MEMORIAL DAY
MAY 25, 2015

On this Memorial Day, our hearts are filled with gratitude and respect for all the men and women who have valiantly served and died in service to our country. For their patriotism, their willingness to serve, and the ultimate sacrifice they made for the common good, we commemorate their memory.
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As a practicing Surgeon and as a Program Director for a General Surgery residency program I am deeply aware of physician work hour issues and concerns about job satisfaction.

While I am responsible for making sure our program complies with mandated work hour limitations for our trainees, I also witness the long hours that my surgical and medical colleagues work. Physician work hours, physician burnout and physician job satisfaction have always been important issues to consider because of the stressful demands placed upon physicians. The practice of medicine requires a deep commitment of time, energy and personal sacrifice to a degree which is not often found in other careers. With this should come the offsetting benefits of career and personal satisfaction, proper compensation and the expectation for continued future career happiness.

These are times of change and along with that change comes a potential impact upon physician work hours and practice arrangement. Many of the changes we are facing relate to changes in physician training, physician compensation models, practice type, regulations, accountability, oversight, etc. all of which may impact work hours and professional satisfaction in ways not yet known.

For physician trainees, work hours have historically been long and arduous. A resident physician typically worked 80-100 hours per week for many specialties and often worked for 36 hours straight. Trainees remained in the hospital to such an extent that they were called “residents” to reflect this fact. In New York this began to change after the death of a young woman named Libby Zion in 1984. It was believed that her care may have been negatively impacted by the tiredness and demands placed upon the medical residents who were caring for her. This led to the Bell commission findings which ultimately created work hour restrictions placed upon the training of residents in New York beginning in 1988. These work hour restrictions moved to a national level in 2003 with requirements established for all allopathic training programs in the nation by the Accreditation Council for Graduate Medical Education (ACGME). These work hour restrictions were further tightened in 2011 to limit hospital shifts for first year residents (PGYI) to 16 hours and for all other residents to 24 hours (plus 4 hours for transitions of care) with an average 80 hour work week maximum. These changes were put in place largely because of societal concerns regarding medical errors and the belief that physician fatigue may play a part. The effects of these work hour limitations now over a decade old are still debated but there seems little evidence that they have led to any benefit in patient safety or clinical outcomes. The effect upon the quality of resident training itself is also debated and there is some evidence suggesting that it may be leading to fewer patients seen by trainees, fewer cases performed by surgical residents, lower board pass rates and an increased number of residency graduates feeling inadequately prepared to enter practice. What is lacking in time spent at the hospital is hoped to be compensated for by more efficient training of residents with less wasted time and more use of simulation as a learning tool.

In the US while we currently have trainee work hour restrictions we do not have post training work hour restrictions for physicians, as is the case for some other professions such as airline pilots and crew, taxi and truck drivers, etc.

Data from the AMA suggests that most physicians work between 40 – 60 hours per week and 25% of physicians work from 61-80 hours or more. Physicians with practices that care for sick patients or hospital based patients tend to have the longest work hours such as Surgical Specialists, Obstetricians/Gynecologists, Medical Specialists in Pulmonary or Critical Care, Medical Oncologists and Neonatologists and Perinatal specialists. Hospital based physicians with shift work schedules such as ER physicians, Hospitalists and other specialty types such as Dermatology, Rehabilitation Medicine, Occupational Health, Psychiatry and others tend to have shorter work hours, yet generally over 40 hours per week.

Career satisfaction appears to be higher among physicians with the shorter work hour schedules. This may be because of an easier ability to balance work and personal life demands and interests.

The amount of time put into developing a career in medicine is itself quite substantial. Four years of college, followed by four years of medical school, followed by at least 3 and often as many as 8 years of post-graduate training before a doctor is able to start their career’s work.

Many factors in addition to work hours however affect physician job satisfaction. The Rand Corporation did a study for the AMA that examined factors affecting physician professional satisfaction and found that the ability for physicians to provide what they perceive as high quality of care is an important factor in determining physician satisfaction. Obstacles to high quality care may include factors within the physician’s practice type or external influences such as insurance company restrictions placed upon care.

Electronic health records (EHR’s) were felt to be of mixed impact with some benefits to medical practice but many negatives such as poor usability, extra time requirements for data entry, less face to face interaction with patients, less precise clinical documentation and an inability to exchange health information between systems.

Physicians are concerned about their future income and regard income stability and arrangements that are fair, transparent and aligned with good patient care as leading to professional satisfaction. The cumulative role of increasing external rules and regulations are beginning to have an effect upon practice satisfaction. EHR meaningful use requirements and compliance with as yet unproven models for assessing physician quality of care as a determinant for future compensation are creating physician worry. Future compensation models such as Pay for Performance and movement away from Fee for Service medicine towards other arrangements such as global payments to Accountable Care Organizations (ACO’s) will undoubtedly impact physician compensation and professional satisfaction.

Historically physicians have been among the professions with the highest level of professional satisfaction. This appears to be changing with all the current stressors placed upon the Healthcare system. Only approximately 50% of physicians would choose to pursue their career again and less than 40% would want their children to be physicians. This is a disturbing trend that physician leadership and government officials need to consider as our Healthcare system under goes further significant change in the coming years.

Being a physician is a wonderful profession, we help many people and modern medicine is rapidly producing more highly effective treatments for many patients. Organized Medicine such as the Dade County Medical Association (DCMA) is working to protect your ability to continue to provide excellent medical care for your patients and to be able to do so with great professional satisfaction.

Please be involved, join if you haven’t done so already and be a part of organized medicine and the DCMA.

All the best,

Tom Mesko, M.D.
104th President of the DCMA
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Cybercrime costs the U.S. economy billions of dollars each year and causes organizations to devote substantial time and resources to keeping their information secure. This is even more important for healthcare organizations, the most frequently attacked form of business. Cybercriminals target healthcare for two main reasons: healthcare organizations fail to upgrade their cybersecurity as quickly as other businesses, and criminals find personal patient information particularly valuable to exploit.

Recent cyberattacks on large health insurance companies further demonstrate cybersecurity risks. On January 29, 2015, Anthem, the second largest health insurer in the United States, announced it was the victim of a sophisticated cyberattack that it believed happened over several weeks starting in December 2014. Reported as one of the largest attacks to date, the Anthem breach exposed the information of up to 80 million current and former members, including names, birth dates, Social Security numbers, healthcare IDs, and addresses. That same day, Premera Blue Cross discovered it was also a victim of a cyberattack, with an initial attack taking place in May 2014. Cybercriminals gained unauthorized access to the information of up to 11 million Premera customers dating back to 2002, ranging from birth dates and Social Security numbers to addresses and bank account information—the second largest breach, after Anthem, in the healthcare industry.

The repercussions of security breaches can be daunting. A business that suffers a breach of more than 500 records of unencrypted personal health information (PHI) must report the breach to the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR). This is the federal body with the power to enforce the Health Insurance Portability and Accountability Act (HIPAA) and issue fines. To date, the OCR has levied over $25 million in fines, with the largest single fine totaling $4.8 million. In 2014, U.S. healthcare data breaches cost companies an average of $314 per record—the highest of any industry.

A healthcare organization’s brand and reputation are also at stake. The OCR maintains a searchable database (informally known as a “wall of shame”) that publicly lists all entities that were fined for breaches that meet the 500-record requirement.

To help safeguard your systems, know the most common ways a breach occurs. The theft of unencrypted electronic devices or physical records is the most common method, accounting for 29 percent of breaches across all industries in the United States. Also common are hacking (23 percent) and public distribution of personal records (20 percent). A breach in the latter category led to the largest OCR fine to date when two affiliated hospitals accidently made patient records public on the Internet.

If you think you may not be fully compliant with HIPAA privacy and security rules, consider taking the following steps:

- Identify all areas of potential vulnerability. Develop secure office processes, such as:
  - Sign-in sheets that ask for only minimal information.
  - Procedures for the handling and destruction of paper records.
  - Policies detailing which devices are allowed to contain PHI and under what circumstances those devices may leave the office.
  - Encrypt all devices that contain PHI (laptops, desktops, thumb drives, and centralized storage devices). Make sure that thumb drives are encrypted and that the encryption code is not inscribed on or included with the thumb drive. Encryption is the best way to prevent a breach.
  - Train your staff on how to protect PHI. This includes not only making sure policies and procedures are HIPAA-compliant, but also instructing staff not to openly discuss patient PHI.
  - Audit and test your physical and electronic security policies and procedures regularly, including what steps to take in case of a breach. The OCR audits entities that have had a breach, as well as those that have not. The OCR will check if you have procedures in place in case of a breach. Taking the proper steps in the event of a breach may help you avoid a fine.
  - Insure. Make sure that your practice has insurance to assist with certain costs in case of a breach.

References

**Primary Care Focus Symposium (14th Annual)**
Friday-Sunday, July 24-26, 2015
Ritz Carlton, Naples (13 CME/CE)
PrimaryCareFocus.BaptistHealth.net

**Topics include:** Nutrition facts vs. myths, anemia, eating disorders, the role of exercise in heart health, smoking cessation, the medical handoff, improving transitions in care, evaluation of chest pain, helping heart patients thrive, congestive heart failure, concussions, update on GERD, geriatric care and COPD.

**Other upcoming symposiums**

**State of Science Symposium: Critical Care Best Practices (Sixth Annual)**
Saturday, June 6
Baptist Hospital Auditorium (6.25 CME/6 CE)
CriticalCare.BaptistHealth.net

**Foot and Ankle Symposium (Third Annual)**
Friday, September 18
The Ritz-Carlton Coconut Grove, Miami (4 CME/CE)
MiamiFootandAnkle.BaptistHealth.net

**Beneath the Surface: In-depth Focus on Wound Care and Critical Limb Ischemia Symposium (10th Annual)**
Saturday, September 19
The Ritz-Carlton Coconut Grove, Miami (6.5 CME/CE)
WoundCLIMiami.BaptistHealth.net

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I recently had the opportunity to address the members of the South Florida Medical Group Management Association. My topic was one that is important to every physician I have ever met - the manner in which their reimbursement (and therefore, their compensation) is changing.

In 1965 Part B of the Medicare program started paying physicians on a fee-for-service basis, based on the “usual and customary” charge in the market (“UCR”). Over time, Congress abandoned the UCR methodology. Starting with making reimbursement determinations based upon what was “reasonable” in the market, the Medicare program began tinkering with the way it reimburses physicians for their services. The program adopted the annual exercise known as the “Physician Fee Schedule”, thereby abandoning UCR. Congress acted to restrict physician reimbursement in a number of other ways, most infamously, through the attempted imposition of the Sustainable Growth Rate (“SGR”). Of course, hospitals and other Part A providers were not immune; their reimbursement shifted from “reasonable cost” to DRGs, RUGs, etc. There is no question that the “good old days” for physician reimbursement are gone, if they ever existed.

Despite these changes, until now, physician reimbursement has retained its essential character as a fee-for-service/productivity model. That is, the more services a physician rendered, the more he would be paid by the Medicare program, as well as private payers. However, the manner in which physician reimbursement will be determined in the future is changing, and it is doing so quickly.

In January of this year, in a New England Journal of Medicine article, HHS Secretary Burwell made clear the Center for Medicare & Medicaid Services’ (“CMS”) intention to fundamentally alter the fee-for-service reimbursement payment system for physicians’ services. According to Secretary Burwell, in 2014 the Medicare program (that is, Part A - Hospital Insurance and Part B - Supplemental Medical Insurance, which together are commonly referred to as “traditional Medicare”) made approximately 20% of its benefit payments through “alternative payment models”, such as accountable care organizations, patient centered medical homes, bundled payments, gainsharing, and various other pay for performance formulae. The growth of these models has caught many people by surprise. Moreover, they are distinguishable from Part C of the Medicare program – the Medicare Advantage program.

In that same article, Secretary Burwell announced it is the Medicare’s intention to rely increasingly on measures that include the quality and value of the services rendered, rather than the volume of services rendered, in determining physician reimbursement. Indeed, the Centers for Medicare & Medicaid Services (“CMS”) anticipates that by the end of 2016, 85% of traditional Medicare payments will be tied to these measures. The volume will continue to increase, so that by 2018, 90% of the payments made by the traditional Medicare program to physicians and other healthcare providers will be tied to the quality and value of the services rendered. In the world of private payers, the move toward these alternative payment models is progressing at least as quickly.

While productivity (the cornerstone of physician reimbursement today) will remain a factor in determining their compensation, physicians need to recognize that the model will look to other factors for determining reimbursement amounts. The Medicare program’s “triple aim” for its Medicare Shared Services Program (“MSSP”), represents the guide for criteria on which the emerging public and private reimbursement models will focus:

1. Increasing the health and welfare of individual patients;
2. Improving the health and welfare of patient populations (ex. diabetics or oncology patients); and
3. “Bending” the cost curve to reduce the rate of growth in healthcare expenditures.

The use of increasingly sophisticated “big data” is enabling Medicare and other payers to measure and compare the performance of individual physicians within a specialty and within a geographic market. The ability to analyze practices’ ability to help its patients reduce the incidence of obesity, stay out of the emergency room, and avoid hospital readmissions within 30 days of discharge are examples of the “big data” which is becoming increasingly important in determining a physician’s reimbursement. Physicians who are able to achieve the goals identified by payers will be the “winners.” Physicians who do not, will be either reimbursed at lower rates or excluded from the panels of private payers.

To achieve the goals identified by “big data”, physicians are going to have to adopt and follow clinical policies and procedures that are founded on evidence, not prior practice. Many opponents of the increasing reliance on data claim that it results in “cookbook” medicine. Supporters, however, view evidence based medicine as the way to identify those practices which are demonstrably safe, effective, efficient and patient focused.

Patient satisfaction surveys, a device long adopted by hospitals and other customer service businesses, also are going to become an increasingly important factor in determining physicians’ reimbursement rates. Physicians will have to either see patients when scheduled and ensure that their staffs provide a professional experience that treats patients with respect, or face the prospect that payers will respond by reducing their reimbursement or removing the practice from its panel, so its insured/enrollees no longer are subject to poor customer service.

The message is clear, physicians and their practices have to understand and adapt to the evolution (some might say, revolution) taking place in the manner payers are determining reimbursement, and they need to get on board quickly. At the time this is being written, there are only 32 months until 2018. That is not a great deal of time to revise many established business policies, procedures and habits in ways that fundamentally overturn the manner in which these practices have operated since their inception.

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Objectives
Following attendance at this educational activity, participants should be able to:

- Differentiate who needs vitamin D levels
- Explain the risk of low vit D levels
- Discuss the relative advantages of different lifestyle modifications in promoting healthy behaviors
- Critically analyze the evidence behind the differing dietary approaches
- Assess the relationship between exercise capacity and longevity
- Discuss the relationship between stress and health
- Educate patients in stress reduction techniques, including meditation and exercise
- Describe how to motivate and give an exercise Prescription
- Explain which supplements are indicated
- Analyze the evidence behind the effectiveness of different supplements
- Stratify patients into low to high risk groups
- Apply the recent 2014 lipid guidelines
- Assess the role of coronary calcium scores
- Discuss when a CT angiogram is helpful
- Help patients make end of life decisions
- How to deal with families and futile care
- Apply several protocols for treating pain
- Describe how to implement safeguards when prescribing narcotics chronically
- Utilize alternative therapies for the management of chronic pain

Faculty
Corey Evans, MD, MPH
Dr. Evans has been a family physician and educator for thirty years. After six years in a rural family practice in South Carolina, he moved to Florida to begin teaching, as an Associate Director in the Florida Hospital Family Practice program in Orlando. In 1994, he accepted the position of Director of the Bayfront Medical Center’s Family Practice program in St. Petersburg and was program director for seven years. In 2002, he accepted the position of Director of Medical Education at St. Anthony’s Hospital. He also works in the St. Anthony’s wound center, is a member of the Palliative care team at St. Anthony’s and has a private practice. He is board certified in Family Medicine, Sports Medicine, Geriatric Medicine, and Palliative Care. He teaches extensively at national Family Practice meetings with a special interest in exercise testing.

Target Audience
Physicians, Physician Assistants, and Nurse Practitioners

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Medical practices and facilities are depending more and more on cloud storage because it gives users the ability to access data across a variety of electronic devices while eliminating the costs and difficulties associated with maintaining a physical storage system.

What exactly is the cloud? Cloud storage is a network of remote servers that allow for centralized data storage and online access to these resources. Your files are stored on a server connected to the Internet instead of being stored on your own computer’s hard drive. This eliminates the need to purchase hardware equipment to store files or to upgrade your hardware to get extra storage space—or the need to delete old files to make room for new ones. The cloud is convenient and cost-effective, providing a way to automatically back up your files and folders.

Despite these benefits, recent publicity around hacks of public cloud storage websites has raised concerns about whether it is appropriate for medical practices and facilities to store health records and information in the cloud. Cybercriminals target healthcare organizations more than any other form of business because criminals find personal patient information particularly valuable to exploit. Providers must ensure they are compliant with the Health Insurance Portability and Accountability Act (HIPAA) in how they secure patient protected health information (PHI). The repercussions of a breach can be daunting under HIPAA. A business that suffers a breach of unencrypted PHI must report the breach to the U.S. Department of Health and Human Services’ Office for Civil Rights. If found negligent, the business can face fines and damage to its reputation.

Is cloud storage a safe way to store PHI? The answer is a qualified “yes”: The cloud can be an appropriate method of data storage, but only under the right circumstances.

As with many new technologies, the safety level of the cloud, and whether it’s appropriate for use, depends on the vendor. To be sure your data is safe and secure when you hand it over to a cloud service provider, you need to research each vendor you consider and do appropriate due diligence. There are several important questions you need to answer and issues you have to keep in mind:

- **Are the vendor’s security standards appropriate?** You have to research each vendor you choose. Make sure the company has a good reputation and solid security policies. You are entrusting the provider to store your information, so the extra time spent researching and comparing providers and their security practices will pay off in the long run.

- **How much data will you be storing?** Many companies charge by the amount of storage you use, so understand what your needs are before choosing a vendor. Ensure the vendor can handle the amount of data you would like to move to the cloud.

- **Ensure your data is encrypted when being uploaded to or downloaded from the cloud.** This is also your responsibility. Make sure your browser or app requires an encrypted connection before you upload or download your data. Also ensure all devices that contain PHI (laptops, desktops, thumb drives, and centralized storage devices) are encrypted.

- **Make sure your data is encrypted when stored in the cloud.** This is perhaps the most important consideration. Data protected by law, such as medical information or personal identifiers, should never be stored in the cloud unless the storage solution is encrypted. Only selected members of your organization should be able to decrypt the data, and your organization should create policies detailing under what circumstances information can be decrypted. Determining whether the stored data will be encrypted requires a careful review of the specific terms of service within your agreement with the cloud service provider. Many cloud service providers store data on a cloud server with no encryption, meaning anyone who has (or can get) high-level access to that server will be able to read your files.

- **Understand how access is shared in your cloud folder.** Many cloud storage providers allow you to share access to your online folders. Be familiar with the details on how that sharing works. Can the user read-only or can the user edit the file? Will you know who the last person to edit a file was? Awareness of who has access and how is critical to monitoring activity within your stored data.

- **Understand your options if the cloud provider is hacked or your data is lost.** Virtually all cloud service providers require a user to sign an agreement that contains a terms of service provision. In most cases, these agreements provide that the user has very little, if any, remedy if a hack or a loss of data occurs. Pay attention to what rights you have given up and make sure you are comfortable with doing so.

Cloud storage can be a valuable asset to medical practices and facilities, but the decision to use the cloud to store HIPAA-protected records should not be made until substantial due diligence has been performed on the cloud service provider. Make sure you have absolute confidence in the service provider’s ability to keep the data safe and secure.

David McHale is The Doctors Company’s Chief Legal Officer. He holds a law degree from the University of the Pacific’s McGeorge School of Law and an MBA from the University of Illinois. He is a Certified HIPAA Compliance Officer (AHIC) and a regular presenter before insurance trade organizations and the National Association of Insurance Commissioners (NAIC).

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

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.
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<tr>
<th>FINANCIAL GOAL</th>
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<th>CONFIDENCE LEVEL (LOW, MED, HIGH)</th>
<th>STEPS I’VE TAKEN</th>
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Florida Society of Rheumatology

4099 Lamine Road, Ste. B
Jacksonville, FL 32218
rheumatology7@aol.com

Dear Dr. Jonathan B. Gavrus:

We, the undersigned, representing many official organization physicians who treat patients who suffer with knee OA, send this letter on behalf of its members to inform you of our membership's strong disagreement with your new policy denying reimbursement for Hyaluronic Acid (HA) for the treatment of knee Osteoarthritis (OA). This misguided policy runs counter to the experience of our members in treating patients with knee OA, and as importantly, the evidence-based practice of medicine as demonstrated in the following arguments; and must, therefore, be reversed.

The rationale by which we protest and oppose this new HA policy is as follows:

1. HAs are FDA approved for use in osteoarthritis. Thus, each approved HA passed rigorous assessment by that esteemed regulatory agency. To do so each HA sponsor had to provide data from multiple, double blind, placebo controlled studies (the standard for medical research) supporting their safety and efficacy.

2. Meta-analysis data supports the therapeutic effects of HAs. Meta-analysis has become a standard methodology by which large amounts of data are aggregated in order to achieve a higher statistical power, or greater likelihood of confidence in effect. In 2013 Larry Miller and John Block analyzed 29 studies comprising results from 4,865 patients with knee OA who received either intra-articular HA or saline injections. Their analysis demonstrated significant improvement in the HA treated group vs. the saline treated group and no significant difference with respect to serious adverse events or withdrawal.

Moreover, a more recent meta-analysis reported by Flannery et al., in the Annals of Internal Medicine demonstrated that intra-articular HA treatment was MORE effective than standard end therapies! That meta-analysis analyzed 137 studies comprising 33,243 participants, and compared oral treatments with NSAIDs, and acetaminophen with intra-articular treatment with HA, corticosteroids and saline solution for pain, function, stiffness and safety. The most significant conclusion of this analysis was that HA treatment was the most efficacious therapy. A copy of this paper is attached here with for your benefit. The conclusions of this study dovetail perfectly with the position of those listed below.

3. Guidelines by national organizations can support or not the use of certain therapies. However, guidelines are just that. By definition they are not recommendations. We are aware that there are national organizations that are uncertain regarding the data about the use of HA in knee OA. The 2012 ACR guidelines state that they have no recommendations regarding the use of intra-articular hyaluronates, dexamethasone or opioids. These guidelines however, were written prior to the above meta-analyses. Further, regardless of national organization guidelines there is data to support the use of FDA approved HAs.

4. Finally, recent studies have demonstrated that intra-articular HA treatment delayed total knee replacement by 2.6 years in patients with knee OA. In this day of cost effectiveness, delaying or avoiding the need for reconstructive joint surgery is desirable.

The conclusions of the cited studies supports our position of maintaining intra-articular HA injections as a treatment option for patients with knee OA. Evidence and experience strongly support HA injections as a clinically indicated, evidence-based treatment for management of knee OA in patients who are not good candidates for surgery or who do not respond to other treatment options such as oral treatment.

Taking this efficacious treatment off the table not only infringes on the doctor-patient relationship, it deprives patients of a clinically proven, evidence-based, cost-effective option. We, strongly urge Blue Cross and Blue Shield of Florida to follow in the footsteps of Blue Cross and Blue Shield of Arizona and reverse its policy immediately and offer continued approval of HA treatment as a reimbursable option.

Thanking you,

Parisa Freeman, MD
President
Florida Society of Rheumatology

Escambia County Medical Society in
Conjunction with Santa Rosa County

Dade County Medical Association
Thomas, Mesko, M.D., President

Pinellas County Medical Association

Polk County Medical Association

Manatee County Medical Society
Hillsborough County Medical Association, Inc.
Collier County Medical Association
Palm Beach County

3. https://www2.rheumatology.org/app/MyAnnualMeeting/Abstract/77383
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MiamiFootAndAnkle.BaptistHealth.net

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Trump National Doral, Miami (11 CME/CE)
MiamiEcho.BaptistHealth.net

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DiabetesSymposium.BaptistHealth.net

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The Ritz-Carlton Coconut Grove, Miami (6.5 CME/CE)
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