OUS NEWS
Ohio Urological Society
2014 Post-Convention/ Fall Newsletter

President's Message

Bodo E. Knudsen, MD, FRCSC

After a several year hiatus, the Ohio Urological Society's Annual Spring Meeting returned to Cincinnati this past spring. The meeting was held at the Hyatt Regency Cincinnati and was well-received by participants. The Hyatt provided first-class facilities and the meeting ran smoothly. Interaction with the speakers and the audience was very good and the changes made to the program over the years seem to be working well.

However, OUS remains challenged in recruiting a greater number of urologists to attend the meeting. There is a core group that attends regularly, but our efforts in reaching a greater number of private practice urologists have not met with great success. While word-of-mouth and speaking directly to our colleagues will be helpful, the executive office of OUS is open to any and all suggestions that may lead to improved attendance at our Annual Spring Meeting.

We are deep into planning for our next meeting, which will be held March 20 – 21, 2015, in Columbus, Ohio. We have selected the Renaissance Columbus (a Marriott property) as the meeting site. In order to change things up, we decided to hold the meeting in downtown Columbus near the Arena District (arenadistrict.com). The location will provide easy access to both the Short North (www.shortnorth.org), the edgy arts district with many fine restaurants and the Arena District, home of the NHL's Columbus Blue Jackets and Nationwide Arena. Unfortunately, the Blue Jackets will not be in town the weekend of the Annual Meeting, but there may be an opportunity to attend an NCAA Basketball tournament game, which will be going on at that time. Dr. Ronney Abaza, this year's secretary of OUS, has brought his typical energy and enthusiasm to the planning process, and we are working on having a live robotic-assisted surgical procedure as part of our program next year.

It is a great honor to serve as the president of the society this year. We have great executives, and we are all interested in hearing from the membership on opportunities to improve the organization. I would also like to personally thank Dr. James F. Donovan Jr. for his service to the organization and the tremendous work he did hosting the Cincinnati meeting. I'd also like to thank Dr. Manoj Monga for his diligent work as treasurer. In his short time with OUS, he has provided some valuable insights into how we can improve the organization. While we miss Dr. Monga on our board, we are thrilled to see him take on the role of Secretary of the AUA, a well-deserved honor and a great reflection of the excellence that exists in Ohio urology. ▼

Bodo E. Knudsen, MD, FRCSC
Ohio State University Wexner Medical Center
2014 – 2015 President, Ohio Urological Society

In This Issue

Secretary's Report

Ronney Abaza, MD, FACS

The Ohio Urological Society's 2014 Annual Spring Meeting was a great success. The meeting was held at the Hyatt Regency Cincinnati in Ohio and was attended by urologists, residents and our industry partners.

The meeting began Friday evening with the Welcome Reception providing an opportunity for our members and other attendees to socialize with each other and visit vendor exhibits. The resident poster exhibit was on display, and a review with questions for the presenting residents was moderated by Dr. Edward E. Cherullo, University Hospitals of Cleveland.

The top three resident abstracts were presented the following morning immediately preceding the first main lecture on "Complications in Endourology" by then-OUS President-Elect Dr. Bodo Knudsen, Ohio State University. Dr. Sri Sivalingam, Glickman Urological Institute, then presented a lecture on strategies to optimize ESWL outcomes and reduce complications, and both were joined by Dr. Geoffrey N. Box, Ohio State University, for a panel discussion on challenging stone cases with input and questions from the audience.

The second session focused on prostate cancer and began with a lecture by Dr. Kenneth W. Angermeier, Cleveland Clinic, on ablative and radiation-based therapies for prostate cancer, including IMRT, brachytherapy, CyberKnife and cryotherapy. A cutting-edge lecture on the current and future status of MRI in prostate cancer diagnosis, specifically the role of MRI and ultrasound fusion in prostate biopsy, was given by Dr. Sadhna Verma, University of Cincinnati, and moderated by then-OUS President Dr. James F. Donovan Jr., University of Cincinnati.

A series of related and very practical lectures were given on complications of medications commonly used by urologists, including a review of testosterone replacement therapy by Dr. Daniel A. Shoskes, Cleveland Clinic, and discussion of PDE5 inhibitors and anticholinergics by Dr. Gregory J. Lowe and Dr. Ketul K. Shah from Ohio State University.

The luncheon between morning and afternoon sessions included a presentation on asset protection, which was well-received by attendees and stimulated many questions. Dr. Robert Dreicer, Cleveland Clinic, kicked off the afternoon session with an update on new systemic therapies for advanced prostate cancer, which was followed by a panel discussion on complications of laparoscopic and robotic surgery by Dr. Krishnanath Gaitonde, University of Cincinnati, Dr. Nilesh Patil, University of Cincinnati, and Dr. Geoffrey N. Box.

The last session focused on female pelvic surgery and prosthetic surgery and their complications by Dr. Ayman Mahdy, University of Cincinnati, and special guest Dr. John J. Mulcahy from the University of Alabama.

The meeting concluded after the resident poster awards were announced and after the Annual Business Meeting. Without a doubt, the topics chosen for this year's meeting were full of relevant and practical information for the membership. Next year's meeting will hopefully be as equally valuable. Please feel free to contact the OUS leadership if you have any ideas for topics you would like to see represented next year. ▼

Ronney Abaza, MD, FACS
2014 – 2015 Secretary, Ohio Urological Society

Treasurer's Report

Mark Memo, DO

Treasurer, Dr. Memo reports on recent OUS funds as of late April:

Our organization has a total of $83,611 between our checking and savings accounts. Our investments are at $224,388. Our total cost for 2013 was $98,325.

The revenue brought into the organization for the past year was $107,290. We had surplus of $8,965. The majority of the revenue came in from industry support at $60,650 in 2013. As we have discussed, this number has been on the decline at all meetings throughout the country.

We have 195 active members paying dues. The revenue from this was $18,500. ▼

Mark Memo, DO
2014 – 2015 Treasurer, Ohio Urological Society

OSMA Delegate's Report

Mark Memo, DO

The Ohio State Medical Association Annual Meeting took place in Columbus in April. The meeting was well-attended. The keynote speaker was Gov. John Kasich, who is running for re-election and has been integral in changing the landscape of doing business in Ohio. During his term, he has moved the state from billion-dollar deficit to gains. In addition, the unemployment in the state is down to 6.1 percent. He was there to discuss a new program, "Start Talking." He recently launched the drug abuse prevention initiative, urging parents to talk to their children. Youths are 50 percent less likely to use drugs when their parents or adults talk with them about substance use and abuse.

From a political standpoint, the OSMA PAC is urging support for Ohio Supreme Court Justices Judith French and Sharon Kennedy in the upcoming election. Since 2003, the medical malpractice rates for the state have been in decline. The conservative court has been integral in this aspect and has had a direct impact on our ability to practice in the state.

The medical education graduate rate in the state remains strong, and there is a projected 130 physician shortage for the state. In 2013, 4,740 students were enrolled in state medical schools and 5,900 doctors participated in GME. More than half, 66 percent, of residents and fellows leave the state to practice medicine outside of Ohio. Our state ranks 19th overall in the number of physicians and 26th for the number of primary care physicians.

The Affordable Care Act could potentially insure an additional 300,000 Ohioans; however, the exact number at this time is not known. This would also be done with the expansion of Medicaid. The level of reimbursement has yet to be established, but has been discussed with our OSMA lobbyist, Jeff Kasler.

Lastly, we had our legislative day at the State Capitol on April 16. Drs. Herbert W. Riemenschneider, James Donovan Jr., Richard A. Memo and I were in attendance. The productive day was coordinated by Kasler. We met with state senators, representatives and their staff. We are going to try to do this again next year, so please consider attending. This legislative day gives our specialty a voice on the state level, and you can be a part of it. ▼

Mark Memo, DO
2014 – 2015 OSMA Delegate, Ohio Urological Society

Report of the Health Policy and Medicare Liaison Committees

Herbert W. Riemenschneider, MD

In April of 2012, the Ohio Urological Society contracted with the Ohio State Medical Association to increase our presence at the Ohio Statehouse. Since then, OSMA lobbyists have worked to inform and represent OUS members on relevant legislative and regulatory issues. These efforts brought about the formation of the OUS State Government Affairs Monitoring Committee.

Since June of 2012, the committee met monthly via teleconference calls. Initially we worked with a well-established representative of the OSMA, Jeff Smith. We now work with the very capable Jeff Kasler, who has grown nicely in his role of representing us in matters important to our state society.

We have been very involved in issues relating to the Medicaid program and the Affordable Care Act. Our focus has been improving the conditions of practice for all urologists. We responded to the attempt by United Healthcare to narrow the networks for their Medicare Advantage Program participants, and we are constructing efforts to address the cost and frustrations created by pre-certification.

On a slightly brighter note, the PSA resolution, sponsored by OUS in response to the US Preventive Services Task Force (USPSTF) recommendations on PSA testing, has passed the House and Senate and awaits the governor's signature and submission to Congress. Also we have had two Advocacy Days at the Statehouse, one in June 2013 and one in April 2014. We met with our representatives and senators and members of regulatory bodies. These meetings are open to all OUS Members.

A more recent issue focused on H.R. 3204, the Drug Quality and Security Act. This federal law, passed in fall 2012, has affected urology practice in delivering care in the field of men's health. Specifically, regulations relating to this legislation have interfered with the acquisition of injectable, intracavernosal pharmaceuticals. However, through Kasler's work we now have access to Kyle Parker, executive director of the Ohio Board of Pharmacy, and we have high hopes that our influence at the state level will allow for a resolution to this problem in the very near future.

These are just a few of the issues on the OUS committee's agenda. We clearly need to assemble state panels of experts in all areas of urology, who will make time in their schedules to participate in discussions with our committee and help establish standards for urologic care, and when necessary, make time for testimony at the Statehouse. Our standards of practice are now being influenced by the actions of those who have little knowledge of what we do, and in some instances such as the compounding pharmacy issue, have challenged what we know as long-standing quality care.

It is clear that our job responsibility has suddenly grown. We not only have direct patient responsibility, but now that same responsibility to societal, economic and regulatory policies exists if we are to preserve and grow the specialty of urology. ▼

Respectfully submitted,

Herbert W. Riemenschneider, MD
Chair, OUS Health Policy Committee

Congratulations to the 2014 Ohio Urological Society Abstract Winners!

BEST OVERALL:

Benjamin Cohen
Withholding an ACE-I or ARB Has No Effect on Perioperative Renal Function Among Patients Undergoing Percutaneous Nephrolithotomy

Authors: Benjamin R. Cohen*, Shubha De, Ganesh Kartha, Ina Li, Carl Sarkissian, Manoj Monga
Department of Urology, Glickman Urological and Kidney Institute, Cleveland Clinic Foundation

Receives: $1,000 plus travel to the NCS 2014 Annual Meeting

Introduction and Objectives: The use of angiotensin converting enzyme inhibitors (ACE-I) and angiotensin receptor blockers (ARB) is common among patients undergoing percutaneous nephrolithotomy (PCNL). The effects of continuing or withholding these medications in the perioperative period on patients undergoing PCNL are unknown.

Methods: Our study received IRB approval. We conducted a retrospective review of all patients undergoing PCNL at our institution from July 2002 through October 2013. In our analysis, patients on an ACE-I who had their medication administered during their surgical hospitalization were matched to patients who had their medication withheld based on sex, age and BMI.

Results: 2,784 patients underwent percutaneous nephrolithotomy during the review period. At the time of PCNL, 15.2% (423/2784) of patients had a listed prescription for an ACE-I in the medical record and 6.5% (181/2784) had a listed prescription for an ARB. 59% (248/423) of patients on an ACE-I and 66.9% (121/181) on and ARB had their medication administered during their operative hospitalization. Comparing patients who had their medication administered versus patients who had their medication withheld, there was no significant difference in baseline systolic blood pressure (SBP) (132 mmHg vs 131 mmHg, p=.726), average length of stay (2.93 days vs. 2.96 days, p=0.94), perioperative change in SBP (-2.5 mmHg vs. -2.79 mmHg, p=.943), perioperative change in serum creatinine (+0.28 mg/dL vs. +0.39 mg/dL, p=.70), change in serum creatinine at one month postoperatively (+0.19 mg/dL vs. 0.079 mg/dL, p = 0.41), or change in serum creatinine at 1 year postoperatively (+0.07 mg/dL vs. -0.03 mg/dL, p=0.082).

Conclusion: From the standpoint of preserving renal function and blood pressure, it appears safe to administer ACE-I and ARBs to patients undergoing PCNL during their operative hospitalization. Administering these medications during a patient's inpatient course may prevent errors in medication reconciliation.

BEST CLINICAL:

Abhinav Sidana
Step-By-Step Technique: MRI-US Fusion Targeted Prostate Biopsy

Authors: Abhinav Sidana*, Nilesh Patil, Sadhna Verma, James Donovan, Krishnanath Gaitonde
Division of Urology, University of Cincinnati College of Medicine, Cincinnati, OH

Receives: $500

(continues on the next page)

Introduction and Objectives: MRI-Ultrasound Fusion Targeted Prostate biopsy is a novel evolving technique in the diagnosis of prostate cancer. The potential benefits include the detection of clinically significant disease in patients with previous negative biopsies and in biopsy naive patients, and for risk stratification of prostate cancer patients considering active surveillance for their disease. The procedure can be performed by urologists in an office setting, using a trans-rectal approach under local anesthesia. The objective of this presentation is to provide a step-by-step description of this novel technique.

Methods: We describe the technique for MRI-US Fusion Targeted Prostate Biopsy procedure in a patient with elevated serum PSA and a previous negative prostate biopsy, using the Artemis Navigation System (Eigen Inc., Grass Valley, California). The steps of the procedure are: 1) Multiparametric MRI (mpMRI) of the prostate 2) Prostate Segmentation and Target identification on the mpMRI images using the Profuse Software 3) Patient positioning and local anesthesia 4) TRUS (Transrectal Ultrasound) 3D volume estimation and prostate segmentation 5) Rigid and Elastic Registration, and Fusion of the mpMRI and real- time ultrasound images 6) MRI-US Fusion guided biopsy of the target areas 7) Template sextant biopsy of the prostate.

Results: The procedure flow and steps of performing a MRI-US Fusion Targeted Prostate Biopsy procedure are explained in this presentation. The procedure is performed in an outpatient setting under local anesthesia. We have successfully adapted this technique in our practice and discuss the results of our first 100 cases using this technique.

Conclusion: MRI-US Fusion Targeted Biopsy using the Artemis Navigation System is an effective, safe and easily adaptable technique, which can be performed by urologists in an outpatient setting under local anesthesia.

BEST OUTCOMES STUDY:

Brian Minnillo
Modifiable Factors Fail to Predict Readmission Following Cystectomy

Authors: Brian J. Minnillo*, Matthew J. Maurice, Aiswarya C. Pillai, Nicholas K. Schiltz, Siran M. Koroukian, Firouz Daneshgari, and Robert Abouassaly

Receives: $250

Introduction and Objectives: In the current era of healthcare reform, performance measures may dictate provider reimbursement. Given its high complication and readmission rate, radical cystectomy (RC) could be a target for quality improvement. We aimed to identify patient and provider predictors of poor outcomes.

Methods: We examined 3,649 patients with bladder cancer who underwent RC from 2005-2009 using discharge data from the California State Inpatient Database of the Healthcare Cost and Utilization Project, an Agency for Healthcare Research and Quality. We reviewed patient and provider factors (i.e. race, hospital volume, discharge disposition) associated with 30-day readmission. We also assessed short-term surgical outcomes such as postoperative complications and in-hospital mortality. Multivariable logistic regression was used to adjust for confounders.

Results: The 30-day readmission rate was 22.8% (833), median length-of-stay (LOS) was 9 days (+/- SD 9.7) and in-hospital mortality rate was 2.3% (83). With respect to disposition, 34.8% of patients were discharged home, 50.8% were discharged home with home healthcare, and 12.2% were discharged to a post-acute care facility (PACF). Within 30 days, 20.3% of patients discharged home, 20.9% of patients discharged with home healthcare, and 42.3% of patients discharged to a PACF were readmitted. After adjusting for confounders, African American race (OR 1.61, 95% CI 1.05-2.47, $P < 0.03$), two or more comorbidities (OR 1.42, 95% CI 1.06-1.90, $P < 0.02$) and discharge disposition to a PACF (OR 3.72, 95% CI 2.83-4.88, $P < 0.0001$) were the only independent predictors of readmission. Patients with a LOS >15 days were less likely to be readmitted (OR 0.43, 95% CI 0.27-0.67, $P < 0.0002$). Hospital procedure volume (<10, 10-50, >50 RCs per year) did not predict complication, in-hospital mortality or readmission.

Conclusion: RC stands to face critical review in the "pay for performance" era as perioperative morbidity, in-hospital mortality and 30-day readmission rates remain high. However, our results suggest that there are few modifiable factors related to readmission and perioperative outcomes.

BEST POSTER:

Raman Unnikrishnan
Levofloxacin is Superior to Ciprofloxacin for Single-Dosing in Preventing Severe Infections After Prostate Biopsy

Authors: Raman Unnikrishnan*, MD, Eric A. Klein, MD, J. Stephen Jones, MD, Jianbo Li, Howard B. Goldman, MD
Cleveland Clinic Foundation

Receives: $250

Introduction and Objectives: To investigate whether there is benefit with a longer acting oral fluoroquinolone, we compared the rate of infection after transrectal ultrasound guided prostate biopsy (TRUSBx) between two prophylactic antibiotic regimens: ciprofloxacin (short) versus levofloxacin (long), each combined with an aminoglycoside.

Methods: A retrospective review was performed of all TRUSBx procedures between September 2011 to January 2013. Initially our protocol entailed one dose of both ciprofloxacin and an aminoglycoside. In June of 2012, we switched the ciprofloxacin to a single dose of levofloxacin. After TRUSBx, all patients were called to evaluate for complications. The records of those not contacted were reviewed for post-procedural infections. Infections were categorized as severe, those requiring hospital evaluation and treatment, or mild, those managed as an outpatient. Univariate and multivariate analyses were performed.

Results: Of 1,190 total biopsies, there were 32 infections; 13 were mild and 19 severe. The rate of total infections was higher in the ciprofloxacin group at 3.36% compared to the levofloxacin group at 2.14% though this was not statistically significant ($p=0.21$). The rate of mild infection did not differ significantly between the two groups with 0.96% in the ciprofloxacin group and 1.23% in the levofloxacin group ($p=0.78$). The rate of severe infection was higher in the ciprofloxacin group at 2.43% compared to the levofloxacin group at 0.92% ($p=0.06$). On multivariate analysis when controlling for aminoglycoside dose and weight, those patients who received levofloxacin were less likely to develop a severe infection (OR 0.27; $p=0.03$).

Conclusion: Empiric prophylaxis for TRUSBx with a single dose FQ augmented with an AG is optimal to reduce infectious complications. We found levofloxacin resulted in fewer severe infections when compared to ciprofloxacin.

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OSMA Legislative Monitoring Report – May 2014

From the Desk of: Monica Hueckel (Director, Government Relations); Tim Maglione, JD (Senior Director, Government Relations)

Legislative Activity

The 130th General Assembly (GA) just left Columbus for the summer, and they won't return until sometime after Labor Day. The final weeks before a recess generally entail a flurry of legislative maneuverings, as lawmakers and advocates all work to pass bills before taking a break. This May was no different, and the last few weeks of spring flew by as the House and Senate worked through wide-ranging legislation that impacts the practice of medicine. Over the past few months, the OSMA government relations team closely monitored nearly 20 legislative proposals; some of the most relevant bills to the Ohio Urological Society are below.

OSMA Tort Reform Legislation Clears Key House Committee

The OSMA, along with the Ohio Hospital Association, developed a medical liability reform package (HB 276) to further enhance Ohio's medical liability climate. Specifically, the legislation does two important things:

• Updates Ohio's "I'm Sorry" law to allow healthcare professionals to have a broader conversation with a patient following an adverse event – beyond just offering an apology – and then protects that conversation from later being introduced into evidence as an admission of liability or statement against interest.

• Prohibits the use of insurer payment policies and guidelines from being used to establish the standard of care. What this means is that federal care guidelines, quality criteria or insurer payment rules – whether mandated by the Affordable Care Act (ACA), another law or by insurers – do not establish a legal basis for negligence or the standard of care to determine medical liability.

HB 276 cleared a key House Committee in early June with bi-partisan support. The legislation will be considered by the full House of Representatives when the legislature returns after Labor Day.

Legislation seeking to make changes to the State Medical Board passes out of House Health and Aging Committee

HB 531- Medical Board Regulations

• What the Bill Does: The bill aims to authorize the State Medical Board of Ohio (SMBO) to fine, as oppose to suspend, professionals it regulates for failing to comply with certain CE requirements and for violating laws administered by the Board. It also changes the terms and conditions for renewal and restoration of a physician certificate to practice.

• Why the Bill Matters: The bill will authorize possible fines on physicians when violating medical board rules or practice act standards.

• What the OSMA Has Done: The OSMA has worked with interested parties and the SMBO to understand the reasoning behind the bill, and we agree with the concept of the legislation, those who break the law should be accountable for their actions, and those who follow the law should not bear additional costs incurred by those that stray from professional licensing standards. We are hopeful that the Board's new fining authority will deter practitioners from violating the law while improving the quality of care provided to patients across the state.

• What to Expect Next: This bill passed out of House Health and Aging committee before the summer recess. When legislators come back in the fall, we anticipate this bill will be heard in the Senate.

CANCER CARE

SB 230 - Standards for the Delivery of Non-Self-Injectable Cancer Drugs

• What the Bill Does: The bill prohibits pharmacists from dispensing non-self-injectable cancer drug to a patient, a patient's representatives, or a patient's private residence.
• Why the Bill Matters: This bill will end the dangerous drug dispensing practice known as "brown-bagging," which occurs when an insurer requires a patient to receive medications from a mail-order pharmacy.
• What the OSMA Has Done: The OSMA supported this bill because it goes a long way towards ensuring the integrity of some very important medications while furthering patients' safety.
• What to Expect Next: This bill is being sent to the governor for approval.

SB 99 – Oral Chemotherapy Cost Parity

• What the Bill Does: The bill requires insurance companies and Medicaid plans that cover traditional intravenous treatments to either establish comparable coverage for oral medications or to only charge up to $100 for a 20-day supply of oral chemotherapy medication.
• Why the Bill Matters: Before SB 99, the cost of oral chemotherapy treatment forced some patients to pursue use of less expensive intravenous chemotherapy drugs. Because of SB 99, individual patients can receive the chemotherapy treatment that their physician feels will be most effective.
• What the OSMA Has Done: The OSMA submitted support testimony to the Senate and the House.
• What to Expect Next: This bill is being sent to the governor for approval.

New Legislation

- Radiation Therapy – No Activity to Report
- Pathology – No Activity to Report
- In Office Clinical Lab Testing – No Activity to Report
- Imaging – No Activity to Report

We will continue to closely monitor the legislative and regulatory activities listed above and report promptly if any state issues arise.

For a more comprehensive overview of legislative and executive activities impacting the practice of medicine in the state of Ohio, please visit www.osma.org/advocacy.

Malpractice Claims Consume Years of a Physician's Career

On average, each physician spends 50.7 months, or approximately 11 percent of an average 40-year career, on resolving medical malpractice cases – the majority of which end up with no indemnity payment. That's the conclusion of a recent study[1] by the RAND Corporation based on data provided by The Doctors Company, the nation's largest medical malpractice insurer. Researchers found that 70 percent of the time physicians spend on claims is spent defending claims that end in no payment to the plaintiff.

Key findings of the study include:
- Physicians experience additional stress, work and reputational damage from the time spent defending claims.
- Fighting claims takes time away from practicing medicine and from the opportunity for the physician to learn from his or her medical errors.
- The lengthy time required to resolve claims also negatively impacts patients and their families.

The effect of malpractice claims on physicians' careers is discussed further by Richard E. Anderson, MD, FACP, chairman and CEO of The Doctors Company, in two short videos that can be viewed at www.youtube.com/doctorscompany.

To help prevent claims that can take up years of your career, follow these key tips to promote patient safety:

1. Communicate with Patients
- Understand the new vital sign: health literacy.
- Do not ask patients if they understand instead, ask them to repeat back the information.
- Document patient understanding of instructions.
- Provide the patient with written instructions.
- Use a translator when necessary.

2. Document Carefully and Objectively
- Do not point fingers at other staff or providers.
- Do not impeach the integrity of medical record by altering it.
- Use only approved abbreviations.
- Review patient information that is automatically populated in the EMR.

3. Monitor Handoffs and Ensure Follow-ups
- Establish a formal tracking system for missed appointments.
- Follow up with patients to reschedule.
- Document missed appointments in the patient record.
- Send a letter to patients who repeatedly miss appointments.
- Explain the importance of follow-up care.
- Refer the patient to another physician, if necessary.

4. Avoid Medication Errors
- Keep prescription pads secure.
- Document samples in the medical record.
- Check allergies at every visit and document in the same place in the record.
- Review and reconcile medications at every patient visit.
- Be aware of LASA (look-alike, sound-alike) medications.

5. Follow HIPAA Regulations
- Avoid unauthorized release or breaches of PHI (protected health information).
- Safeguard against lost or stolen PHI through laptops or drives.
- Examine office practices and layout that may compromise confidentiality.
- Assess your methods to protect electronic communications.
- Follow federal requirements and know your state regulations which may be stricter.

1. *Seabury SA, Chandra A, Lakdawalla DN, Jena AB. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. Health Affairs. 2013;32(1):1-9.*

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

Thank You to Our 2014 Industry Partners & Exhibitors

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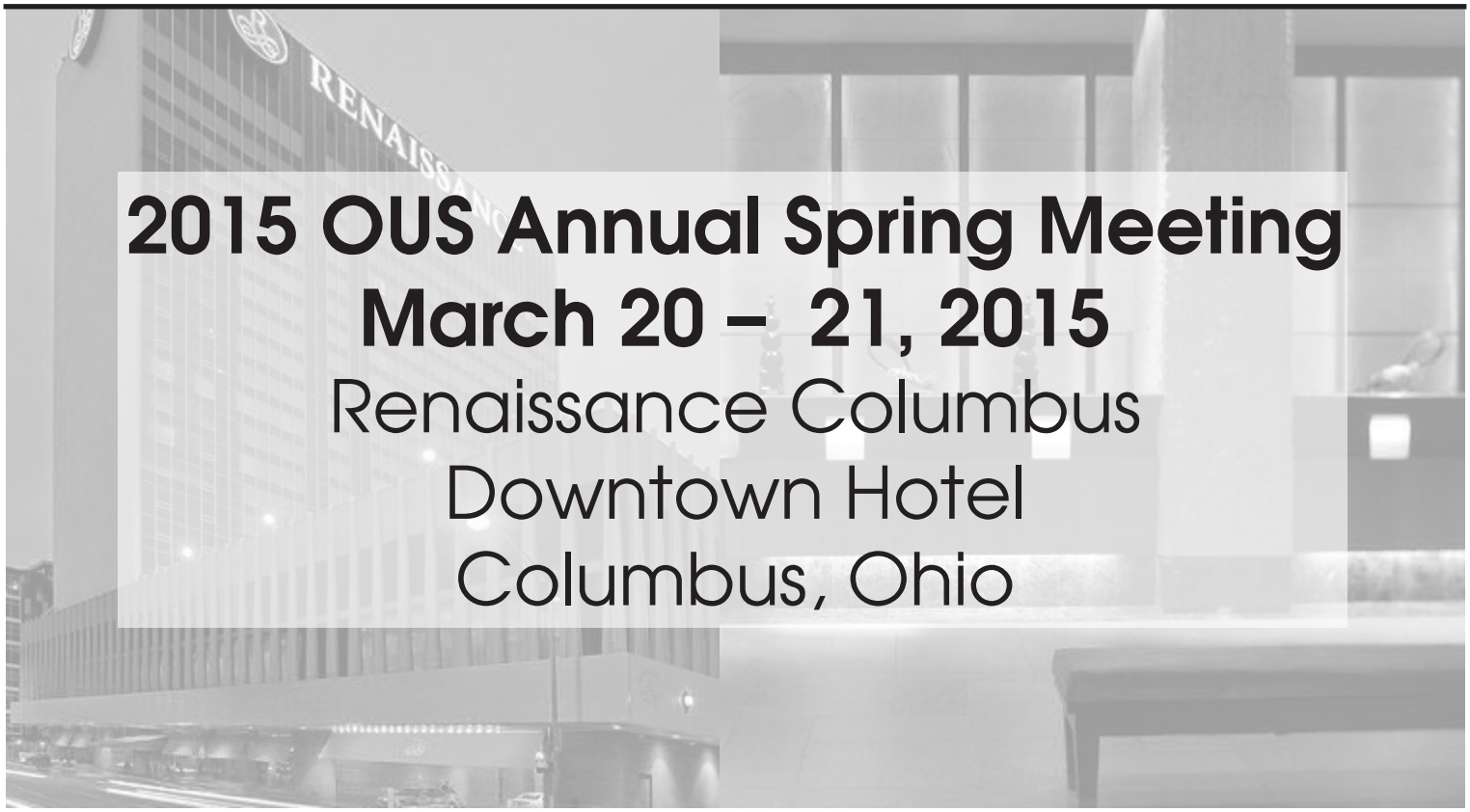

2015 OUS Annual Spring Meeting
March 20 – 21, 2015
Renaissance Columbus
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