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on the cover: Sirinya Prasertvit, M.D.

Cover photo by Greg Campbell

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Some Improvement, More Work to Do
by: Roland W. Gray, M.D., DFASAM
What Do They Do For All That Money?

Doctors Maligned Again

This may just be too dull to waste your time reading. It’s about money.

I look, dispassionately, at least a few days a week at The Commercial Appeal business pages listing stocks of local interest. Dispassionately I say, since I don’t have much skin in that game. But ESRX has caught my attention lately, ESRX, the stock symbol for Express Scripts. It’s listed as a local Memphis company, but that’s hardly true, since it’s actually based in St. Louis, with a Memphis area call center and specialty drug distribution facility, both mainly in Cordova.

Express Scripts is there because it acquired Medco in 2012, which had acquired Accredo in 2005 which started 36 years ago in Memphis as Southern Health Systems (remember I told you this would be dull).

It turns out Express Scripts is a Fortune Top 100 Company, the 22nd largest in the country by revenue, Fortune’s list headed by Walmart at number 1, followed by 2 Exxon, 3 Chevron, 4 Berkshire Hathaway, 5 Apple. There are four health related companies in the top 25, 10 CVS, 11 McKesson, 14 United Health Care and as I said 22 Express Scripts. ESRX is bigger than IBM, Bank of America, Boeing, even Amazon.

Clearly ESRX is a big deal.

So what do they do?

Pharmacy Benefits.

That’s right, they don’t make anything, they don’t take care of patients, they don’t get up in the middle of the night for a heart catheterization, they don’t answer suicide calls, they don’t comfort the bereaved, they don’t... well you get the drift.

They are a middleman, they administer drug benefits.

Their CEO George Pax age 57, soon to retire, made $57 million dollars total compensation in a recent year. Given the size of the company, he probably deserves it.

So what’s the point?

Our healthcare system is criticized for excessive administrative costs. You’ve just read about it in action. And here’s what a popular health economics textbook says: Physicians are not normally price sensitive since they are effectively spending someone else’s money.

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Memphis Surgery Associates, PC

President’s Message

Just call me doctor...

Tommy J. Campbell, M.D.

I recently returned from the Tennessee Medical Association (TMA) annual meeting held in Murfreesboro. The meeting was filled with opportunities for CME, networking with colleagues, discussing various challenges for medicine and renewing old friendships. One of the dominant discussions was TMA’s team oriented healthcare delivery bill that was filed in the last state legislative session. There was much said, including the offering of a resolution to the House of Delegates regarding the definition of doctor. This resolution was not passed. However, it generated a lot of discussion regarding the role of the physician in the healthcare system.

As a result of the discussions, I conducted a very unscientific study of ten random people and asked, “When someone introduces his or herself as “doctor” what is your first impression?” The response was unanimous that their impression was the individual was a medical doctor. While all of you will agree this was not a conclusive study, our society at large assumes when a person calls his or herself “Dr.”, he/she is identifying as a medical doctor.

Unfortunately, with doctorates popping up all over the health professions, there has been disagreement over the use of the title “doctor”. The TMA House of Delegates realized this back in 2009 and approved a resolution to encourage legislation regarding title identification. The Tennessee General Assembly passed legislation that became law in 2011. Here is an excerpt from www.tnmed.org/lawguide:

Prior to this year (2011), physicians (M.D. and D.O.), chiropractors, dentists and optometrists already had requirements in Tennessee statute regarding signage outside of the office. These requirements have been around for at least twenty-five years and state that each licensee is supposed to:

1. Post his/her license/certificate of registration in the office.
2. Display a sign at the entrance with the licensee’s name, the recognized abbreviation and words specifically describing the specialty (e.g. “medical doctor”, “physician”, “medical doctor and surgeon”). These descriptive words are in the statute for each profession that must meet this requirement. The lettering must be at least one inch in height.

In 2011, the Tennessee General Assembly passed legislation requiring additional healthcare professionals (podiatrists, advanced practice nurses, physician assistants, psychologists, acupuncturists and certified professional midwives) to display their license and post a sign at the building entrance.

The one new requirement for all licensees (including physicians) covered by the statute is that a healthcare practitioner must communicate his/her specific license to every patient that is seen by the practitioner in a freestanding, unlicensed setting (such as a provider’s office) in one of two ways:

1. The physician must wear a photo identification name tag during all patient encounters. The name tag must be of a sufficient size and worn in a conspicuous manner so as to be visible and apparent. The name tag must contain the following information:
   a. A recent photo
   b. The full name of the physician
   c. The type of license (using the words in #2 above).
   OR

2. The physician must communicate to a patient his/her full name and type of license (again using the words in #2 above) in writing at the patient’s initial office visit.

This new requirement was added because of a concern that the majority of patients often do not have a clear understanding of the background of the healthcare provider who provided the healthcare services. Patients naturally assume that the professional that walks into the exam room, often in a white coat, is a medical doctor.

Robert Hickey in his book Honor & Respect, The Official Guide to Names, Titles, & Forms of Address says the following:

In hospitals and some other healthcare environments, as well there is often a practice no one holding a doctoral degree except the physicians (medical doctors, dentists, osteopaths, podiatrists, veterinarians ...) is addressed as Dr. (Name). This is out of consideration for the patients who want to know who are the doctors and who are nurses, support staff and allied professionals. It can be confusing with so many people walking around in white!
This makes for some unhappy professionals who earned doctorates in hospital administration, pharmacy, physical therapy and nursing, etc. who might prefer to be addressed as Dr. (Name) too. It’s my understanding that all of these professionals might well be addressed as Dr. (Name) in other situations (teaching or consulting, for example). But for patients in the doctor’s office, clinic, or hospital the practice of reserving Dr. (Name) for the physicians makes sense.

While this may all seem quite logical to most physicians and even the average layperson, many of those who have earned a doctorate in some health related profession feel strongly that they should be addressed as “doctor” since they have had a doctorate degree conferred on them, in spite of whatever confusion that the patient might experience.

So what is my point? We, as physicians, should make sure that we are not getting side tracked while chasing after a title. We must focus on regulations that insure quality, efficient care for our patients. What someone calls me is unimportant if my patients are getting the best care possible. We must also insure that others who are rendering care have this same motivation since there is already legislation that dictates all healthcare providers must identify themselves regardless of degree. While it is disappointing that the team oriented legislation proposed by the TMA was not passed and sent for a summer study, physicians must continue to look out for the best interests of our patients since at the end of the day we are the last line of defense.

As I thought about being called “Doctor” it came to mind that my grandchildren call me “Doc”, my employees call me “TC”, my children call me “Dad”, the members of my church call me “Dr. Tommy”, my mother when she was alive called me “my son THE DOCTOR” (she was overly proud), and my wife calls me “Dear”. Regardless of what I am called, I still have many jobs to fill, and in each arena, I must fulfill my role to the best of my abilities.

I close with a brief story from an earlier time in my life. I had completed the requirements for graduation from medical school and was helping my dad work on his house. While digging a ditch for a sewer line, I exclaimed to my dad that “I’m a doctor. Doctors don’t dig ditches.” He calmly asked the following series of questions. 1) Are you licensed to practice medicine in any state? 2) Can you write a prescription? 3) Does anyone call you doctor other than your mother? After I sheepishly replied “no” to each of his questions, he said, “Well then you are not a doctor! Get back to work!” Whatever situation you find yourself in - don't be blinded by a title, do good work.

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UTHSC – College of Medicine – Memphis Holds Match Day

The University of Tennessee Health Science Center – College of Medicine held its annual Match Day on Friday, March 18. Approximately 156 (out of 165 total) fourth year medical students and their families gathered at the Pink Palace and waited for the letters that would tell them where they will go next for their residencies. The M4 students joined their peers from across the country in simultaneously opening the envelopes that revealed their respective match locations. Of the 156 students participating in the match, 45 percent went into primary care (Family Medicine, Internal Medicine, Pediatrics and OB-GYN), 37 percent are staying in Tennessee, and 38 percent matched for residency and are remaining in the UT – Memphis / Jackson, TN program.

Strategic Planning Process Benefits Practices

by: Kathy Hunt
MSMGMA President

Many of us have participated in strategic planning sessions. There is the old adage, if you do not know where you are going, any road will get you there. In today’s healthcare world with such rapid changes, there is an ongoing need to take steps to identify strategic issues confronting our practices and to build awareness, participation and support for the direction among key stakeholders. National trends, local and regional influences, physician alignment, clinical integration, specialty specific issues, payer models, competition, population changes, and geographic distribution of services are some of the many issues to consider.

The strategic planning process includes developing action steps to improve areas and achieve the goals through a variety of driving strategies. Driving strategies are typically five to seven things the organization intends to do to accomplish its strategic intent and leverage its value proposition, the way the organization will differentiate itself from competitors in a way that is meaningful and valuable to the customers it serves.

Tactics are how each driving strategy will be accomplished. Tactics should be focused with five to seven to support each strategy. Timing, responsibility and resource requirements should be defined for each tactic. In doing so, we assess our marketplace and our own strategic position. Some organizations form strategic planning committees that are comprised of physician leaders, members of the executive team and sometimes community board members. Physician only forums can support this committee as a key planning group. In addition, you can broaden input through other individuals participating in focus groups, personal interviews, surveys and open forums.

MGMA, TMGMA and Mid-South MGMA have a number of resources that may be beneficial to your strategic planning process. Membership affords professionals additional networking opportunities to learn from each other and share ideas. There are also a number of great resources available through other state and community organizations, some at no charge. We invite you to attend our meetings and call if you think we may be of additional support.

Photos courtesy of UTHSC

(Above) Sherell Hicks, M4 shows off her match in emergency medicine to the University of Alabama - Birmingham

(Left) Rutviben Patel, M4 matched in ophthalmology at the University of Tennessee – Memphis and Keith Michael Nord, M4 matched in orthopedic surgery at the University of Arkansas – Little Rock

(Above) Sherell Hicks, M4 shows off her match in emergency medicine to the University of Alabama - Birmingham

(Left) Rutviben Patel, M4 matched in ophthalmology at the University of Tennessee – Memphis and Keith Michael Nord, M4 matched in orthopedic surgery at the University of Arkansas – Little Rock
Dr. Canale receives National Orthopaedic Award

S. Terry Canale, M.D. an orthopaedic surgeon who practiced at Campbell Clinic for the past four decades has received the prestigious William W. Tipton, Jr., M.D. Leadership Award. The honor was announced at the American Academy of Orthopaedic Surgeons (AAOS) annual conference that was held in Orlando in March. The award is among the highest recognition bestowed by any national healthcare academy. It is a lifetime achievement honor that recognizes fellows or members who have demonstrated outstanding leadership qualities that have led to benefits for the orthopaedic community, patients and the American public. Dr. Canale is a past president of both the AAOS, as well as the Pediatric Orthopaedic Society of North America (POSNA).

Dr. Kelly selected for POSNA Fellowship

Derek Kelly, M.D. a pediatric orthopaedic surgeon at Campbell Clinic was one of three physicians in North America who was recently selected to be a traveling fellow by the Pediatric Orthopaedic Society of North America (POSNA). This prestigious fellowship included visiting three to four European medical centers this spring, as well as attendance at the annual European Pediatric Orthopaedic Society (EOPS) meeting in Rome.

Dr. Ensor elected Vice-Chairman of TMA Board

James K. Ensor, Jr., M.D. an internist at Germantown Wellness and Internal Medicine was elected Vice-Chairman of the TMA Board of Trustees (BOT) at the Tennessee Medical Association’s annual meeting in April in Murfreesboro. Dr. Ensor was elected to serve on the TMA BOT in 2015. He has held various leadership positions with the Memphis Medical Society (MMS). He served on the MMS Grievance Committee from 1997-2004, Ethics Committee (1991, 1993 and from 1997-2001), was a board member from 2004 – 2011 and a past president (2010) of the Society. Dr. Ensor has served as a TMA delegate from the Society from 2005 to present. He also serves on the TMA legislative committee. Dr. Ensor is a past president of the Memphis Academy of Internal Medicine.

Dr. Beaty named chair of UT-Campbell Clinic Department of Orthopaedic Surgery and Biomedical Engineering

James H. Beaty, M.D. a pediatric orthopaedic surgeon at Campbell Clinic has been named chair of the UT-Campbell Clinic Department of Orthopaedic Surgery and Biomedical Engineering in the College of Medicine at UTHSC – Memphis. He was also awarded the Harold B. Boyd, M.D. Professorship in Orthopaedic Surgery. Dr. Beaty, a UTHSC alumnus, is the ninth department chair since its founding in 1911. He will oversee the day-to-day operations of the department. Dr. Beaty is a past president of the American Board of Orthopaedic Surgery, the Pediatric Orthopaedic Society of North America, the Mid-America Orthopaedic Association and the Tennessee Orthopaedic Society. He is a member of the American Academy of Orthopaedic Surgeons, for which he also served as president in 2007-2008.
What would you tell your son or daughter if they said that they want to be a doctor? For those of you who have practiced over a decade, would your answer be the same today as it would have been ten years ago? Most of us would agree that practicing medicine today is much different than it was as recently as ten years ago. But some things have not changed. Physicians continue to care deeply about the quality of care that their patients receive. We still view ourselves as the patient’s advocate. Like those before us, we stand up for the patient when something the hospital or insurer does is not in the best interest of the patient. In many ways, what is different today is that insurers have started to focus on quality too. So why aren’t we celebrating?

Are insurers in a position to determine what constitutes quality patient care? That answer is an easy “no.” But even the insurers agree on that point. To their credit, CMS and other insurers have relied on organizations like the Agency for Healthcare Research and Quality (AHRQ) which invests in research and evidence to generate measures and data used to track and improve performance on making U.S. healthcare safer and better. Significant opportunities exist for embracing these metrics and reducing the burden of reporting quality data. But our passion for quality patient care is headed to the next level as evidence-based quality metrics are used to measure and compare the quality of care rendered by each physician and each hospital. If we really care about quality, each of us must be willing to be held accountable for the quality we provide. Patients already have access to these metrics allowing them to make a more informed decision about where they go for their healthcare.

**Improving quality while decreasing cost**

Why does this country spend over twice as much of our GDP on healthcare as other advanced countries? Why do we spend three to five times as much for elderly healthcare as Germany, the UK, Sweden or Spain? With over sixty million Baby Boomers entering Medicare, there will be more elderly patients for whom reimbursement will be at Medicare rates. No, the cost of healthcare will not doom the U.S. economy. The house of medicine is already evolving to make certain that this does not happen. The good news is that the overall cost of healthcare can be reduced without decreasing physician reimbursement. By leveraging technology, applying engineering efficiency models (lean six-sigma, the Toyota model, etc.) and using mid-level providers, physicians are already becoming more efficient. Most importantly, quality can be increased at the same time that costs are reduced.

**The Intersection of Technology and Medicine**

While some of us struggle to get comfortable with the electronic health record (EHR), interns and residents expect it and depend on it. There is no denying that the EHR has markedly reduced the time it takes to get the old chart, find test results, or order and receive a medication. The data entered can be programmed to provide instantaneous feedback on how we are doing. Hours of manual data extraction are no longer necessary. Changes in behavior are much more likely when feedback is delivered on the spot instead of several months later. Sure, there are opportunities to refine both the system and our workflows. But we are in the early stages of this journey and we have the benefit of tapping into the successes already achieved by many other industries.

Technology is also helping patients become more responsible for their own health. Patient portals provide instant access to their personal medical records. When patients are alerted the moment their test results are back and they can schedule an appointment with their doctor any time of day from their cell phone, they naturally become more engaged. Video visits with their doctor or instant video visits with a doctor on call save both time and money with a dramatic increase in patient satisfaction.
Technology is also providing specialty care where none existed thanks to telemedicine. Using telecommunication technologies and medical devices that can be controlled remotely, physicians are able to provide virtual medical services. Not only are individual patients able to be evaluated by specialists remotely, but highly trained and experienced nurses and physicians are able to provide care to hundreds of ICU patients in different locations all at the same time. Enhancements in how data is visually presented make this possible.

**Focusing on People and their Processes**

Successful integration of healthcare and technology requires a renewed focus on the health care team and their processes. Many health systems are tailoring highly successful practices used in other industries to become more efficient and effective in delivering healthcare. Our hospitals and clinics are starting to dig deep to fully understand what we are actually doing today so that we can run rapid cycle experiments and measure their effect on increasing our efficiency and quality at the same time we decrease our costs. The entire team is given the freedom to propose a change and collaborate on testing the impact of that change. Positive results become infectious and stir the competitive juices in others to come up with an even better idea.

**Putting it all Together**

Any one of these changes, by itself, holds great promise. For those who successfully combine these innovations, the future of healthcare is bright, very bright!

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John C. “Jack” Brown, M.D. is the Chief Medical Information Officer for Baptist Memorial Healthcare Corporation (BMHCC) – Memphis. Dr. Brown serves as a key member of the BMHCC leadership team. In his current position, he is responsible for providing clinical support in developing and implementing electronic information systems in Baptist’s fourteen hospitals and over one hundred clinics in West Tennessee, East Arkansas and North Mississippi. Dr. Brown received his medical degree from Indiana University School of Medicine. He completed his residency in emergency medicine at Methodist Hospital – Indianapolis, Indiana. Dr. Brown may be contacted at (913) 689-8782 or jack.brown@bmhcc.org.
Value Engineering Your EMR Interfaces

by: Cameron Brackett
Executive Director
MidSouth eHealth Alliance

Payers, registries, TN Health & Finance, technology vendors, providers and many more are starting to knock on your door asking for an interface to your system. It is very important for you to recognize not just the initial cost to set up, but the year-over-year cost to maintain. In addition to the cost, one must be cognizant of the issues related to maintaining the integrity of the data as it is passed to a variety of systems.

Value Engineering is a concept that all device makers, such as GE, Honeywell, Siemens, Philips and others employ to reduce the cost of their product while not sacrificing quality, specifications and production. For example, if company X is making 100,000 widgets per month, and the company is able to remove $1 from the widget, an annual savings of $1.2M can go back into the business for growth. This same concept can be applied to population health. The standardization of healthcare for a given population may have room for improvement without sacrificing quality of care – returning dollars back to the business.

Unfortunately, I do not see this concept employed in providers’ technology infrastructure. The most common miss is interfaces to other systems. Each interface has not only an associated cost, but a year-over-year maintenance cost. A practice should review its interfaces to look for areas of value engineering. Health Information Exchanges, such as the MidSouth eHealth Alliance, can provide an opportunity wherein the practice could connect once and off-load the burden and cost of many other interfaces being requested of them to MidSouth eHealth Alliance.

If you played the telephone game as child, you can appreciate how information can become scrambled as it passes from one person to the next. This can occur in computer systems. While there are many reasons why this occurs, two significant reasons are; specific data mappings and time in which data is sent. The more you try to specify your data outside defined standards, the greater the risk of the receiving system dropping or misinterpreting the data.

While this may all be readily apparent, many organizations do not take the time to evaluate. It is good practice to annually review your IT infrastructure costs to look for value engineering opportunities. This cannot only save costs, but also help mitigate security risks and reduce data integrity issues as you transmit data to other systems. For more information, contact Cameron Brackett, Executive Director of the MidSouth eHealth Alliance at (901) 866-1382 or cbrackett@memphisbioworks.org.

Mr. Cates Announces Retirement

Michael Cates, CAE, Executive Vice President of The Memphis Medical Society has announced his retirement. Mr. Cates has led the Memphis Medical Society since 1985. Prior to that, he spent ten years with the North Carolina Medical Society and Mecklenburg County Medical Society in Charlotte, N.C. His leadership and community service distinctions include helping to establish the Mid-South chapter of the Medical Group Management Association, serving on the Dean’s Advisory Committee for the University of Memphis School of Public Health, serving on the board of the Mid-South eHealth Alliance, the first regional health information exchange throughout Memphis hospitals, and serving on the Advisory Committee of the Common Table Health Alliance (formerly Healthy Memphis Common Table). Mr. Cates is a Certified Association Executive by the American Society of Association Executives. He is also a former AAMSE board member and active committee participant, and former president of the Tennessee Society of Association Executives. He has been honored with the 2015 AMA Medical Executive Lifetime Achievement Award and the 2013 Outstanding Alumnus Award by his alma mater, Campbell University in
About the Anorectal Physiology Center

Functional bowel disorders, including constipation, incontinence and prolapse affect millions of Americans each year. Many people fail to seek care or treatment for these conditions because they are too embarrassed.

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Since the development of robotic surgery, gynecologic and urologic surgeons have taken advantage of its ability to improve on laparoscopy in providing minimally invasive surgery. Only in recent years has its applications been integrated into general surgery. Throughout the country, robotic surgery has been increasingly utilized in cholecystectomy, hernia repairs, and colorectal surgery. Recently, Memphis has welcomed this same movement. Robotic surgery provides a three-dimensional improvement in visualization, zoom, and camera stability as well as angulating instruments, which allows complete surgeon-controlled retraction and dissection. This technology has allowed for improvements in the ease of single-site surgery – such as robotic single site cholecystectomy – and in multiport pelvic dissection in minimally invasive colorectal, decreasing conversions to open resections with larger incisions.

These advantages translate into minimizing incision size, minimizing pain and discomfort, faster recovery of bowel function, and minimizing length of stay for our patients. We are proud to offer these advances in our general surgical practice with robotic cholecystectomy, hernia repairs, and colon resections. Below, I will highlight some of the recent advances in these operations that have allowed us to improve patient satisfaction and outcomes.

**Cholecystectomy**

Diseases of the gallbladder can vary from symptomatic cholelithiasis to gallbladder dysfunction with decreased ejection fraction, or from an acutely inflamed gallbladder to pancreatitis resulting from gallstones. All of these disease processes can be treated with the assistance of robotic surgery in performing cholecystectomy. Robotic surgery minimizes complications through better visualization of the critical view of safety in our dissection of important structures. In selected patients who are candidates, cholecystectomy can even be performed through a single site 2.5cm incision that can be hidden in the umbilicus, using a single site port, reducing the appearance of scarring and improving cosmetics of healing from the surgery itself.

**Hernia repair**

In this area, the most beneficial advantages in our practice have been seen with hiatal hernia repairs. Patients often present with reflux and even, in the more severe cases, dysphagia and more severe symptoms. The advance of the camera zoom allows better visualization of the hiatus and improves dissection and repair, compared to previous laparoscopic or open approaches. Additionally, the technology has been applied to ventral and other types of hernia repairs.

**Colorectal surgery**

Whether it is a polyp that is unresectable endoscopically or a colon cancer that is discovered on colonoscopy or diverticular disease requiring resection, these resections can be performed with the assistance of robotic surgery. Recent advances of the vessel sealer and robotic stapler with its smart clamp technology have allowed for intracorporeal anastomoses of the remaining colon with ease and minimize the size of the surgical incision.

At Memphis Surgery Associates, we are proud to offer these services in our practice and continue to work on integrating the best technologies to improve our patient outcome and satisfaction.

Sirinya Prasertvit, M.D. is a board certified general surgeon who recently joined Memphis Surgery Associates. Dr. Prasertvit was born and raised in Baton Rouge, Louisiana. Also, she spent part of her childhood in Thailand where her parents were born. She earned her undergraduate degree from Penn State University. She graduated from the University of Tennessee - College of Medicine - Memphis. She completed her residency in comprehensive general surgery at the UTHSC - Memphis. Her practice involves the diagnosis and treatment of a large variety of general surgical diseases. She is a member of the American College of Surgeons, Tennessee Medical Association, and Society of American Gastrointestinal and Endoscopic Surgeons. She considers it a privilege to take care of her patients and their families like she would her own family. After completing the majority of her training here in Memphis, she considers herself an adopted Memphian. Outside of medicine, she is an avid college football fan and enjoys food whether it be cooking or trying new restaurants and recipes.
Baptist Medical Group opens Outpatient Care Center

Baptist Medical Group recently opened the BMG-Outpatient Care Center, giving Mid-South physicians and their patients a more convenient option for diagnostic testing, rehab services, and diabetic education. The outpatient care center is in tune with Baptist Medical Group’s commitment to grow with the community to meet the ever-changing health care needs of families.

The center’s staff of 80 to 100 employees provides access to diagnostic services, therapies, and diabetic education for approximately 150-200 patients per day who visit the center. Most major insurance plans are accepted, further enhancing accessibility for patients. Baptist Medical Group-Outpatient Care Center is located at 2100 Exeter Road in Germantown. Services offered include:

- **Diagnostic Imaging Center:** Appointments are available Monday through Friday for MRI, CT, Ultrasound, X-ray and Modified Barium Swallow.
- **Outpatient Rehabilitation Care:** Comprehensive services include physical, occupational and speech therapies for adult and pediatric patients.
- **Next Step Program:** Intensive rehabilitation for stroke and brain injury patients; sessions are held three to five days a week.
- **Pediatric Rehabilitation:** Pediatric specialists provide physical, occupational and speech therapy to infants, children and adolescents in a dedicated pediatric setting.
- **Diabetes Education Center:** Educational classes and programs recognized by the American Diabetes Association are available to Type I, Type II and pediatric diabetics and expectant mothers with gestational diabetes.

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Bridging the Divide of Cyber Security Risks with Technology Adoption and Physician Satisfaction

by: Robert Hanson

The assertion that “healthcare is under attack” is an understatement. The cyber threats facing healthcare providers today are the most challenging in history. According to a study by the Ponemon Institute, criminal data breaches against healthcare providers have more than doubled in the past five years, as evidenced by the compromise of 120 million individuals’ healthcare information since 2009 (Department of Health and Human Services). Even more alarming, over 96 million data breaches occurred in the last 18 months. As stated in a Washington Post article, “2015 is the year of the healthcare hack—and it’s only going to get worse.”

With intense public awareness of cyber threats in the forefront, healthcare is moving out of the “shock and awe” phase and into the liability phase. This transition, coupled with HIPAA pressure, is applying greater liability exposure and demand on hospitals and physicians to step up efforts to protect the personal information in their possession. Intensifying the spotlight are recent ransomware attacks (malware that denies access to a device or files until a ransom is paid). The first ransomware hospital victim highlighted in the news was breached in February 2016 and paid $17,000 in bitcoins (a form of cryptocurrency stored in anonymous, untraceable digital wallets) for the key to unlock their encrypted files. Since then, 11 more hospitals and 250 outpatient clinics have been hit by ransomware.

At first glance, one would think that HIPAA-compliance would safeguard provider data and networks. It helps to have basic security technologies in place like firewalls, spam and spyware filters, and encryption, but as the breaches pile up and the threats multiply, cyber security becomes harder to achieve. The experts agree; the tried-and-true principles of “people, process and technology” are the best defense, with technology taking a leading role by filling the gap where humans fail.

According to Verizon’s 2015 Data Breach Investigation Report, the weakness of passwords is the main cause of network exploitation, with 95% of intrusions occurring from stolen credentials. Another major culprit of breaches is “phishing”, a form of fraud in which an attacker tries to learn information, such as login credentials, by masquerading as a reputable entity in email, instant messaging or other communication channels. An attachment or link in the message may install malware on the user’s device or direct them to a malicious website.

There is no silver bullet to achieve impregnability to cyber-attacks. However, there are contemporary technologies that considerably increase the level of protection from hackers accessing passwords, communication systems and networks. “Mobile Biometric Authentication” (i.e., SafeShield™) is such a technology, requiring only fingerprint touch on your smart phone to access systems without the need for passwords. This process increases security exponentially, while significantly improving physician login efficiency, workflow and satisfaction. Mobile biometrics also drastically decreases IT support calls for password resets, which is the number-one help desk call in hospitals. In addition, private communication platforms that integrate text, email, chat and social software in one system (i.e. ShareSafe) can significantly increase security and user satisfaction.

The new landscape for healthcare providers is to operate as though they are in a continuous state of compromise and have real-time surveillance of their networks, EHRs and communication systems. In addition, constant education for staff and physicians on security risks is essential in adapting to ever-changing threats. Combining innovative and well-designed technology that aligns with the workflow of physicians, nurses and staff and can operate in synchrony with legacy IT systems is the next-generation tool to help mitigate security risks. Visit www.sharesafesolutions.com for more information.

ShareSafe’s Unified Platform is a breakthrough in technology that integrates security, communication, education and accountability. ShareSafe’s convergence technology allows your organization to access a suite of applications built around your needs at the time that you need them. The cloud-based system offers a collection of modular products that takes previously separate modes of communication, information and content and integrates them into a single platform—allowing for synergistic interaction. Elastic and extensible, ShareSafe’s technology can be used to shape and grow your organization in ways never before available.
Be treated by the best.

METHODOIST HOSPITAL NAMED BEST BY U.S. NEWS

It's recognition for unsurpassed excellence that so many in Memphis recognized long ago. For the fifth year standing, Methodist’s Memphis Hospitals are proud to be ranked Best in the Memphis metro area by U.S. News & World Report. In addition to this top recognition, we are recognized as high performing for Nephrology and Neurology/Neurosurgery. This honor is the gold standard in rankings for healthcare and a testament to our talented physicians, nurses, partners and Associates who truly believe that being the best starts with putting the patient first.

Be treated well. Methodist Healthcare

Go online to see the full story: MethodistHealth.org/Best
Question: I recently received a notification from my IRA custodian that outlined industry changes to money market mutual funds. Is this something I need to be concerned about?

Answer: During the 2008 financial crisis, a large money market fund (Reserve Primary Fund) broke the buck and fell below the standard net asset value (NAV) of $1 per share. The widespread panic on money market funds forced the U.S. Treasury and Federal Reserve to guarantee money market fund redemptions. In 2010, the Securities and Exchange Commission (SEC) introduced structural changes for money market funds that mandated liquidity levels, stronger credit quality requirements, shorter portfolio maturities, and stress testing. After further discussions, the SEC agreed upon additional regulations designed to increase transparency and further protect money market investors. These changes are scheduled for implementation by October 2016 and include the following:

1. Defining the distinction between “Retail” and “Institutional” prime and municipal money market funds, and creating a new definition for government money market funds.
2. Adjusting the daily pricing of Institutional prime and municipal money market from a fixed to a floating NAV.
3. The implementation of liquidity fees and redemption gates on all non-government money market funds.

The definition for retail accounts will limit owners to natural persons (an investor associated with a social security number). Examples of a retail account include individual brokerage accounts, retirement accounts, college savings plans, health savings plans, and some trust accounts. Institutional accounts will be defined as those associated with a Tax ID number where the beneficiary is not a natural person. Examples include small business accounts, defined benefit plans, endowments, and other accounts not owned by a natural person. Government money market funds will be defined as those that invest 99.50% of total assets in cash, government securities, or repurchase agreements collateralized by government securities. Retail and Government money market funds will be exempt from the floating NAV rule and will stay fixed at $1 per share. Unfortunately, a floating NAV means that cash invested in an institutional money market fund could lose value.

The implementation of liquidity fees and redemption gates affect both retail and institutional non-government money market funds. A redemption liquidity fee of 1% will be charged if the weekly liquid asset level fell below 10% of total assets. If the weekly liquid asset level falls below 30% of total assets, the fund will be allowed to charge up to a 2% fee and could temporarily suspend redemptions up to 10 business days during a 90 day period. Only government and U.S. Treasury money market mutual funds will be eligible for a fixed NAV and no liquidity fees or redemption gates.

The vast majority of investor money market funds will be classified as retail, so the impact will be minimal. However, you should consult your account custodian for clarification and additional information. Based on the new liquidity rules, I also recommend you seek the advice of a financial professional in your area for adjustments to any long-term cash management strategy you might have.
TMA 2016 Legislative Recap

**TMA Bills:**
- **In-Office Dispensing** - Passed – This law will allow physician practices that have in-office dispensaries to continue to dispense controlled substances. Those particularly benefitting by the legislation are pediatric practices and practices which treat workers' compensation patients.
- **Silent PPO** – Passed – This law gives new enforcement authority to the Workers’ Comp Bureau when a payer violates the workers’ compensation silent PPO statute.
- **Healthcare Provider Stability Act** – The House failed to adopt the conference committee report by 5 votes. Senate sponsor, Bo Watson, has vowed to file a similar bill next year.
- **Tennessee Healthcare Improvement Act/Team-Based Care** - Taken off notice after both the Senate and the House decided to create a task force to look at the issue.
- **Constitutional Amendment to Require Caps on Medical Malpractice Suits** - Coalition chose not to pursue the issue after the administration said it would oppose it. The governor’s office believes that the Tennessee Supreme Court will uphold the constitutionality of caps on non-economic damages, and did not want an amendment filed that might cast doubt about the laws in the minds of the members of the Court.

**Issues sent to Summer Study:**
- Patients for Fair Compensation
- Balance Billing
- Nurse Task Force

**Other Bills on which TMA Advocated:**
- **Prescription Safety Act** – Passed - Renews and revises the law that passed in 2012 that requires queries to the controlled substance database, among other requirements.
- **CMV** – Passed - The new bill only requires a physician's office to hand out info on CMV. TMA stopped onerous previous versions that would require physicians to educate patients on CMV.
- **Right to Earn a Living** – Passed - Requires government operations committees to review rules from all departments, councils, etc. except for health related boards and healthcare facilities. TMA got health exempted because it could have led to easier passage of unsafe scope of practice laws and rules.
- **TennCare Technical Advisory Groups Continuation** - Passed - Ensures that the TAG recommendations are reported to the General Assembly along with information about whether their recommendations were accepted.
- **Pain Clinics** - Passed - Requires pain clinics to be licensed before they can operate. It gives the Department of Health the authority to inspect medical practices to determine if they are a pain clinic that has avoided the licensure process. It must have probable cause to suspect that the practice may be operating as an unlicensed pain clinic.
- **Certificate of Need** - Passed - The law is updated and removes the requirement that a CON is required for MRI machines in counties with a population of 250,000 or more.
- **Med Spas** – Passed – Makes it clear that only physician practices that advertise as a med spa or are primarily engaged in cosmetic medical procedures must register with the state.
- **OTC Oral Contraceptives** – Passed – TMA and the Tennessee Pharmacist’s Association worked on an amendment that permits pharmacists to dispense contraceptives as long as such authority is written into a collaborative practice agreement with a physician.
- **Motorcycle Helmet Repeal** – Failed.
The 109th General Assembly has adjourned sine die. As citizen legislators, we’ve all got different backgrounds. As I have written here previously, the Tennessee Senate is especially well represented by those in the medical field. We have four doctors, two pharmacists and one physical therapist. With their help and experience, the Senate has worked hard to increase access to meaningful healthcare at a reduced cost to patients.

Several bills enacted this year address specifically how patients interact with their personal physicians. The “Health Care Empowerment Act” removes state roadblocks to the growing Direct Primary Care (DPC) healthcare model. Under the DPC model, patients pay their doctors a monthly fee in return for agreed-upon primary care services. In order to be Obamacare-compliant, a patient may supplement a DPC membership with a high-deductible "catastrophic" insurance policy. The combined cost of monthly membership fees and insurance premiums is anticipated to be substantially lower than a traditional health insurance plan with co-pays, deductibles, and premiums.

Another new law provides that coverage and reimbursement for telehealth services cannot be impacted by the geographical location of the patient. Also this year, lawmakers voted to give women more convenient access to birth control by allowing them to go directly to a pharmacist to get a prescription. The new statute applies to women over the age of 18 and emancipated minors.

The General Assembly also worked to ease the burdens on those medical providers who serve in free clinics. One such law will allow civil immunity to persons who are involved in the free distribution of eyeglasses. Another helps ease the burden of rural free clinics by authorizing nurse practitioners or physician assistants who practice in such clinics to arrange for required chart reviews by a supervising physician in the physician's office or remotely via HIPAA-compliant electronic means instead of at the clinic site. Further, the General Assembly has enacted legislation allowing charitable clinics to directly employ physicians, optometrists, ophthalmologists, dentists and psychologists to continue to allow the organizations to provide access to comprehensive health care services to the most vulnerable citizens of the state.

When the 110th General Assembly convenes in January, we will continue to work to increase access to meaningful healthcare at reduced costs to patients.

Senator Norris practices in commercial litigation and business matters with Adams and Reese, LLP. He is Senate Majority Leader and represents West Tennessee in the state senate.

For more information on the firm, visit www.adamsandreese.com.

“...the Tennessee Senate is especially well represented by those in the medical field. We have four doctors, two pharmacists and one physical therapist. With their help and experience, the Senate has worked hard to increase access to meaningful healthcare at a reduced cost to patients.”
**NEW SERVICE!** E-versions of these books (and any other printed materials you offer to your patients or peers) are available. This can get your literature in front of your email contacts instantly.
The title of this article implies that there is competition to own or purchase healthcare real estate. To a certain extent that is probably true. Large properties and campuses are still in the sights of larger REITs and values have continued to increase in many areas. Individual properties are still of interest to smaller investors as well.

Another component of healthcare real estate is to ensure that your property is addressing what patients, your customers are expecting and in some instances demanding. As more Americans have access to health insurance and more people are living longer, there is more opportunity for expanding your practice. But, you may also be in competition with other providers for the same services and the very same patients.

As you consider your current facilities or new properties, keep some emerging trends in mind. Innovative designs and proximity to patient homes are important factors. Suburban options are increasing in terms of numbers and patient interest. Ample and close proximity parking for ease and safety reasons may influence decisions. A single location where all services are “under one roof” can allow patients to have multiple appointments, which is more convenient. This design can also be helpful to keep costs down and efficiencies up.

The importance of expert property management is something else to consider. This item has always been important, but this area of healthcare real estate ownership is more vital because of increase in costs, compliance and healthcare laws and regulations. Enforcement of current laws and increase in concerns over air and water quality has become more important. Environmentally friendly building materials and sustainable properties are also under more scrutiny. As always, please carefully consider your real estate team prior to making any long range decisions about your real estate.

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The TMA recognized Jerre Minor Freeman, M.D. with their Outstanding Physician Award at their recent annual meeting. The award is given each year by the TMA House of Delegates to member physicians who through their illustrious medical career make an impression among their colleagues, peers and on the profession of medicine. Dr. Freeman, an ophthalmologist at Memphis Eye & Cataract Associates (MECA) has been a leader in the Memphis medical community for over fifty years. He has worked tirelessly to promote and advocate better vision on the local, national and international levels. In 1978, Dr. Freeman founded the World Cataract Foundation (WCF), a nonprofit, international charitable foundation, the mission of which is to help combat the vast problems of cataract blindness in developing countries. Through his work with the WCF, Dr. Freeman, along with volunteer surgical teams has traveled extensively to teach and perform cataract surgery in numerous countries that have included, among others, China, Mexico, India, Pakistan, Kenya, South Africa, Egypt and Russia. Dr. Freeman has been involved in various organizations including past president of The Memphis Medical Society (1998), and past president of the American Board of Eye Surgery (2001–2003).

Dr. Freeman honored with TMA Outstanding Physician Award

A Step Ahead Foundation (ASAF) was a winner of the TMA’s Community Service Award, given annually to persons or organizations who contribute significantly to the advancement of public health in their respective communities. ASAF was founded in 2011 by Claudia Haltom, Esq., a former City of Memphis Juvenile Court Judge. The Foundation’s mission is “to offer women of Memphis and Shelby County free, long-acting reversible contraception (LARC) – the most effective method of birth control, thus preventing unplanned pregnancies”. The organization is dedicated to recognizing and providing financial support for promising young women from the greater Memphis community who are committed to public service in the areas of academic success, and effective, responsible life planning. The program awards multiple scholarships to young women who plan to pursue a career in public health or social services, and who will promote a wider understanding and use of the most effective contraceptives to assist Memphians in planning their lives and achieving their education and career goals.

receives TMA Community Service Award

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In March, The University of Tennessee College of Medicine introduced the world’s most comprehensive Mobile Stroke Unit, capable of conducting advanced quality imaging for stroke diagnosis and noninvasive CT-angiography with a Siemens SOMATOM® Scope CT scanner. This is the first time CT capabilities of this magnitude have been available in a mobile setting creating the ability to quickly diagnose and treat patients. Healthcare workers onboard can launch treatment including tPA and blood pressure drug nicardipine within the critical first hour timeframe. Patients treated in the Mobile Stroke Unit will often be taken to the hospital’s Neuro ICU, Cath Lab or Stroke Unit for treatment, bypassing the Emergency Department.

“If we eliminate the treatment delay getting to and through the emergency room, we can save up to 90 minutes. Time is brain, so the more time we save, the less likely it is that permanent brain damage will occur in a patient. Our hypothesis is that we will deliver hospital-level standard of stroke care faster, equally safe, but with better outcomes due to the ability to intervene much earlier -- less than one hour from symptom onset,” said Andrei V. Alexandrov, M.D. the Chairman of the Department of Neurology at The University of Tennessee Health Science Center and Semmes-Murphey Professor. “Our ‘time to treatment' target is less than one hour from symptom onset.”

The Mobile Stroke Unit, weighing in at 14 tons, has capabilities never before assembled for mobile deployment including a hospital-quality CT scanner with advanced capabilities to conduct brain and blood vessel imaging. Other Mobile Stroke Units use smaller portable CT scans that only image the brain (without vessels) and require the team to move the patient for each slice (image) that is taken. UT’s Mobile Stroke Unit provides the same number of slices in high resolution as obtained in the hospital setting because it is equipped with a dedicated gantry that automatically moves the patient to obtain images.

It is the largest Mobile Stroke Unit in the world, complete with an internal power source capable of matching regular electrical outlet access. The Mobile Stroke Unit is also the first to be staffed with stroke fellowship-trained, doctorally-prepared nurses certified as advanced neurovascular practitioners, ANVP-BC. “We have a tremendous burden of stroke in Memphis, with a stroke rate per 100,000 people that is 37 percent higher than the national average,” said David Stern, M.D., the Robert Kaplan Executive Dean and Vice-Chancellor for Clinical Affairs for The University of Tennessee College of Medicine and The University of Tennessee Health Science Center. “The goal of the Mobile Stroke Unit is to minimize mortality, to have more patients walk out of the hospital fully functional.”

Dr. Anderson installed as 2016-2017 TMA President

Keith G. Anderson, M.D. a cardiologist at Sutherland Cardiology was installed as the 162nd president of the Tennessee Medical Association during the annual TMA House of Delegates meeting in April in Murfreesboro. As the TMA’s president, Dr. Anderson will serve on the TMA Board of Trustees, which is responsible for implementation and direction of Association activities between sessions of the House of Delegates, the Association’s governing body. He will also serve as the public spokesman and official representative for the TMAs nearly 8,500 physician members. Dr. Anderson is a former speaker of the TMA House of Delegates and a past president (2008) of the Memphis Medical Society (MMS). He served on the MMS Legislative Committee from 1997-2002 and as a TMA delegate from the Society. He also served on the TMA’s Strategic Planning Oversight Committee in 2010.
Correction:

The spring issue incorrectly listed the medical school for new board member, David L. Cannon, M.D. Dr. Cannon received his medical degree from Cornell University Medical College. We apologize for this error.

As many of you know, Nancye Elizabeth Hines died on April 15, 2016. She was the wife of Leonard H. Hines, M.D. Dr. and Mrs. Hines had relocated to East Tennessee, after residing in Memphis for forty years. During that time, Mrs. Hines served as president of the Memphis and Shelby County Medical Society Alliance in 1987 – 1988. Also, she was president of the Tennessee Medical Association Alliance in 1997 – 1998. Mrs. Hines was a sincere advocate for organized medicine. She will be truly missed.
NEW MEMBERS

Seema Abbasi, M.D.
Pediatrics
BMG River City Pediatrics
6401 Poplar Avenue, Ste. 610
Memphis, TN 38119
901-761-1200
Dow International Medical College, 1988
University of Texas — Houston (R-PD)
University of Tennessee — Memphis (F-PD)

Abdullah N. Abdullah, M.D.
Anesthesiology
Medical Anesthesia Group, PA
1755 Kirby Parkway, Ste. 330
Memphis, TN 38120
901-725-5846
University of Tennessee, 2008
University of Virginia — Richmond (R-IM)
University of Tennessee — Memphis (R-IM)

Bolanle M. Adamolekun, M.D.
Neurology
Wesley Neurology Clinic, PC
1211 Union Avenue, Ste. 400
Memphis, TN 38104
901-725-8920
University of Ibadan, 1979
Southern Illinois University — Springfield (R-IM)

Arthur L. Bellott, III, M.D.
Internal Medicine
Inpatient Physicians of the Mid-South
6263 Poplar Ave, Ste. 1052
Memphis, TN 38119
901-761-6157
University of Tennessee — Memphis (R-IM)

Jeffrey A. Blalock, M.D.
Anesthesiology
Medical Anesthesia Group, PA
1755 Kirby Parkway, Ste. 330
Memphis, TN 38120
901-725-5846
University of Tennessee — Memphis (R-IM)

Joseph Patrick Blankinship, Jr., M.D.
Radiology
Memphis Radiological, PC
7695 Poplar Pike, Ste. 101
Germantown, TN 38138
901-685-2696
University of Tennessee, 2008
University of Tennessee — Memphis (R-RAD)

C. Christopher Brown, M.D.
Ophthalmology
Eye Specialty Group
825 Ridge Lake Blvd, Ste. 200
Memphis, TN 38120
901-685-2200
Case Western Reserve University, 2005
University Hospital Cleveland (R-OPH)

Andrew W. Crothers, M.D.
Ophthalmology
Eye Specialty Group
825 Ridge Lake Blvd, Ste. 200
Memphis, TN 38120
901-685-2200
Southern Illinois University, 2007
University of Virginia — Richmond (R-OPH)

Ravis B. Curry, M.D.
Pulmonary Diseases
Memphis Lung Physicians Foundation
6025 Walnut Grove Road, Ste. 508
Memphis, TN 38120
901-767-5864
East Tennessee State University, 2000
Wayne State University — Detroit (R-PD)
Wayne State University — Detroit (F-PMR)

Gregory W. Fink, M.D.
Thoracic & Cardiovascular Surgery
The Cardiovascular Center
7655 Poplar Ave, Bldg. A, Ste. 350
Germantown, TN 38138
901-761-2470
Tennessee State University, 2011
University of Arkansas — Jonesboro (R-FM)

Leah Christine Fryar, M.D.
Family Medicine
Inpatient Physicians of the Mid-South
6263 Poplar Ave, Ste. 1052
Memphis, TN 38119
901-761-6157
University of South Florida — Tampa (R-OPH)

Judith R. Lee-Sigler, M.D.
Physical Medicine & Rehabilitation
Tabor Orthopedics
1244 Primacy Parkway
Memphis, TN 38119
901-767-8662
Tennessee University School of Medicine, 1986
Schwab Rehabilitation Ctr. — Chicago (R-PH)
Schwab Rehabilitation Ctr. — Chicago (F-PH)

Mubasher E. Malik, M.D.
Rheumatology
BMG Rheumatology
6025 Walnut Grove Road, Ste. 301
Memphis, TN 38120
901-225-4770
Medical Univ. of the Americas, 2010
Michigan State University — Grand Rapids (R-IM)

JASON L. McKEOWN, M.D.
Anesthesiology
Medical Anesthesia Group, PA
1755 Kirby Parkway, Ste. 330
Memphis, TN 38120
901-725-5846
University of Tennessee — Memphis (R-IM)

Catherine Anne Munn, M.D.
Internal Medicine
Jenkins and Nease Internal Medicine
8138 Country Village Drive
Cordova, TN 38016
901-260-3100
University of Tennessee, 2012
University of Tennessee — Memphis (R-IM)

Dana Ann Nash, M.D.
Family Medicine
Inpatient Physicians of the Mid-South
6263 Poplar Ave, Ste. 1052
Memphis, TN 38119
901-761-6157
University of Tennessee, 1999
University of Tennessee — Memphis (R-FM)

Luke T. Peterson, M.D.
Ophthalmology
Eye Specialty Group
825 Ridge Lake Blvd, Ste. 200
Memphis, TN 38120
901-685-2200
Emory University School of Medicine, 2010
Emory University — Atlanta (R-OPH)
Emory University — Atlanta (F-OPH)

Andrew S. Pierce, M.D.
Internal Medicine / Pediatrics
Methodist University Hospital
1265 Union Avenue
Memphis, TN 38104
901-372-3200
University of Tennessee, 1976
University of Tennessee — Memphis (R-PD)

Mark L. Reed, M.D.
General Practice
Covington Pike Medical
3789 Covington Pike
Memphis, TN 38135
901-227-9870
Texas A&M University, 2000
Indian University — Indianapolis (R-FM)

John A. Sandoval, M.D.
Pediatric Surgery
BMG Pediatric Surgery
6215 Humphreys Blvd, Ste. 300
Memphis, TN 38120
901-685-2200
University of Cincinnati, 1975
Baylor University — Dallas (R-OPH)

James Savage, M.D.
Ophthalmology
Eye Specialty Group
825 Ridge Lake Blvd, Ste. 200
Memphis, TN 38120
901-685-2200
University of Cincinnati, 1975
Baylor University — Dallas (F-OPH)

Guy V. Teach, M.D.
Internal Medicine
Inpatient Physicians of the Mid-South
6263 Poplar Ave, Ste. 1052
Memphis, TN 38119
901-761-6157
American University of the Caribbean, 1995
Morehouse School of Medicine — Atlanta (R-IM)

Bradley A. Wolf, M.D.
Cardiovascular Surgery
BMG Cardiovascular & Thoracic Surgery
6029 Walnut Grove Road, Ste. 301
Memphis, TN 38120
901-226-0456
University of Tennessee, 1990
University of Tennessee — Memphis (R-FM)
University of Tennessee — Memphis (F-CVS)
36th Annual Insurance Workshops

**DATES AND LOCATIONS:**
All sessions will be held from 8 AM to 4:30 PM and include lunch.

- Tuesday, Oct. 4 | Memphis
- Tuesday, Oct. 11 | Kingsport
- Wednesday, Oct. 5 | Jackson
- Wednesday, Oct. 12 | Knoxville
- Thursday, Oct. 13 | Chattanooga
- Tuesday, Oct. 25 | Nashville

**BRINGING TENNESSEE’S BIGGEST HEALTHCARE PAYERS TO YOU**
Join us at one of our workshops in October to hear directly from Amerigroup, BCBST, Bureau of TennCare, Cahaba GBA, Cigna/Cigna Healthspring, Humana, and UnitedHealthcare.

**PRICING:**
- TMA Members: $179
- Additional Attendee from Member Practice: $129
- Nonmembers: $229

**Register at**
tnmed.org/insurance-workshops
Since last quarter’s article on Scientific Marketing, a number of groups and physicians have expressed interest and had questions about how to implement this methodology for their marketing and development programs. Some key points:

1) Evidence based marketing is trackable and does not increase marketing spending – it proves to substantially reduce overall costs and risks.

2) It can be used along with other marketing activities or constitute the entire marketing effort – adding fact based targeting to your efforts.

Because this approach uses data for its fuel, it is very efficient. And because results are trackable with data analysis, a high degree of efficiency is obtained. As noted by health data analysis expert Dr. Richard K. Thomas, "With the methods that are now available it is possible to identify growth areas and potential additional sources of practice revenue. Knowing where your patients will be coming from in the future is the key to continued success."

Good Science is always the best answer. For more information on how to integrate scientific/evidence-based marketing into your practice or hospital, contact Alan Flippin, MBA, CMDS - CEO of ADF Medical at 901-490-2330 or via email at alanflippin@gmail.com
Eric, a car mechanic in Memphis, has suffered from kidney stones his entire life. A couple years ago, the pain became so intense that it prevented him from giving his work his full attention.

Through the Church Health Center, Eric received the compassionate and timely care he needed.

Join the mission that keeps Memphis working.

"they took care of everything."

Eric Goad, Church Health Center patient

churchhealthcenter.org
When I came on board the Tennessee Medical Foundation (TMF) in late 2001, Dr. David Dodd had just stepped back in for a few months to run the program and I wasn’t sure whether I could do the job or even wanted to. Fortunately, there were some good people who believed in me and gave me the confidence I needed. There is really no place to learn how to direct a physician health program so a lot of it is on-the-job-training. Fast forward 15 years and I am about ready to wrap up my chapter at the TMF Physician’s Health Program (PHP).

During my time as medical director, I’ve been able to work with over 2,000 physicians. My goal when I took this job was to leave the PHP better than I found it and I do feel I have done that. The program has broadened its scope during my tenure. When I started, almost every doctor we encountered had an alcohol or substance use disorder; today that is only about half of the cases we deal with. Medicine is changing, not necessarily for the better for the practicing physician; numerous studies show more physicians are affected by stress and burnout and at a younger age. We still see between 100 and 120 new identifications each year and the need for this program is greater than ever.

We have a confidential rehabilitation track available for physicians for whatever difficulties they have in their life – not every state has that available. We have been a model for other PHPs and our reputation has grown. I’ve spoken to the Australian Medical Association, in Latin America, in Canada, Europe and all over the U.S. One of the things I point to with pride is the fact that four state PHPs across the country are now run by graduates of Tennessee’s program. Increasingly, the Department of Health has looked to TMF for ways to deal with the opiate prescription crisis in Tennessee; since 2007 we’ve worked with the TMA to offer seminars that allow physicians to meet state licensure prescribing requirements.

We are seeing improvement in Tennessee: we are now prescribing fewer opiates, we have fewer doctor shoppers, and the quantities of MME have decreased significantly. Unfortunately, over 1,000 Tennesseans still die each year from unintentional drug overdoses and around 1,000 babies are born each year with Neonatal Abstinence Syndrome (NAS), so there is still a lot of work to be done. This year’s prescribing seminar includes a presentation on “Is Marijuana Medicine?” There is probably more myth and misinformation surrounding marijuana than anything else in medicine right now, so we need to better educate doctors.

Our primary mission continues to be assisting physicians who suffer from substance use disorders. Unfortunately, alcoholism and drug addiction in the physician population is not decreasing; as stated earlier, it still comprises about half of our referrals. The good news and a statistic I’m proud of is that through our program, over 96 percent of participants are able to get into persistent recovery and return to practice and complete their careers.

As I prepare for my departure, I leave with gratitude. There are too many people to thank but I will mention my thanks to the TMA, the local medical societies, the State and SVMIC for their ongoing support of this program. It is my hope that physician support for their PHP will continue and grow. One thing my father always taught me is to take care of people who take care of you. There are few resources that advocate for physicians practicing medicine today; for this reason it is more important than ever to support those organizations, including the TMF. Sometimes I say if there’s no money, there’s no mission. The need for a comprehensive physician health program is greater than ever, so please give to the Tennessee Medical Foundation.

Learn more about the TMF Physician’s Health Program: www.e-tmf.org

“My goal when I took this job was to leave the PHP better than I found it and I do feel I have done that.”
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