by mid-September; please check your mail for your copy. Extra copies will also be delivered to the hospitals and major medical facilities. Should you need any additional directories, more will be distributed at CCMS events or can be picked up at the CCMS office.

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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.

MEMBER NEWS

New Members:



Robert G. Baily, M.D.

SWICFT Institute of Southwest Florida
625 9th St N Ste 201
Naples, FL 34102
Phone: (239) 261-2000 Fax: (239) 261-2266
Board Certified: Cardiovascular Disease,
Internal Medicine



Blane Mitchell Crandall, M.D.

Naples Gynecology, LLC
1012 Goodlette Rd N, Ste 101
Naples, FL 34102
Phone: (239) 213-9111 Fax: (239) 213-9115
Board Certified: Obstetrics & Gynecology



Heather E. Pontasch, M.D.

Riverchase Dermatology
261 9th St S
Naples, FL 34102
Phone: (239) 216-4337 Fax: (239) 261-5594
Board Certified: Dermatology



Scott A. Springer, D.O.

Naples Radiology Services
300 5th Ave S, Ste 203C
Naples, FL 34102
Phone: (239) 228-5883 Fax: (888) 674-2418
Board Certified: Radiology

New Practice:

Jose M. Baez, M.D.

Internal Medicine
11181 Health Park Blvd, Ste 2230
Naples, FL 34110
Phone: (239) 594-2700

F. Michael Gloth, III, M.D.

Geriatric Medicine
5859 Rolling Pines Dr
Naples, FL 34110
Phone: (239) 293-2097

Natalia Keyser, M.D.

Internal Medicine
Avow Hospice
1095 Whippoorwill Ln
Naples, FL 34102
Phone: (239) 261-4404 Fax: (239) 593-5854

New Locations:

Aesthetic Surgery Center has relocated:

Anurag Agarwal, M.D.

Richard Maloney, M.D.

Kiranjeet Gill, M.D.

1175 Creekside Pkwy, Ste 100
Naples, FL 34108
Phone: (239) 594-9100 Fax: (239) 594-3054

Snead Eye Group has opened an additional location:

Brad A. Snead, M.D.

John W. Snead, M.D.

Pebblebrooke Plaza
15205 Collier Blvd, Ste 101/102
(next to Publix)
Naples, FL 34119

The Vascular Group of Naples has relocated:

Santiago H. Chahwan, M.D.

Hiranya A. Rajasinghe, M.D.

Alvaro J. Zamora, M.D.

2350 Vanderbilt Beach Rd, Ste 303
Naples, FL 34109
Phone: 239-643-8794 Fax: 239-430-7820

Practice Merger:

Naples Heart Rhythm Specialists, P.A. and The James Buonavolonta, M.D. Cardiac Imaging and Cardiac PET Center have merged:

Kenneth Plunkitt, M.D.

Andrew Yin, M.D.

Louis Wasserman, M.D.

James Buonavolonta, M.D.

Electrophysiologic or general cardiology phone: (239) 263-0849.
Cardiac imaging division phone: (239) 682-6603
Locations remain the same

CCMS Member Dues

The 2017 CCMS membership dues deadline is December 31, 2016. You or your group can pay at ccmsonline.org/membership (where Alliance members can also download their join/renew form), or call CCMS, 239-435-7727. Printed dues invoices will also be mailed to members who pay individually or to practices for group payment. To pay your FMA dues, go to flmedical.org, and to pay your AMA dues go to ama-assn.org.

A Message from the President

Rafael C. Haciski, M.D., President, Collier County Medical Society



Continuing on my inauguration theme of “Call To Arms,” I am intent on raising awareness of impending catastrophic problems in our HealthCare/Medicine, both in physicians, who surprisingly seem unaware of the gathering storm, and the even less aware public. Under pressure from business and government, where there is a perception of spending too much

money for medicine, an effort has arisen to try to limit those expenses. Unfortunately, those efforts have resulted in the usual unintended and unforeseen consequences that one sees with any well-intentioned but poorly envisioned governmental intrusion.

Historically, the downturn begun with the introduction of Medicare and Medicaid, when on July 30, 1965, President Johnson signed into law that huge bureaucratic gorilla. Not that we should not have financial help to those who need it, but often that help comes with a huge baggage of unintended consequences. For example, prior to Medicare, a \$100 per diem charge for hospital stay would have included ALL tests and procedures carried out during that day (diagnostic tests, IVs, drugs, etc.). After the government’s entrance into the medical field, on the premise that there was no accounting for what went on, blanket and all encompassing “day” charges were eliminated in favor of itemization of each item used. Obvious consequence was a dramatic escalation of costs with the ability to charge for each IV line, each strip of tape, each pill. The government overseers asked for itemization, and the administrators seized on the opportunity to increase revenue.

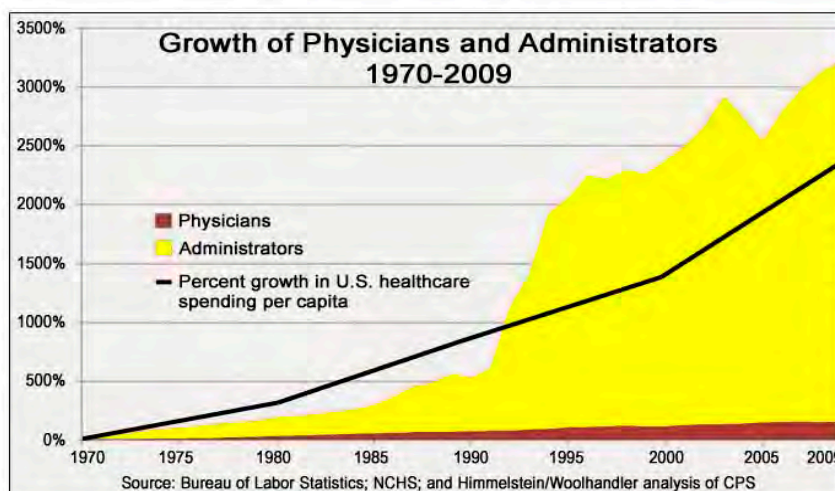
In the 80s, with the last big push for cost control and the advent of HMOs, capitation, and other bureaucratic efforts, the result was a dramatic expansion of the “administrative” sector, interestingly coinciding with a steady and continued rise in expenses. (See Graph 1.)

Here in the U.S. we have just gone through the “Meaningful Use” process, and are facing the new “Value Based System” where payment for our services will involve complicated and unproven quality

control measures. These programs are all bureaucratic efforts applied to a system that does not function well as a bureaucracy. What is interesting, is that these efforts are aimed at minimizing waste and expenses, while improving health, yet they DO NOT address the core problems and the sources of waste in the current health care system. It is accepted that our legal system contributes to at least 25% of unnecessary expenditures (tests obtained simply because of the possibility of being sued and accused of not doing enough) yet NOTHING is being done to alleviate this source of expense. (See Graph 2.)

Fraud is rampant, and accounts for another 20-25% of unnecessary expenses, yet very little is being done about that. Another source of unnecessary expense is the cost of medications. In my segment of medicine, we have drugs that cost over \$100 per month in the U.S., while the same medication may be obtained from Canadian pharmacies for \$30, and for \$5 in France. Just in those three areas, reducing those costs would have reduced the cost of medicine by a whopping 75%! But there is nothing on the horizon to address those expenses.

Currently, various national polls place physician dissatisfaction with their work environment and their positions at astoundingly high and previously unseen levels (50-60%). This dissatisfaction centers on the added workload (poorly designed EHRs, mandated goals and criteria that need to be met), which does nothing to improve patient outcomes, and in fact impedes patient-physician interaction. Such impedance may then lead to increased costs and potential mistakes. Concomitantly, increased time spent on administration combined with reduced payments, leads to the need to increase patient volume, contributing to the further dissatisfaction of both patients and physicians. However, the biggest problem is brought up by the Centers for Medicaid and Medicare Services’ own assessment that with the advent of the new regulations (MACRA etc.



Graph 1

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which become active in January 2017) groups of less than 27 physicians will NOT BE ABLE to financially survive due to lack of information technology infrastructure.

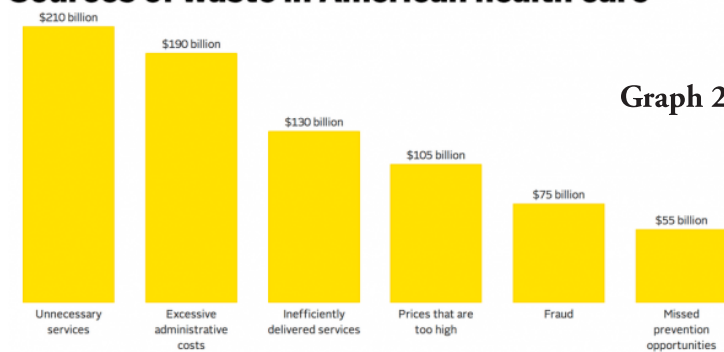
In other words, the government is forcing all the “small practice groups” out of existence, and acknowledges that situation. Faced with such onerous conditions, it is not at all unexpected that most of those 50-60% of currently dissatisfied physicians will actually do what they have been talking about – retire, stop practicing, quit. And how will this country handle sudden loss of half of its available physicians? There are no contingencies for that. We already have a relative shortage of physicians – in many situations doctors are not taking new patients, and in other instances, a patient has to wait months before getting an appointment.

So what are we to do? The options before us are several: we can ignore this impending storm and continue doing what we have been doing without any changes; but that will become financially untenable in 2-3 years. Many of us can and will retire – that path is fairly straightforward. Some will choose to stop participating in Medicare (many already have done so). And some will switch to “concierge” or “direct access” practice style. Others will choose to join large groups or become hospital employees (55% of physicians are currently

hospital employees). To those, collective bargaining becomes an increasing option. We will be planning education on those options in the future.

Most importantly, we have to coalesce together. The quote attributed to Benjamin Franklin comes to mind: “We must, indeed, all hang together or, most assuredly, we shall all hang separately.” Too many of us are laboring in our own little world, hoping that none of the swirling storms will affect us adversely. Yet that is the wrong approach. We must participate in organized medicine, and push back to try to bring some sanity into the process of change. Become involved! Talk to your colleagues. Talk to your patients and recruit their help. Call your senators and representatives (repeatedly, frequently). The time to do that is NOW. Do not delay.

Sources of waste in American health care



Source: The Institute of Medicine

Graph 2






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CCMS Delegates – Your Voice at the FMA Annual Meeting

Your CCMS delegation recently returned from the Florida Medical Association 2016 Annual Meeting, July 29-31 in Orlando. The delegation was active with appointments to each of the reference committees, as well as the credentials & rules committee and a resolution brought on behalf of CCMS members. The meeting included a full weekend of House of Delegates sessions, CME, keynotes from speakers Dr. Kevin Pho of KevinMD.com and Sen. Marco Rubio, and celebrating the installation of new FMA officers.

CCMS was allotted seven delegates, based on the number of FMA members in our County. This was an increase in one delegate allotment from 2015. The delegation consisted of CCMS President and delegation chair Dr. Rafael Haciski and delegates Dr. Rebekah Bernard, Dr. Cesar De Leon, Dr. Rafael Haciski, Dr. Catherine Kowal, Dr. Paul Makhlof, Dr. Alejandro Perez-Trepichio and Dr. James Talano; and alternate delegate Dr. Jose Baez. Additional CCMS members present at the Annual Meeting included FMA Speaker of the House AMA Delegation Chair Dr. Corey Howard; Dr. Craig Eichler, delegate for the Florida Society of Dermatology and Dermatologic Surgery; Dr. Jerry Williamson, a CME presenter; and Dr. Kriston Kent, representing Physicians Indemnity Risk Retention Group.

In addition to the important tasks of offering testimony, voting on resolutions, and casting votes in the elections on behalf of the CCMS membership's concerns, each year the delegation makes critical connections with colleagues from around the state and in particular, in the Lower West Coast Caucus (Charlotte, Collier, Hillsborough, Lee, Manatee, Polk, and Sarasota counties). These connections can further increase our county's voice at the state level.

FMA Elections

Each year at the Annual Meeting the House of Delegates elects FMA's leadership. Dr. David Becker from Pinellas County was installed as FMA's 140th President. This year, only one of the races was contested, that for President-Elect, which was won by Dr. John Katopodis. CCMS is proud to announce the re-election of Dr. Howard as FMA Speaker, and he also announced his candidacy for 2017 FMA President-Elect, to run at next year's annual meeting.

The FMA Alliance (FMAA) and the Conference of Florida Medical Society Executives (CFMSE) also met and held their elections during the Annual Meeting. CCMS Alliance members Mona Chami and Bobbi Jo Mendez were elected to the FMAA board, and CCMS Executive Director April Donahue was to the CFMSE board.

Committees

CCMS was privileged to have representation on all FMA reference committees, which review the resolutions proposed to the House, hear testimony and make recommendations for action. Dr. Talano and Dr. Bernard served on the committee for Health, Education and Public Policy; Dr. Kowal was a member of the committee on Finance and Administration for the third straight year; Dr. Perez-Trepichio was appointed to the Legislation committee; and Dr. Haciski to the committee on Medical Economics. Dr. De Leon was a member of the Credentials & Rules committee, which makes recommendation to the House on late resolutions and has the responsibility of ensuring fair elections.

Resolutions

The CCMS resolution, "Florida Physician Exemption from Jury Duty", brought forth by request of a CCMS member, received thoughtful testimony on both sides. With the reference committee's recommendation, the House of Delegates decided not to adopt the resolution. CCMS is hopeful this resolution did bring more attention to the issue of physician shortage areas in Florida.

Below is a synopsis of some of the meeting's more noteworthy adoptions. Find the complete list of actions at [ccmsonline.org/documents/HOD_Final Actions_2016.pdf](http://ccmsonline.org/documents/HOD_Final%20Actions_2016.pdf).

Board Recommendation B-1: Resolution 15-203 Equal Participation by FMA Delegates. Provide that each recognized specialty medical society shall be entitled to select annually and send to each meeting of the House of Delegates one delegate for every forty active members of the FMA or fraction thereof within that society, and ensure that counties and specialties are treated the same in regards to submitting resolutions to the House of Delegates. [Previously, specialty societies were allotted one delegate for every 100 active members.]

Board Recommendation C-1: Resolution 15-309 Florida Based Solution for Graduate Medical Education Funding. Support legislation that would enable counties to invest revenue generated from local Tourist Development Taxes to fund Graduate Medical Education and Residency Programs within their communities in order to decrease the physician shortfalls projected in the future and satisfy the desire of the State of Florida to enhance its reputation as a Medical Tourism destination.

Board Recommendation C-3: Resolution 15-109 Board Certification as Proof of Competency. Support legislation which would allow physicians to submit any board certification accepted by the Florida Board of Medicine and Florida Board of Osteopathic Medicine, that has educational requirements that meet or exceed current requirements for state licensure active

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ABMS or American Osteopathic Association certification as an alternative pathway for compliance with MD/DO Florida licensure and re-licensure continuing medical education requirements with the exception of that required by statute.

Resolution 16-104: Human Trafficking Continuing Medical Education an Important Alternative to the Current Mandatory Domestic Violence CME Requirement. Work with the Florida Board of Medicine, State Medical Societies and others to secure a definition of human trafficking to be an alternative to the current mandatory Domestic Violence requirement.

Resolution 16-105: Collective Bargaining/Negotiations. Identify legal opportunities for physicians to strengthen their ability to fully negotiate with health plans about important issues involving reimbursement and patient care.

Resolution 16-107: Gun Violence Requires a Public Health Response. Make a public statement that gun violence requires a comprehensive public health response and solution; and support our AMA in lifting the gun violence research ban.

Resolution 16-109: Extraordinary Response of Local Community to Terrorist Attack. Work collaboratively with all Florida communities and the appropriate state agencies after a disaster especially as it relates to future medical care and behavioral health needs; and that the delegation to the AMA advocate for the continued involvement of organized medicine at all levels in the coordination of disaster response and recovery, public health and community collaboration, and ongoing education and training for medical professionals that will continue to improve our ability to sustain life in the face of such tragedy.

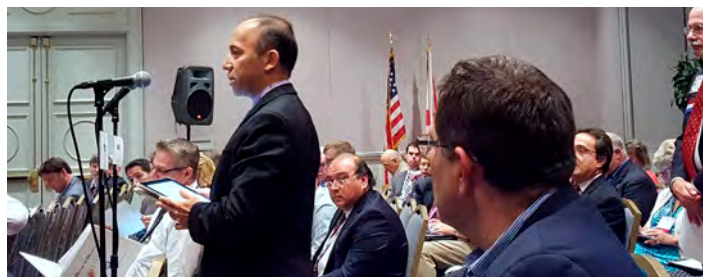
Resolution 16-301: Call for a Moratorium on Maintenance of Certification. Make every effort to support legislation to protect against physicians being dropped from hospital medical staffs based solely on maintenance of certification.

Resolution 16-307: De-linkage of Medical Staff Privileges from Hospital Employment Contracts. Pursue state legislation to statutorily de-link/uncouple medical staff privileges from physician employment contracts and purchase service agreements.

Resolution 16-315: Oppose Constitutional Amendment to Legalize Marijuana for Medical Conditions. Oppose Amendment 2, the constitutional amendment to legalize marijuana for medical conditions.



Dr. Alejandro Perez-Trepichio



Dr. Cesar De Leon



Dr. Corey Howard



Dr. James Talano



Dr. Rafael Haciski, Dr. Catherine Kowal, and Dr. Kriston Kent



Dr. Rebekah Bernard, Dr. Paul Makhoulouf, Dr. David Wilkinson

Recent Changes to Overtime Rules: What Employers Need to Know to Ensure Compliance with the Recent Final Rule

Amanda L. Waesch, Esq. and Richard Annunziata, Esq., Brennan, Manna & Diamond, PL



On May 18, 2016, President Obama and the United States Department of Labor (“DOL”) released the long awaited and anticipated Final Rule revising the minimum salary requirement for an employee to qualify for the overtime exemption under the Fair Labor Standards Act (“FLSA”). All changes under the Final Rule will take effect on December 1, 2016, affording employers about 6 months to prepare in order to conform to the Final Rule.



The reason behind the changes is well articulated by the DOL in the Final Rule: “when left unchanged, the salary threshold is eroded by inflation every year. It has only been updated once since the 1970s – in 2004, when it was set too low...[Therefore,] too many [employees] have been left working long hours

for no additional pay, taking them away from their families and civic life without any extra compensation.”

In summary, the Final Rule does the following:

- raises the standard salary threshold for full-time salaried employees to qualify for the overtime exemption from \$455 a week (\$23,660 per year) to \$913 a week (\$47,476 per year).
- raises the highly compensated employee salary threshold to qualify for the overtime exemption from \$100,000 per year to \$134,004 per year.
- allows up to ten percent (10%) of the salary threshold for non-highly compensated employees to be met by non-discretionary bonuses, incentive pay, or commissions, as long as these payments are made on at least a quarterly basis.
- imposes automatic updates to the salary threshold every 3 years, beginning on January 1, 2020, to account for inflation. The DOL anticipates that beginning on January 1, 2020, the minimum salary threshold will be \$51,168 for full-time salaried employees and \$147,524 for highly compensated employees.

The Final Rule does not make any changes to the “duties test” that determines whether salaried employees earning more than

the salary threshold are eligible for overtime pay. The DOL estimates that fewer employers will have to utilize the “duties test” because the increase in the salary threshold means more employees’ exemption status will be clear just from their salaries alone.

In order to comply with the Final Rule, employers will need to consider a few different options for employees that earn more than the current salary threshold, \$23,660 per year, but less than the new salary threshold, \$47,476 per year. Employers can choose from the following options:

1. Beginning on December 1, 2016, employers can remove the exemption status from these employees and begin paying overtime for all hours worked over 40 hours per week;
2. Beginning on December 1, 2016, employers can remove the exemption status from these employees, forbid overtime, and hire or reassign additional employees to cover any increase in workflow; or
3. Beginning on December 1, 2016, employers can increase the salaries of these employees to meet the minimum salary threshold of \$47,476, which will qualify them for the overtime exemption.

The ultimate decisions made by the employer should be strongly considered as any change in employee classification or reorganization of employee structure may impact employee morale. For these employees whose salaries are on the border of the salary threshold, it is now more important than ever before that employers ensure correct exemption classification and, if employers ultimately discover improper classifications, use this time as an opportunity to reclassify the exemption status for these employees.

The DOL expects the below changes to affect approximately 4.2 million salaried employees. The DOL estimates that average annualized direct employer costs will total approximately \$295 million per year over the first 10 years. The average transfer of income from employers to employees for newly overtime-eligible workers is estimated to be approximately \$1.2 billion per year over the first 10 years.

In preparing for compliance with these changes, employers should do the following:

1. identify a work group to assist with FLSA compliance;
2. review employee classifications and the organization’s compliance with wage and hour laws;
3. review employee handbooks and policies and procedures;
4. perform annual assessments;
5. make any necessary changes; and
6. budget for changes.

Foundation of CCMS Board Announces New Appointments for Darstek and Dannenberg



The Board of Directors of the Foundation of Collier County Medical Society is pleased to announce the election of Jeremy Darstek to Secretary/Treasurer of the Board and the appointment of Mitchell Dannenberg as a new Board Member. Darstek and Dannenberg will work with the Board to raise and manage funds for healthcare scholarships and programs that provide care for the underserved, as well as plan the Foundation's "Docs & Duffers" charity golf tournament scheduled for September 17, 2016.

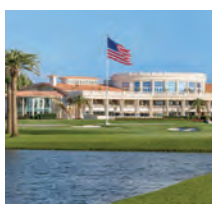
Jeremy Darstek has been an advocate for the medical community for over 16 years. Throughout his professional career as a Wealth Manager and Business Consultant he has

advised physicians and medical organizations on the business and finance of medicine. He currently works as a Wealth Manager for JD Wealth Management LLC and presides as Chief Executive Officer for two multi-physician medical practices in Naples.

Mitchell Dannenberg, President of LTCi Marketplace, leads a team with over three decades of experience in structuring life insurance, long term care planning, disability income protection, and critical illness coverage. He has worked with many individuals, families, members of the medical community, and business owners along with their management teams, to create integrated insurance plans for key executives, as well as their employees, and as part of business succession planning initiatives.

The Foundation's mission is to provide support and leadership to programs that address access to healthcare, promote health education and serve the community's public health needs. The board has awarded \$20,000 in scholarships this year. The Foundation is a 501(c)3 charitable organization launched by the Collier County Medical Society in 2012. For more information, visit ccmsfoundation.org or call (239) 435-7727.

Upcoming Symposiums



Echocardiography Symposium (35th Annual)

Friday-Saturday, September 23-24
Trump National Doral, Miami
(11 CME/CE)

MiamiEcho.BaptistHealth.net



Diabetes Symposium (Fourth Annual)

Saturday, October 15
Baptist Hospital, Auditorium
(4 CME/CE)

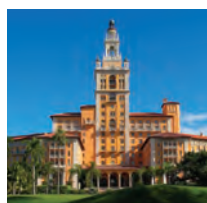
DiabetesSymposium.BaptistHealth.net



John M. Cassel, M.D., Memorial Breast Cancer Symposium (Fourth Annual)

Saturday, September 24
Baptist Hospital, Auditorium
(4 CME/CE)

BreastCancerSymposium.BaptistHealth.net



Miami Neuro Symposium (Fifth Annual) and Miami Neuro Nursing Symposium (Fourth Annual)

Thursday-Saturday, December 1-3
The Biltmore Hotel, Coral Gables
(18.5 CME/CE)

MiamiNeuro.BaptistHealth.net

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CANDOR Toolkit:

Physicians Now Have the Right Tools to Do the Right Thing After an Adverse Event

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

In the past, hospitals and physicians could appear cold and distant after adverse events. The fear of malpractice lawsuits created a culture in which physicians were expected to avoid most contact with a patient or family who might have reason to sue—and physicians certainly weren't supposed to accept blame.

Even when a well-meaning physician wanted to acknowledge the tragedy and express concern, hospitals sometimes discouraged the conversation because they were afraid the doctor's comments would implicate the hospital in a malpractice case. The actual effect of this way of thinking was just the opposite of what hospitals and doctors desired. Rather than shielding them from liability, patients and family members perceived this culture of silence as callous and uncaring, in some cases encouraging them to file lawsuits.

That was then. Over the past decade the healthcare community has embraced the idea that saying "I'm sorry this happened," or at least acknowledging that an unanticipated adverse event occurred with genuine sympathy and concern, can go a long way toward healing the relationship between the healthcare provider and patient. Physicians have moved progressively toward a culture that expects an adverse event—a medication error, for instance, or a death during routine surgery—to be followed by a full disclosure of the facts to the patient and family. Hospital administrators and physicians both can say they're sorry for what happened and even acknowledge they made a mistake in some circumstances when a clear-cut error has occurred that could have been prevented.

This is not just the right thing to do; it also helps the hospital and physicians avoid malpractice litigation, especially the lawsuits motivated not by actual errors or substandard care but by patients and family members who were left angry and abandoned.

Now we have not just the right idea, but the right way to execute it.

When Bad Things Happen to Good Doctors

The Agency for Healthcare Research and Quality (AHRQ) developed the Communication and Optimal Resolution (CANDOR) Toolkit – view at <http://bit.ly/1P2A17C> – with the input of healthcare professionals who studied the different tools, policies, and procedures in use at various hospitals, including the disclosure resources offered by The Doctors Company – view at <http://bit.ly/2b9lyqd>. David B. Troxel, MD, medical director at The Doctors Company, served on the oversight committee, and I served on the technical advisory committee, which assessed expert input and lessons learned from AHRQ's \$23 million Patient Safety and Medical Liability grant initiative launched in 2009. The CANDOR Toolkit then was tested in 14 pilot hospitals across three U.S. health systems: Christiana Care in Delaware, Dignity Health in California, and MedStar Health in the Baltimore/Washington, DC, metropolitan area.

"CANDOR is one of the most important patient safety programs to be released in the last 10 to 15 years," said David Mayer, MD, vice president of quality and safety at MedStar Health and one of the originators of the toolkit. "CANDOR promotes a culture of safety that focuses on organizational accountability; caring for the patient, family, and our caregivers; fair resolution when preventable harm occurs; and most importantly learning from every adverse event so our health systems are made safer."

This tool is just as useful for doctors as for hospitals. When a hospital is sued, physicians who were involved in the case will likely be named in the suit, whether they are employed by the hospital or not. Even though the CANDOR Toolkit is designed for hospitals, physicians should become aware of the valuable resources available to them in this toolkit, such as the videos that demonstrate how to have an effective disclosure conversation and tools that help doctors assess their own interpersonal communication skills.

The toolkit facilitates communication between healthcare organizations, physicians, and patients while promoting a culture of safety, said John Morelli, MD, vice president of medical affairs at Dignity Health's Mercy General Hospital in Sacramento, California. "The CANDOR Toolkit helps our caregivers improve how we rapidly communicate with patients and families when harm occurs. Consistent with our mission and values, we have always communicated with compassion and empathy; however, the toolkit provides a framework to respond quickly and in a learned manner to patients and families while also offering support to our caregivers."

CANDOR calls for a prompt response and specific actions after an adverse event. Within one hour, specially trained hospital staff should:

1. Explain the facts, and what might still be unknown, to patients and family members.
2. Contact the clinicians involved and offer assistance, because the stress and grief of the healthcare professionals can easily be overlooked in these incidents.
3. Immediately freeze the billing process to avoid further stressing the patient with a bill for the services that may have caused harm.

CANDOR calls for the hospital to complete a thorough investigation within two months, keeping patients and relatives fully informed along the way. When the investigation is complete, the patient and family are provided with the findings and engaged in a discussion of how the healthcare organization will try to prevent similar adverse events in the future.

Encouraging Open Communication

The investigation will not always find that the physician or other clinicians failed to meet the standard of care, and in those cases the patient and family members can still benefit from understanding what happened. In many cases, they will

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not sue despite their loss because they are satisfied that the hospital and physicians did their best and were forthcoming with information.

The Doctors Company encourages physicians to disclose and speak to patients about unanticipated events as early as possible. We also suggest they go to their hospital administration to find out what the hospital's disclosure process is and how closely it follows the CANDOR plan, because a cooperative approach is ideal. Working in harmony with the hospital is easiest in a closed system, where the physician is employed and insured by the hospital. Even when the hospital and physician are in adversarial positions and limited in communication, both parties still can adhere to the best practices outlined in the CANDOR program.

The philosophy and actions outlined in the CANDOR Toolkit can help hospitals and physicians avoid malpractice litigation, but even when the matter cannot be resolved and goes to trial, the fact that the patient and doctor talked early on can make a huge difference in the outcome of the case. Patients tend to pursue litigation with a vengeance when they think the doctor doesn't care, but they tend to be much more reasonable when they can see that the physician is a human being with emotions, regret, and sympathy for the patient.

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

Adverse Events Need a Timely, Thorough, Just Response



The AHRQ CANDOR Toolkit helps hospitals and doctors respond when unexpected events cause patient harm. Within one hour, specially trained staff should:

1. Explain the facts, and what might still be unknown, to patients and family members.
2. Contact the clinicians involved and offer assistance, because the stress and grief of the healthcare professionals can easily be overlooked in these incidents.
3. Immediately freeze the billing process to avoid further stressing the patient with a bill for the services that may have caused harm.

LEARN MORE AT
WWW.THEDOCTORS.COM/CANDOR

Source: The Doctors Company

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Update on Physician Led Access Network of Collier County (PLAN)

William Kuzbyt, Psy.D., J.D., Chair, PLAN Board of Directors



PLAN is a nonprofit 501(c) (3) that coordinates health care for low-income, uninsured residents in our county. Originally launched by CCMS in 2003, PLAN is a community-based referral network program of over 200 volunteer physicians, clinics, hospitals and other healthcare providers who help provide access to quality health care for that

underserved population.

PLAN offers physicians and facilities an efficient and rewarding system for assisting eligible patients. The volunteer physicians refer patients to a PLAN patient care coordinator who qualifies individuals and coordinates their care through the participating community network. Specifically, PLAN sets appointments and manages all of the patients' progress through to discharge. Services currently available are office visits, diagnostic testing, laboratories, surgeries, hospitalizations, and many other ancillary services.

PLAN volunteer physicians, who treat income-eligible individuals without remuneration, are allowed to utilize the Florida Department of Health's Sovereign Immunity Protection rather than rely on his/her own malpractice insurance. CME credits are also calculated and tracked for each visit. During the course of two years, physicians may accumulate a sufficient number of credits to waive re-licensure fees.

It is PLAN's continued mission to "Make a Difference in the Health of Our Community" by maximizing the donated

resources available through our network of providers. There continue to be challenges in accommodating all the needs of patients presenting to our program across all specialty areas. We welcome all healthcare professionals to become PLAN Providers and extend their services to the underserved community in any capacity possible. Working together, we can improve the health of our less fortunate Collier County neighbors.

To date, PLAN has provided over \$22 million in medical care to over 15,500 participants, coordinating delivery of all volunteer medical care for qualified residents including consultations, procedures, surgeries and laboratory services.

If all physicians participate in a small way, then no single physician is overwhelmed, and a small effort from many results in a huge impact on "making a difference in the health of our community." Call PLAN today at 239-776-3016 to learn more. On behalf of all patients, the Board of Directors of PLAN, and PLAN staff all express gratitude to our PLAN providers.

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Physician Led Access Network (PLAN) of Collier County is a 501(c)(3) organization that coordinates access to free medical care for eligible low-income uninsured Collier County adults via a network of volunteer physicians and medical facilities.

To help support this worthwhile organization
visit www.plancc.org or call (239) 776-3016

Your generous support is needed to help PLAN fulfill its mission.

"Making a Difference in the Health of Our Community"

Calling all Member Authors!

CCMS is accepting article submissions and story ideas from all members for future issues of *The Forum*. Whether you have an interesting story about your practice, training, or other medical experiences, or if you have particular expertise in healthcare issues, we welcome your ideas. Send proposals to info@ccmsonline.org or call (239) 435-7727.

The Foundation of Collier County Medical Society presents

Docs & Duffers 2016

3rd Annual Charity Golf Tournament benefiting efforts to address access to healthcare, promote health education and serve the community's public health needs

Saturday, September 17th

8:00 am - 2:30 pm

Bonita Bay Club Naples

3700 Wildwood Blvd, Naples, FL 34120

Open to the Public! Visit ccmsfoundation.org

Raffle tickets also available - need not be present to win

Sponsorships

at ccmsfoundation.org
or april@ccmsonline.org/435-7727

Golfers

\$175/person, \$600/foursome
ccmsfoundation.org

Highlights

*Win a 2017 Porsche in our
Hole-In-One contest!*

8:00 am

Registration & Refreshments

8:45 am

Shotgun Start, Scramble Format

1:15 pm

Luncheon & Awards

*Golfer Goodie Bags, Raffles,
and more!*



BayWater Exclusive Boat Club Catherine Kowal MD PA Comfort Keepers
Imperial Homes of Naples LLC Juniper Village of Naples Leading Edge Benefit Advisors
Moorings Park Home Health Agency Nurse on Call Prestige Printing Vi at Bentley Village



CCMS After 5 Social – June 30th
 CCMS Seminar on Physician Burnout – August 11th
 CCMS After 5 Social – August 17th



Andrew Hill, medical student and FCCMS scholarship winner Karisa Brown,
 and Dr. Susan Liberski



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Docs & Duffers charity golf
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