



THE FORUM

Jan/Feb 2013 ♦ Volume 12, No. 1 THE OFFICIAL MAGAZINE OF THE COLLIER COUNTY MEDICAL SOCIETY

WHEN THE ADDICT IS **YOU**

HOW THE PROFESSIONALS RESOURCE NETWORK
IS SAVING MEDICAL CAREERS IN FLORIDA

2013

ALSO INSIDE: 6 RETIREMENT RISKS YOU MUST AVOID / WHAT TO DO WITH A BAD REVIEW

MEMBER NEWS

Family Foot and Leg Center welcomes **Diego L. Adarve, DPM** to their practice. He is located at the Gridley Medical Office, 12250 Tamiami Trail East, Ste. 101, Naples, FL 34113, ph: 430-3668

Jonathan Frantz, M.D., Ophthalmology, has renamed his Florida Eye Health practice to **Frantz EyeCare**, ph: 430-3939, fax: 274-0388

Kriston Kent, M.D., **Naples Facial Plastic Surgery** has relocated to 870 111th Avenue N. #10, Naples, FL 34108, ph: 514-7888, fax: 514-7977

Steven F. Woodring, D.O., is now board certified in Anesthesiology

NEW PRACTICE

Monica Robles, M.D., Psychiatry, formerly with David Lawrence Center, has opened a new practice at 5052 Tamiami Trail N., Ste. C, Naples, FL 34103, ph: 784-2297, dr@monicaroblesmd.com

Scott H. Jaffe, D.O. of **Gulf Coast Certified Primary Care, P.A.**, 3384 Woods Edge Circle #103, Bonita Springs, FL 34134, ph: 498-5760 fax: 498-5763 has been reinstated as an active CCMS member

Millennium Physician Group has relocated its primary care office to 1735 SW Health Parkway, Naples, FL 34109, ph: 249-7800, www.MillenniumPhysician.com
The following providers have recently moved to the new location: **Maria del Rio-Giles, M.D., Alejandro Perez-Trepichio, M.D., Luis Pozniak, M.D. and Michael Y. Wang, M.D.**

IPC The Hospitalist Company has relocated their Southwest Florida Regional office to 9015 Strada Stell Court, Ste. 201, Naples, FL 34109, ph: 597-0196, fax: 597-5628.

Board of Directors 2012-2013 CCMS

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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.



CIRCLE OF FRIENDS NEWS

Express Employment Professionals has relocated its office and is now located at: 3358 Woods Edge Circle, Suite #102, Bonita Springs, Florida 34134
New Phone: (239) 498-5000 & Fax: (239) 498-5015

CALENDAR OF EVENTS

Register for these events at (239) 435-7727 or info@ccmsonline.org

THURSDAY, FEBRUARY 28TH Neapolitan Community Networking Event

5:30pm-7:00pm

*Enjoy gourmet Italian Appetizers & Desserts,
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Naples, FL 34109
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R.S.V.P., at (239) 659-2800 or email
Michelle.McLeod@FirstCitizens.com

SAVE THE DATE

THURSDAY, MARCH 7TH Membership Meeting

Host: Arthrex

1370 Creekside Boulevard, Naples
details coming soon

Take Advantage of this New Member Benefit: CE Broker Setup

CCMS is pleased to offer this
service to all its members for free!

Changes in the Florida license renewal system will require physicians to track their CME credits in the Department of Health (DOH) online continuing education tracking system called **CE Broker**.

EFFECTIVE DATES:

For allopathic physicians – the renewal in January of 2014

For osteopathic physicians – the renewal in March of 2015

As a member of Collier County Medical Society, we will register and set up each participating physician member with a professional account. Normally this would cost \$29 a year, but there is **no charge** to CCMS members.

Contact Nancy at the CCMS office by phone (239) 435-7727 or e-mail info@ccmsonline.org and provide your name and license number.

As soon as we register your details, you will receive information directly from CE Broker as to how to get started. Don't delay; start reporting your CME credits NOW!

Save THE Date

FIFTH Community AWARENESS LUNCHEON

Thursday, March 07, 2013
11:30 a.m. - 1:00 p.m.

Hilton Naples

5111 Tamiami Trail North, Naples, Florida

Drug Free Collier will honor one of the founding members of this Coalition, **Hon. Lauren L. Brodie**, 20th Judicial Circuit

Keynote Speaker: Michael Perryman, BSSE, CADC
Michael grew up in Naples and now lives in Louisville, Kentucky where he is dedicated to helping others who struggle with addiction. His own personal recovery is a story of hope. Join us to find out how you can make a difference.

Special guest appearance and performance by Casey Weston: singer, songwriter and finalist on The Voice.

Individual ticket - \$75.00

Sponsorship opportunities available.

Visit DrugFreeCollier.org for more information.
To reserve seating, please email us at:
info@drugfreecollier.org or call: 239-377-0535.

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Mon.-Fri., 7:30am-5pm

Naples Police Department
Drop-Off Box
355 Riverside Circle
Mon.-Fri., 8am-5pm

Naples Recycling Center
(no controlled substances)
2640 Enterprise Avenue
Tues.-Sat., 8:30am-4:30pm

Collier County Medical Examiner
3838 Domestic Avenue
Mon.-Fri., 9am-4pm

MARCO ISLAND

Marco Island Police
Drop-Off Box
51 Bald Eagle Drive
Mon.-Fri., 8am-5pm

Marco Island
Recycling Center
(no controlled substances)
990 Chalmers Drive
Tues.-Sat., 8:30am-4:30pm

EVERGLADES CITY

Everglades City Hall
Drop-Off Box
102 Copeland Avenue
Mon.-Fri., 8am-5pm

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p: 239/377-0535 | e: info@DrugFreeCollier.org

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Hurt Your Practice?

Unhappy patients rarely retract derogatory or even defamatory statements made online. Should you fight the commenters?

Fighting defamation, at least in some cases, might make the situation worse. Even if disgruntled commenters desist, the defamation is in the public domain and will circulate again and again.

Consider the following recent court case: A neurologist in Duluth, Minnesota, sued a family member of an unhappy patient for defamation because of a negative review written on a third-party Web site. The media picked up the story, multiplying the negative aspects of the case and presenting additional facts that were not supportive of the physician's office staff. Ultimately, the case was dismissed by the judge, who declared that "the court does not find defamatory meaning, but rather a sometimes emotional discussion of the issues."

Fighting commenters on an Internet review site can escalate a poor interaction or outcome into a full-blown complaint to the state medical board, as it did in Texas, where anonymous commenters and complainants led to medical board actions. In response, physicians banded together, and pushed the passage of a law which prevents the Texas Medical Board from considering anonymous complaints against physicians for disciplinary actions. Other states may take the issue up as well.

If you receive a negative or unfair comment or review online:

- **Avoid responding to the post.**
- **Review the comment from the critic's point of view. Can any information shared in the comment help improve the practice?**
- **Trust that established, potential, or new patients will use their own intelligence and judgment when reading the post.**

To help maintain positive relationships with your patients, consider the following ideas:

- **Don't have patients sign "gag orders" preventing them from commenting or discussing their experience. This puts a therapeutic relationship into a potentially adversarial footing.**
- **Give patients a direct line to the practice through patient satisfaction surveys. Discuss the results in regular staff meetings and address any patient concerns.**
- **Consider sending a letter to new patients after their first visit. Thank them for choosing the practice and saying that you hope to see them in the future.**
- **Encourage satisfied patients to post their experience as well, to help balance the reviews.**

Contributed by The Doctors Company/FPIC. MediGuard®, a coverage provided at no cost to members of The Doctors Company, provides defense in the case of complaint procedures brought before state medical boards. For additional information please visit www.thedoctors.com/mediguard.



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6 RISKS THAT COULD HURT YOUR RETIREMENT PLAN

by Diane Layton, CFP, ChFC, CLU, CLTC, CASL, Northwestern Mutual, A CCMS Circle of Friends Preferred Vendor

As baby boomers approach retirement, many may find themselves in different economic circumstances than what they planned for. Recent economic events have taught us the downside of risk, yet careful planning can help soften the impact. Northwestern Mutual says that your retirement plan can stay on track if you focus on these six key risks.

RISK #1: Health Care

Rising medical and prescription drug costs, fewer employer-sponsored retiree benefits and limitations of Medicare are all impacting income and retirement savings. According to Medicare.gov, estimated health care costs for a 65-year-old range from \$3,000 for someone in excellent health to \$10,000 for someone in poor health, including premiums, deductibles and co-pays but not including long-term care, vision or dental expenses.

RISK #2: Inflation & Taxes

With inflation reducing purchasing power and taxes impacting liquidation strategies, less money will be available to spend or invest in retirement planning.

RISK #3: Longevity

Americans are living longer and the possibility exists that they could outlive their resources. There is a 10 percent chance that a 65-year old male will live to 97 years of age and a 1 percent chance the same male will live to 105 years of age. Yet, the “average” life expectancy is only 85 years, meaning half of the population will die before that age and the other half is expected to live longer.

RISK #4: Legacy

Many Americans want to leave a legacy, making an impact beyond their lifetime by leaving a financial gift to a loved one or a charity. It is necessary to balance this desire with the need to fund an individual’s retirement.

RISK #5: Long-term Care

The cost of care for an unexpected event, or long-term illness not covered by private insurance or Medicare is requiring more Americans to prematurely deplete their assets. A 2009 LIMRA (Life Insurance Marketing and Research Association) survey of pre-retirees and retirees aged 55 to 75 found that health care and long-term care expenses together account for between 12 and 15 percent of retirement expenses, depending on the household income ².

RISK #6: Market

Participating in the stock market can give an individual’s retirement savings and income the potential to keep pace with inflation, however, volatility in investment markets can significantly affect retirement income and savings.

² “Retirement Income Trade-offs, Implications for Product Development,” LIMRA, 2009

RESOURCES

Northwestern Mutual has a range of online resources to help individuals think about and plan retirement needs:

- Retirement Savings Calculator at <http://www.nmretirementsavingscalculator.com/> can be used to show how contributions can affect an individual’s ability to fund their retirement.
- Cost of Care Calculator at http://media.nmfn.com/tnetwork/LTC_Calc to help better understand the potential cost of long-term care services.
- Lifespan Calculator at <http://media.nmfn.com/tnetwork/lifespan> to estimate out how many years an individual may live past retirement.

Prepared by Northwestern Mutual with the cooperation of Diane Layton, a Financial Advisor with Northwestern Mutual, the marketing name for The Northwestern Mutual Life Insurance Company (NM), Milwaukee, WI, and its subsidiaries. Diane Layton is based in Estero, FL. Contact her at (239) 676-2309, e-mail at diane.layton@nmfn.com, or visit nmfn.com/dianelayton.

NEXT MEETING set for mid-February

What Practice Administrators Need to Know About Local HIE Development



In November 2012, the first meeting of the local chapter of MGMA (Medical Group Managers Association) was held at the Country Club of Naples (picture from meeting at right). **Lori-Ann Martell**, LPN, CMPE, Practice Administrator of Advanced Medical Center, is the newly formed organization's President.



The SW Florida MGMA chapter holds monthly educational meetings designed to provide timely information, education and trends in healthcare to area practice managers. Membership is exclusively for those in medical management and will focus on supporting practices through mentors, trending, account receivable management, risk management and opportunities to become certified in practice management through MGMA. Each meeting starts with networking. Membership is open to all office managers and physicians currently practicing in Southwest Florida.

A **February meeting** will include a panel discussion on developments in the Health Information Exchange (HIE) industry as well as how implementation is progressing locally. A national expert on HIE will be a panel member along with representatives from both local hospitals. Guest will hear views on national and state trends along with anticipated launch details, practice access information, and their associated costs. Go to www.mgmasouthwestfl.org for registration details, updates, applications and information about this chapter and its meetings.



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Welcome New Member Reception

at Tiburon Golf Club • Nov 16, 2012



**ABOVE (l-r): Dr. Bradley Kovach,
Dr. Sajan Rao, Dr. Shona Velamakanni,
and Dr. Jaelyn Kovach**



**RIGHT: CCMSA President
Monique Owens
and Dr. Alex Owens**



Robert Sanchez and Dr. Joanna Chon

BELOW: Dr. David and Barbara Nolan Pitts



**ABOVE: Dr. Joseph & Sue Gauta,
Dr. Rolando and Claudia Rivera**



**Dr. Jay Wang, Dr. Shardul Nanavati
and Dr. Prathima Moorthy**



HELP FROM WITHIN

WHEN ADDICTION BECOMES YOUR MONKEY

by Martha E. Brown, MD, Assistant Medical Director, PRN
and Associate Professor of Psychiatry, University of Florida College of Medicine
with assistance from Judy Rivenbark, MD, Medical Director, PRN



The mission of the **Professionals Resource Network (PRN)** is twofold. One of PRN's missions is to help practitioners who have problems or potential problems with substance abuse or dependency, psychiatric issues, behavioral issues (disruptive and boundary), cognitive illness (such as dementia), and physical illness that could affect their ability to practice with reasonable skill and safety. The other mission of PRN is to protect Florida's citizens by identifying and monitoring impaired practitioners, and when indicated, intervening upon and ensuring they seek evaluation and the correct treatment for their impairment. Ultimately, PRN seeks to rehabilitate these practitioners and assure their safety to practice. PRN is the consultant on the above issues to the Department of Health (DOH) and the Department of Business and Professional Regulation (DBPR). As such, PRN is accountable not only to DOH and DBPR, but also to 29 Boards and Councils.

3 WAYS TO GET HELP TODAY

1. SELF-REFERRAL: When an individual self-reports to PRN, it is often on the advice of employers, colleagues, treatment providers, attorneys, or family members. If a person self-refers to PRN and his/her level of impairment has not risen to the level of patient harm, the practitioner's licensing Board never becomes involved with the practitioner. Eighty percent of PRN's participants are not known to their respective Boards.

2. DOH, DBPR, OR THE INDIVIDUAL'S LICENSING BOARD: When DOH files a complaint regarding a practitioner, it recommends that they contact PRN. Often, if impairment is the only issue and there has been no patient involvement or harm, as the case proceeds through the steps necessary to come before the Board, the panel of the licensing Board will not find probable cause if the individual has contacted PRN and followed PRN's recommendations (including signing a monitoring contract). In this case, the individual's license will never reveal disciplinary action. If there has been patient involvement or harm, then the case usually proceeds through probable cause to the Board. As part of the settlement agreement with the Board, a clause is often included referring the individual to PRN.

3. LICENSING PROCESS: If an individual answers "yes" to questions on his or her license application indicating there may be an impairment issue, the Board that licenses the individual frequently will refer them to PRN for evaluation and, if needed, a monitoring contract.

When an individual contacts PRN in one of the above three ways, it is usually by phone. PRN learns as much as possible from the practitioner and identifies any information the Boards may have. The practitioner is then referred to an evaluator.

Depending upon the reason for the referral, PRN provides the names and locations of three evaluators who specialize in the fields of the health care practitioner's potential impairment. PRN then accumulates all of the data available about the practitioner and forwards this to the evaluator the practitioner has chosen. When the evaluator returns the evaluation to PRN, a decision is made based on the report, information that PRN has accumulated, and PRN's prior experience whether the practitioner requires treatment and/or a PRN contract.

If the individual has been referred by DOH or by its respective Boards, then the Department or Board is notified of PRN's findings and recommendations. If necessary, the individual then enters into a PRN contract. When treatment is required, the practitioner is given the names of three facilities (if it is to be inpatient or intensive outpatient treatment), or three individuals capable of treating the person on an outpatient basis. If monitoring rather than treatment is required, PRN will work with the practitioner to establish appropriate oversight.

A PRN contract varies in length. Contracts can be as short as one year, and up to licensure long, depending on the diagnoses and the individual's stability. These contracts are binding and are covered under Florida Statute 456.072 (1) (HH). Failure to follow PRN's recommendations or the contract can result in PRN reporting the practitioner to their respective agency, DOH or DBPR, requesting either an emergency suspension or action against the practitioner's licensure until they are deemed to be able to practice with reasonable skill and safety.

Monitoring is done in multiple ways depending upon the impairment. Toxicology testing including urine, hair, nail, and even blood may be used on a random basis. The practitioner may be required to attend a weekly monitoring group. Additionally, they may be required to have psychological and/or neuropsychiatric testing once or on a scheduled basis.

Many times, the practitioner must see a physician as well as a therapist on a regular basis and PRN will receive quarterly reports from the monitoring and treating personnel. With some diagnoses and difficulties, satisfaction surveys are required of



all if the practitioner's patients and staff. All monitoring is done in very specific and methodical ways, including random checks on the individual's progress. If the practitioner follows all recommendations, PRN is able to advocate on the practitioner's behalf to the practitioner's licensing Board, to their insurance carrier, and to employers, if required.

If for some reason the practitioner falls out of compliance with their PRN contract, PRN has a "three strike" clause in the state contracts that they must follow and which guides what will

happen. On the first issue of material non-compliance (relapse, positive drug test, significant work problems, arrest, etc.), if the participant chooses to ask PRN for another chance, PRN handles the issue internally. At this time, PRN may require the individual to refrain from practice, have another evaluation, and/or seek addiction treatment.

On the second issue of material non-compliance, PRN will request that the practitioner sign a voluntary withdrawal from practice, which PRN through DOH, will have posted on the practitioner's license. DBPR/DOH are not informed of the reason for the voluntary withdrawal, nor do they inquire. When the practitioner has followed all of PRN's recommendations and PRN has determined that they are again able to return to practice with reasonable skill and safety, PRN sends a rescission form to the DOH and the withdrawal is removed from the licensure website.

On the third issue of material non-compliance, PRN notifies the Department by letter. If the participant agrees to remain in PRN to attempt to become compliant with PRN's recommendations, PRN will again post a voluntary withdrawal but they also must turn the entire file over to the Department which can result in Board action against the practitioner's license based on non-compliance. If the practitioner declines to attempt to rectify their non-compliance, PRN will either ask for an investigation into the practitioner's ability to practice, or if PRN feels that the person is an imminent danger to the public, an emergency suspension order will be requested. When this happens, PRN cannot remove the voluntary withdrawal from the website. At this point, the voluntary withdrawal can be removed only after Board action.

PRN has an 80 to 90-percent success rate for participants in a five-year monitoring contract.

The success rate depends on the diagnosis, and, in the case of chemical dependency, the substance being used. The general public success rate for first-time treatment is usually gauged at 10 to 25 percent. What makes PRN so successful is the contract length and the amount of accountability the program demands.

PRN is constantly working to improve the program. One of the ways to identify areas for improvement is through research. PRN has partnered with the University of Florida to bring PRN to the standard of complete evidence-based monitoring. We are a member of the Federation of Physicians Health Program and we use our research and the Federation's research to achieve this goal.

PRN is also one of the leaders in the nation in establishing contracts with medical schools for monitoring students. PRN believes that the earlier we intervene on impairment issues in a student, the less fulminating the disease or impairment becomes and the less harm to the public. All allopathic schools in Florida have ongoing contracts with PRN and just recently, Lake Erie College of Osteopathic Medicine (LECOM) also agreed to contract with PRN to help their students.

The challenges for the future are multiple. As always, obtaining appropriate funding is an issue. Through our contract with the DBPR/DOH, we are paid for monitoring and through DOH we receive a small allocation of research funds. Unfortunately, these contracts do not cover the full cost of research, scholarships for financially strapped participants, or updating equipment and technology on an as-needed basis. Another challenge is the changing political climate. As there are new appointments to the Boards every year, PRN must continually reestablish who we are and educate the Boards, state leaders, and healthcare practitioners about the mission of PRN to both protect the public, as well as help practitioners who have problems in order that they may return to work and be productive again.

PRN is a 501 c (3) non-profit organization and has recently begun a campaign to raise tax-deductible donations to further help the practitioners of Florida. Any donation is appreciated, as it goes back to help the practitioners of Florida. PRN is also very fortunate to have a 22-member board and six individuals appointed as advisors to the board for two-year terms. The Florida Medical Association President appoints PRN board members and through them we maintain a relationship with the FMA and seek its guidance when needed. All of our board members are actively involved in PRN's fiscal policies and business practices, but have no involvement with the individual practitioners' files. The PRN office is open daily from 8 a.m. to 5 p.m., toll-free at (800) 888-8776 (8PRN), and is available 24 hours a day in an emergency. Remember: Reporting an impaired practitioner is not punishment. Monitoring a health care practitioner prevents harm to more than one person and may save the life either of a patient or of the practitioner.

It Hurts

The Patient with **Noncancer Pain**

By Susan Shepard, MSN, RN, Director, Patient Safety Education, The Doctors Company. Updated by Howard Marcus, MD, FACP, Chair, Texas Alliance for Patient Access, and Chairman, The Doctors Company Texas Physician Advisory Board. A CCMS Circle of Friends Preferred Vendor.

The patient's pain started on an otherwise normal day—another day of hard work as a certified nurse assistant who frequently did more physically demanding work than she should. The patient awoke with excruciating pain in her back. When she called her family physician, she was told that she didn't need to be seen, that she just needed to rest and use nonsteroidal anti-inflammatory drugs (NSAIDs) for a day or so.

Fast forward a few years: the patient, still in the same job, injures her back again, overexerting herself at work. This time, the pain doesn't go away. The patient is seen by multiple physicians, none of whom alleviate the pain to the patient's satisfaction, despite ever-increasing doses of opioids.

Does this patient seem familiar to you? She represents your patient in the emergency room, who hears the nurse say quietly, "There's another drug seeker in bed two." Or, he is the patient in the exam room who digs in his heels and insists that he has to take multiple doses of Vicodin just to get through the day. Or, she is the customer at the pharmacy being lectured about the dangers of addiction to narcotics. Treating the patient with chronic pain can be difficult, frustrating, and even dangerous—not only to the patient, but also to you.

Facts and Figures

Twenty percent of the general population is significantly affected by chronic nonmalignant pain (CNMP)¹. According to Doris K. Cope, MD, a member of the American Society of Anesthesiologists' Committee on Pain Medicine, the most common types of chronic pain include headaches, back pain, and joint pain².

The Dilemma

Patients want relief from pain while physicians are often concerned about longer-term issues concerning opioid abuse. Patients with untreated pain may feel that the physicians they consult are unfeeling, paternalistic, judgmental gatekeepers, while physicians must be alert to patients with a high potential for substance addiction. In addition, physicians deal with feedback from pharmacists about over-prescribing, pressure from reimbursement channels to hold down costs, bad experiences with other opioid patients, and the knowledge that some of their colleagues have been punished by state medical boards and even indicted for prescribing opiates.

Opioid Use Is Skyrocketing

In the past 10 years in the U.S., prescriptions for hydrocodone and Oxycontin have increased by approximately 300 percent, while the number of opioid-related deaths has increased fourfold. There are tragic reports of iatrogenic inpatient opioid-related deaths from opioid analgesics. Opioids are now number one on the list of drugs implicated in medical malpractice litigation³.

Guidelines

Physicians who treat acute and chronic pain need to be comfortable and secure in their competency. Physicians need to be cognizant of correct dosing guidelines, which may have dramatically changed in the past decade. For example, current dosing recommendations for Dilaudid are much lower than previous recommendations. Before prescribing opioids, physicians need to obtain a patient's history of any substance and alcohol abuse, his or her psychiatric history for anxiety or depression, and any comorbidities, such as obstructive sleep apnea.

In response to the dramatic increase in opioid use and the fallout complications, the U.S. Food and Drug Administration (FDA), state medical boards, and professional associations are developing regulations and guidelines for the safe and effective use of opioids. Here are a few examples:

- The FDA is developing a Risk Evaluation and Mitigation Strategies (REMS) program for the use of long-acting and extended-release opioids. These continuing medical education (CME) programs will be voluntary and funded by the manufacturers of opioids⁴.
- Legislatures have mandated regulations by state medical boards.
- Online real-time access to drug-monitoring databases that contain patient prescription history is available in some states so that physicians can evaluate for doctor shopping and have a complete prescription history.
- Urine drug testing for patients on chronic opioids to evaluate compliance and make certain the patient is not abusing synergistic drugs is becoming the standard of care.

Clinical Pearls to Remember

- All patients deserve to be thoroughly assessed for pain and to have their pain managed appropriately to increase the quality of life.
- Noncancer pain is a common and frequently debilitating experience for many patients.
- Because of the risk for misuse and/or abuse of opiate agents, patients with chronic pain should be evaluated and supported according to their level of risk.
- Pain patients need to be listened to, receive validation of symptoms, have their fears calmed, be treated with respect and belief, and have a medical partner for dealing with their pain.
- Understand the risks and barriers to effective pain management.
- Prescribe only to your patients.
- Educate and provide informed consent and/or use patient-provider prescription agreements.
- Document! Use a flow sheet to monitor prescription refills.
- Utilize pain management specialists in your community whose practices are designed to manage and monitor chronic pain patients.

We need to adequately treat acute and chronic noncancer pain, protect patients from the unintended consequences of opioids, and ensure patient compliance. Because narcotic prescriptions are aggressively monitored by multiple agencies, physicians may worry that prescribing narcotics can cost them their license.

The Florida Board of Medicine provides guidelines for prescribing controlled substances for pain. The board considers the treatment of intractable pain with properly prescribed controlled substances and properly documented medical conditions and treatment plans to be acceptable and within the standard of care. The treatment of intractable pain with controlled substances has been recognized in Florida through the provisions of Section 458.326, Florida Statutes. The board expects physicians to follow the standard of care in managing pain patients.

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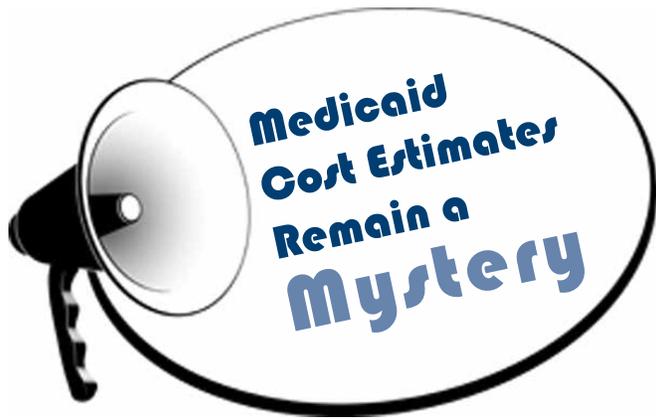
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Medicaid; they calculated the state would receive \$16 for every dollar it spent.

An **Urban Institute and Kaiser Family Foundation** report found Florida's Medicaid costs would rise 4.6 percent over 10 years, or just over \$1 billion, while covering an additional million people. Subtract the money that the state and local governments now spend on care for the uninsured, the added cost would be even lower.

According to AHCA spokeswoman Michelle Dahnke, "... the forecast for state costs went up after the federal government released its rules on how states should carry out the law... For example, as it relates to the physician fee increase, it wasn't until the recent rule came out that we learned ... the federal government wouldn't be covering the entire administrative cost. The mandated physician fee increase was portrayed to be 100 percent federally funded for the initial two years. However, federal regulations revealed that states will bear certain administrative costs. Florida's costs are projected to be \$4 million per year in both 2013 and 2014." Dahnke said the amount the state pays HMOs to care for Medicaid patients will have to rise to cover the Health Insurance Tax that is part of the law. Read the entire article at <http://health.wusf.usf.edu>

Will Gov. Rick Scott approve a joint federal/state Medicaid program? The following reports don't make his decision easy, as reported in WUSF News:

Agency for Health Care Administration: According to an Associated Press report, the Agency's new 10-year estimate of cost to the state forecasts a cost of nearly \$26 billion over 10 years.

Georgetown University's health policy analyst Joan Alker reports the state would actually save money overall by expanding

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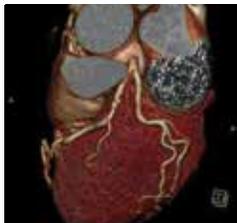
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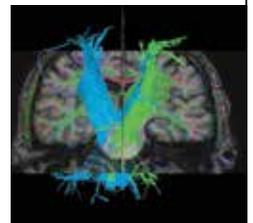
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