Practice Management Tools

PRODUCTS AND SERVICES TO HELP IMPROVE YOUR BOTTOM LINE

Endorsed by the Tennessee Medical Association

AUTO LEASING
AutoFlex Auto Leasing • 1-888-678-FLEX (3539)
AutoFlex helps you get the exact vehicle you want and delivers it to your door at the best rate.

BANKING SERVICES
InsBank • 1-866-866-4268
The latest tools and technologies so you can bank without leaving your office. Visit the website to learn about commercial and personal banking services.

COLLECTION SERVICES
J.C. System, Inc. • 1-800-279-3511
One of America's largest privately-owned debt collection agencies - offering TMA members the finest account receivable management services.

CONTINUING EDUCATION SEMINARS
Call us for a current schedule at 1-888-616-7873 or check online at www.TMAphysicianservices.com

CLAIMS MANAGEMENT SOLUTION
Medical Software Associates • 1-800-946-2980
Introducing EDI Claim Manager - an internet based program that is secure and easy to use, offering a way to increase office productivity and cash flow with real-time claims management solutions that meet HIPAA compliance.

CREDENTIALS VERIFICATION SERVICES
TPVO • 1-888-779-0300
A credentials verification organization, owned by physicians, that aims at reducing credentialing paperwork for healthcare organizations and medical practices.

CREDIT CARDS
Bank of America • 1-800-832-2775
Earn points and get the rewards you want — cash, travel, gift certificates and merchandise.

CREDIT CARD PROCESSING SERVICES
Unlimited Payment Services • 1-888-886-4833
Offering credit and ATM/debit card processing. TMA members receive lowest overall cost guaranteed: free terminals; no application fees; no programming fees; easy setup and 24/7 customer service.

GROUP PURCHASING PROGRAM
DoctorsManagement • 1-888-855-4040
Join the DoctorsManagement Power Buying Program and start saving up to 30% on your supply costs.

IDENTITY THEFT RECOVERY SERVICE
ID Theft Assist • 1-866-NY-4ID-911
NEW! For less than $8/month the service saves an identity theft victim time, effort and costs in restoring credit and repairing the damage caused by an identity theft.

INSURANCE SERVICES • www.TMAinsurance.com
The TMA Association Insurance Agency, Inc. • 1-888-616-7873
Offering a complete line of employee benefit plans and personal insurance.

INVENTORY SPECIALIST
AVI Asset Verification Incorporated • 1-800-335-0513
Protect yourself from disaster with accurate, comprehensive documentation and valuation of your assets. AVI will provide you with an inventory list on CD-ROM with detailed pictures and annual updates to keep you current, TMA members will receive a 10% discount.

MAGAZINE SUBSCRIPTIONS
TMA Magazine Program • 1-866-289-6247
The lowest rates on all your subscriptions.

TAX AUDIT SERVICE
TaxResources, Inc. • 1-800-922-8348
Expert representation by tax audit professionals. TaxResources will defend business and personal audits. Compare the low, annual fee of TaxResources to the charge (per hour) by your attorney or CPA.

For more details, call the above associates direct or visit our website, www.TMAPhysicianServices.com

1.888.616.7873
Editorials
5 Congress Should Weigh Unintended Consequences of Deep Provider Cuts—F. Michael Minch, MD, FACS
7 Merry Christmas 2011—John B. Thomison, MD
10 Letter to the Editor

Ask TMA
9 Help with Compliance on New Pain Clinic Law?

Member News
13 TMA Approves Budget, Legislative Pkg, Web App; “Drastic” MedPAC SGR Plan Opposed; TMA Election Time; PLC Nominations Due; TMA Annual Awards; TMA Public Health Champion: Dr. Wayt; TennCare Cuts; Doctor of the Day; Survey Vitals; IMPACT Needs Your Help; IMPACT Capitol Hill Club; Member Notes

Practicing Medicine
27 Truly Meaningful Medicine—Yasmine Subhi Ali, MD, MSCI, FACC, FACP

Special Feature
29 Erosion—Charles E. Leonard, MD, FAAFP

For the Record
40 TMA Alliance Report—AMA Mission Accomplished Through the TMAA—Dottie Pennington
41 New Members
42 In Memoriam; AMA PRA
43 Index to Volume 104
46 Advertisers in This Issue; COA Instructions; Instructions for Authors
7th Annual Scientific Conference
Tennessee Society for Laser Medicine and Surgery

March 30 - April 1, 2012
Downtown Hilton
NASHVILLE, TN

A weekend of educational learning and training to grow your knowledge of lasers, light sources, and the cosmetic industry.

Laser Fundamentals
Filler & Toxin Update
Tattoo Removal
Vascular & Pigment Lasers
Ablative and Non-Ablative Resurfacing
Laser Hair Removal
Treating Skin of Color
Laser Lipo & Fat-Grafting Industry Workshops
Exhibits

Information, Schedules, and Registration available at tnlasersociety.com

2012 FACULTY
Eric F. Bernstein, MD
Brian S. Biesman, MD
Patrick J. Clark, CMLS
Darrel L. Ellis, MD
Julius W. Few, MD
Michael H. Gold, MD
David J. Goldberg, MD
Mary P. Lupo, MD
Michel A. McDonald, MD
Jason N. Pozner, MD

Tennessee Medicine
Journal of the Tennessee Medical Association (ISSN 1088-6222)
Published monthly under the direction of the Board of Trustees for members of the Tennessee Medical Association, a nonprofit organization with a definite membership for scientific and educational purposes, devoted to the interests of the medical profession of Tennessee.

This Association is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to Tennessee Medicine for publication. The author or communicant shall be held entirely responsible. Advertisers must conform to the policies and regulations established by the Board of Trustees of the Tennessee Medical Association.

Subscriptions (nonmembers) $30 per year for US, $36 for Canada and foreign. Single copy $2.50. Payment of Tennessee Medical Association membership dues includes the subscription price of Tennessee Medicine.

Copyright 2011, Tennessee Medical Association. All material subject to this copyright appearing in Tennessee Medicine may be photocopied for noncommercial scientific or educational use only. Periodicals postage paid at Nashville, TN, and at additional mailing offices.

POSTMASTER: Send address changes to: Tennessee Medicine
PO Box 120909, Nashville, TN 37212-0909
In Canada: Station A, PO Box 54, Windsor, Ontario N9A 6J5

President
F. Michael Minch, MD
Chief Executive Officer
Donald H. Alexander, MPH
Executive Vice President
Russ Miller, CAE

Office of Publication
2301 21st Avenue South
PO Box 120909
Nashville, TN 37212-0909
Phone: (615) 385-2100
Fax (615) 312-1908
brenda.williams@tnmed.org

Editor
David G. Gerkin, MD
Editor Emeritus
John B. Thomson, MD
Managing Editor
Brenda Williams

Editorial Board
Loren Crown, MD
James Ferguson, MD
Robert D. Kirkpatrick, MD
Karl Misulis, MD
Greg Phelps, MD
Bradley Smith, MD
Jonathan Sowell, MD
Jim Talmage, MD
Andy Walker, MD

Advertising Representative: Beth McDaniels – (615) 385-2100 or beth.mcdaniels@tnmed.org
Graphic Design: Aaron & Michelle Grayum / www.thegrayumbrella.com
While the Congressional Joint Select Committee on Deficit Reduction ponders budget reform in Washington, the medical community understands the tough decisions that will have to be made. We have long struggled with increasing overhead and dwindling reimbursement.

For at least the last decade, Medicare payments have failed to keep pace with physicians’ costs. Our practices, like any other businesses, have had to make difficult decisions because compensation did not offset expenses.

During this same decade, we have been fighting to change the way Medicare calculates our payments—using a funding formula that both Republicans and Democrats concur is flawed. This formula has caused havoc in the provider community, threatening to impose deep payment cuts each year. Everyone agrees it is a broken formula but there has been no consensus to fix it. Each time, a temporary measure has been passed that kicks the problem down the road a bit, increasing the cost.

Now, on January 1, the medical community faces a nearly 30-percent cut from Medicare.

Cuts in Medicare and Medicaid affect much more than a physician’s bottom line. They affect the quality of care: investments in electronic health records, e-prescribing and other needed technology tools become more difficult. Human resources must be cut as well, and staff reductions clearly affect the quality of care a patient receives at a hospital or doctor’s office.

Cuts also affect access: physicians are already frustrated and, with these additional hurdles, more doctors have indicated they will limit or stop seeing Medicare patients altogether. This means fewer doctors will be available to take care of our senior citizens and military retirees.

Regardless of the Select Committee’s recommendations, healthcare providers are resigned to some amount of reduced reimbursement from Medicare. We understand there is only so much money to go around. If cuts are necessary, they should be proportionate and all the stakeholders should bear the burden together. Healthcare providers and facilities need to work together as a team, and it is counterproductive if everyone doesn’t share equally in the pain. An additional 30-percent cut in physician reimbursement is disproportionate and unreasonable, and Congress needs to understand the harm that it would do.

Medicare and Medicaid patients need their doctors, and they need their hospitals. And doctors and hospitals need each other if they are to care for this important, growing population. While Congress searches for a way to balance the books, lawmakers need to ensure their fiscal solutions don’t have unintended consequences for patients.

Let your voice be heard. Call your representatives and take a stand on this issue.

Share your thoughts with Dr. Minch at president@tnmed.org.

An additional 30-percent cut in physician reimbursement is disproportionate and unreasonable, and Congress needs to understand the harm that it would do.
Save Time and Administrative Costs

Determine patient liability before or at time of care

You can enjoy the convenience of determining accurate BlueCross BlueShield of Tennessee patient liability at or before the time of care through the real-time claims adjudication tool available in the provider secure area of bcbs.com. By using this tool, your billing staff will know the exact amount your patient is required to pay under his or her BlueCross health plan. It helps eliminate confusion at the point-of-service and helps avoid the administrative burden of balance billing or refunds.

For more information on how real-time claims adjudication works, log on to bcbs.com today!
Merry Christmas 2011

By John B. Thomison, MD
Editor Emeritus

Beginning in 1973, when I became editor of the Journal of the Tennessee Medical Association, now Tennessee Medicine, and until 1997 when I retired, I wrote two or three editorials each month, which is a lot. Each year I wrote a special Christmas essay, some of which the present editor, Dr. David Gerkin, has generously seen fit to reprint. Each year I have been asked why I don’t write a new one and I always reply that my Muse has deserted me, which when translated means I’m too lazy.

But not entirely.

I became editor of the Journal because the practice of medicine was changing and my dear friend and mentor, the previous editor, Dr. Rudie Kampmeier, thought the change to an editor viewing it from a contemporary viewpoint was appropriate. I retired thirty years later for the same reason. And so I stopped writing.

Most of my editorials were necessarily about contemporary medical problems but since nobody told me not to, in many others I took the liberty of airing my views about various other topics of interest to me. Christmas was one of them.

The Saturnalia was a Roman holiday in December in which citizens gave presents to their slaves and often even changed places with them for the day, so when Constantine decreed that all Romans were to be Christians, the feast was easily transformed into one celebrating the love of the giving God. But just as the pagan Roman Saturnalia had over time deteriorated into a debauch, Christmas morphed into the time when God rested the gentlemen merry, and the gift-giving God finally became jolly old Saint Nick, by one or another of his aliases.

But my Muse always dictated much more. The muses were channels of the gods to their lesser beings, having dictated for instance the great Grecian tragedies and Beethoven’s glorious Ninth Symphony. Maybe the part of Christmas that has become its superficial façade originated with them also. I just read that Christmas is now second to Halloween in popularity. Halloween sells more candy, more decorations, and has more celebration, at least in the United States, than Christmas. Halloween is the witches’ Sabbath that precedes All Saints’ Day. The Muses probably shudder at what their hands have finally wrought.

Thus Christmas is in a popularity contest? Excuse me, but I thought Christmas is unique.

So I consulted my Muse, who transported me to a hillside near Bethlehem in Judea two millennia ago, where the angels were announcing the glorious news of a birth that would change the course not only of human history, but of human life forever more. And above it all, after Peace on Earth, Good Will Toward Men, came the strains from Handel’s great Messiah, “For the Lord God Omnipotent reigneth forever! Hallelujah. Amen.”

So much at Christmas once again for me and my Muse, who has once more resurrected itself, to say with Tiny Tim, God bless us every one. Tune in this Christmas. You never know what message your Muse might have for you besides…

MERRY CHRISTMAS.
ICD-10: EVERYTHING YOU KNOW IS ABOUT TO CHANGE (The TMA Can Help)

PREPARATION IS THE KEY TO AVOIDING DISRUPTION IN PATIENT CARE AND REIMBURSEMENT.

TMA’s ICD-10 Educational Series
Introducing a three-phase program with seminars and webinars to bring you the latest information on how to prepare for the upcoming changes, learn your responsibilities and educate your staff on the ICD-10 transition.

Topics include:
- 5010/ICD-10 Implementation Timeline
- Impact on Physician Practices
- Increased Documentation & Compliance Mandates
- Cash Flow Disruption
- Physician Profiling
- And more

Who should attend?
- Physicians
- Practice Managers
- Coding Specialists
- IT Consultants
- Nurses

SPACE IS LIMITED!
Cost:
$29 TMA members/TMA member employees
$99 Non-members

Register online today at:
www.tnmed.org/icd-10

Coming Soon to a Location Near You!
November 1 .................Memphis
November 2 .................Jackson
November 3 .................Martin
November 8 .................Columbia
November 9 .................Clarksville
November 10 ...............Nashville
November 15 ............Johnson City
November 16 .............Knoxville
December 6 .............Chattanooga

Questions?
Contact Insurance Affairs Director Phyllis Franklin
at 800-659-1862 or Phyllis.Franklin@tnmed.org

A special thanks to State Volunteer Mutual Insurance Company and Blue Cross Blue Shield of Tennessee for their support of this program.
Q: I read your Law Guide topic regarding certification of pain management clinics in Tennessee recently and noticed a section of the law prohibits a clinic from accepting cash as payment for services. Based on the law, it looks like my practice falls within the definition of “pain clinic.” A lot of my patients with legitimate pain issues do not have credit cards or checking accounts. Do you have any suggestions on how I may continue to see them and maintain compliance with the law?

A: The law requiring certification of pain management clinics was passed in 2011 to help protect pain clinics that are providing legitimate medical services and weed out those clinics that are not operating in the best interest of a community. This new law is codified at T.C.A. § 63-1-301 to 311 and is effective January 1, 2012. It is important for physicians who treat chronic pain to know if the law applies to them.

In T.C.A. § 63-1-310, the topic of paying for treatment with cash is addressed. The law prohibits a pain management clinic from accepting cash as payment for services except in limited circumstances. A clinic may accept cash when the patient is paying for a:

1. copay
2. coinsurance, or
3. deductible

If the clinic accepts cash as payment for one of the three mentioned options, the clinic must then submit the rest of the charges for the services rendered to the patient’s insurance plan for reimbursement.

For patients without insurance or who will not have the charges submitted to an insurance plan, the clinic may only accept a check, credit card or money order as payment for services provided.

When scheduling a patient, the clinic should consider asking how the patient will pay for the services and let them know cash is prohibited except in those limited circumstances named above. The clinic can inform the patient that a check, credit card or money order is the only acceptable method of payment. Of course, payment via money order may only be used if the clinic does not expect payment at the time services are rendered and sends a bill to the patient. If the clinic expects payment at the time of service, a policy should be developed regarding how to handle patients who are not able or willing to pay after the office visit, if one is not currently in place. Below are the payment options available depending on when the clinic will expect the patient to pay for services:

**PAYMENT OPTIONS: REQUIRED ON DATE OF SERVICE**

1. Cash (for co-pay, coinsurance or deductible only)
2. Check
3. Credit Card
4. Prepaid Credit Card - Many locations (convenience stores, drug stores, grocery stores, Western Union) sell prepaid credit cards. An individual can purchase the card with cash and then use it at the pain management clinic to pay for services when they are rendered.

**PAYMENT OPTIONS: PATIENT IS BILLED**

1. Check
2. Certified Check - An individual must have a bank account to pay by certified check. The individual goes to the bank and the bank verifies there are sufficient funds in the individual’s bank account to cover the check. The individual leaves with the “certified check.” The bank sets these funds aside until the check is cashed or returned.

(Continued on page 11)
To the Editor:

I recently read the multiple articles about the Primary Care Physicians (PCPs) (“Of Primary Concern: Challenges and Possible Solutions to Tennessee’s PCP Shortage,” Tennessee Medicine, Vol. 104, No. 8); though some think that means Primary Care Providers, I do not. Some, even the TMA president, chat all about using extenders, mid-levels and “models” that have the MD as the head of the team of extenders. Well, I’m here to share with you that my patients don’t care for “extenders or mid-levels;” they pay for a doctor and want to see one — the person with a four-year undergraduate degree prepared for medical school, then a four-year medical degree, and at least one year of residency that had 4,100 patient contact hours (80 hours x 52 weeks), nine years’ minimum of training.

It would be one thing if your visit to the NP/DNP (that’s right, Doctor Nurses) cost $20, then you would know what you were paying for and getting: someone who has never spent a single day in medical school. According to the American Association of Colleges of Nursing, most if not all NP program graduates will be “Doctor of Nursing” practice by 2015. That is not a clinical degree. They have mandated that all ANP/FNP schools convert to a DNP degree and get this: those degrees, DNP/FNP can be completed online — just Google “online DNP and FNP.” You would be shocked that it is a valid pathway for your “doctor” in this “model” that some tout as health care by extenders. Given a choice, would you send your parents or children to an NP or “doctor” of nursing? No way, because I know what it took to get into and through medical school and the vast knowledge gained during that journey.

Here’s an idea to get more MDs out practicing primary care: make residency shorter. If PAs and Nurses can get out here in 18-24 months (after RN license then MSN), then so can doctors. PCPs are competing with FNP/DNPs for jobs and what medical student wants to devote three years after medical school in a Family Practice residency to compete with NPs and “doctors” of nursing? They have the same opportunities and claim the same qualifications as MDs who completed a three-year residency and got there in a third of the time; heck, they even claim to be board certified by passing the Option 1 national test, claiming it to be equivalent to Step 3. Thanks, NBME, for selling out the real Doctors for some coins.

MDs could get their medical license after one year of residency, which would get real Doctors out seeing patients two years faster. The General Practice pathway was a valid way to practice until the AMA started with the core training mantra of three years, thus opening the door further for the “doctor” nurses. I have not found an insurer that doesn’t reimburse GPs. Some states like Georgia and California have abolished the three-year residency requirement for FNP/IMG and now mirror U.S. grads with only one year of GME required to get your medical license. Now that would be a real solution for a real shortage of MDs in primary care.

There is a dire need for Primary Care Physicians and with ObamaCare looming with 32 million-plus new patients, why not rekindle the GPs? Medical Schools have increased enrollment by 20 percent while GME residency spots have grown just eight percent in 24 years, with Congress likely to decrease funding further. Are the excess graduates going to be GPs? I think it’s an untapped resource for primary care. The U.S. military employs thousands of GMS (General Medical Officers), its version of GPs. If it’s good enough for our troops, then why can’t the public utilize the same quality care?

Currently with all GPs being licensed, trained and able to work as medical professionals, it makes no sense to exclude that pathway and not promote it today.

Remember, it’s about the patients and what’s best for them. Do you think President Obama sees an NP or Doctor Nurse? I think not. The greatest need is for primary care doctors (PCDs), and the AMA’s push for “core competency” is not realistic with fewer GME spots. There needs to be a viable GP pipeline to get doctors out faster seeing patients. Nurses have been successful in pushing their agendas and qualifications on government and state agencies. We need to roger up and meet the challenge or your doctor will be the “doctor nurse” with the online degree.

Alan L. Cox, MD
Johnson City

Related links:

Dr. Minch responds:

I agree with a lot of what Dr. Cox has to say. We are looking at a severe shortage of primary care physicians, and we should use whatever means we have to produce qualified doctors to meet this need. But I am also a realist. We are not training enough physicians today, and we are not increasing our output fast enough to meet the chal-
lenge. While I hope this will change, I fear it will not. The government is still cutting spending on graduate medical education.

Meanwhile, there are many people who already have some level of medical training. If each of these contributed what they do best and the team was managed and coordinated well, we might have enough manpower to take care of the baby boomers. The doctor’s place would be to manage everything, not to do everything. A well-managed team should be able to deliver better care—not worse.

The problem here is not the team concept but those mid-level professions that want to practice independently, without physician input or availability. That reduces the amount of training and expertise available to patients and will diminish the medical system as a whole.

F. Michael Minch, MD
TMA President

HELP WITH COMPLIANCE ON NEW PAIN CLINIC LAW?

3. Credit Card

4. Money Order - A money order is purchased by an individual using cash at various locations and typically pays a small processing fee. If a pain management clinic agrees to see a patient who does not have a checking account, a credit card or insurance, a money order is one of two legal payment options available. Money orders are available at various outlets such as Western Union, U.S. Post Office, convenience stores, grocery stores, etc. A quick call to any local business on the list above will verify whether money orders are available for purchase and the fee involved. The money order will be made out for a specific amount.

5. Prepaid Credit Cards - See #4 in Payment Options: Required on Date of Service, on previous page.

Q: I work in a primary care office and an employee of a pain clinic recently told me that after December 31, 2011, the physicians here will no longer be able to write prescriptions for any narcotic. Is that true?

A: No, and as long as your office does not meet the requirements in law for a pain management clinic you will not need certification from the state. It appears the pain clinic you spoke with misunderstands the law that passed this year. A physician’s office is considered a pain management clinic and must be certified by the state of Tennessee only if it writes prescriptions for opioids, benzodiazepines, barbiturates or carisoprodol, but not including suboxone, for 90+ days for more than 50 percent of its patients in a 12-month period. Practices that do not meet the definition of a pain management clinic may continue to prescribe for their patients as usual.

For additional information on the requirements for certification of a pain management clinic, see our Law Guide topic titled Pain Management Clinics at www.tnmed.org/lawguide. Any questions on this guidance should be directed to the TMA Legal Department at 800-659-1862 or becky.morrissey@tnmed.org.
Have You Considered Selling or Merging Your Practice?

DoctorsManagement Has The Expertise You Need.

- Experienced practice consulting professionals with MBAs, JDs and CPAs
- Thorough assessment of your goals
- Comprehensive valuation of your practice by a Certified Valuation Analyst
- Aggressive marketing and representation of the practice
- Careful analysis of the culture, competitive position and financial strength of potential acquiring organizations
- Evaluation of the compatibility of the acquirer with the practice
- Negotiation of transaction financing, terms of the contract, benefits, structure, expectations and decision-making processes after the sale
- Assurance of confidentiality and constant communication throughout the process
- Cooperation and collaboration with practice’s other advisors (attorneys, accountants, etc.) and with advisors of the acquiring organization
- Commitment to timely resolution

Your Mergers & Acquisitions Team

Valora S. Guganious, MBA
T. Blake King, CPA, MAcc, CVA
Gene Good, JD, CPA, MAcc

10401 Kingston Pike | Knoxville, TN 37922
(800) 635-4040 | (865) 531-0176 | (865) 531-0722 (fax)
www.DoctorsManagement.com

Call Us To Discuss Your Practice
(800) 635-4040
TMA Board Approves Budget, Legislative Pkg, Web App

For the ninth year in a row, the TMA Board of Trustees has agreed to keep membership dues at the same level amid a challenging economy and reimbursement changes.

The decision came during its fourth quarter meeting, traditionally a planning session for the coming year. “Once again, we were successful in approving a balanced budget for 2012 that does not include a dues increase,” said TMA BOT Chairman Matthew Mancini, MD, of Knoxville. “Our members will benefit from this strategic move to maintain our value as they face increasing demands on their practices and pocketbooks.”

The Board also addressed a number of priorities for the coming year, updating its position on health system reform to address a health insurance exchange being developed for the State of Tennessee, and approving a plan presented by TMA Insurance Affairs Director Phyllis Franklin on preparing members for the ICD-10 transition.

“The cuts approved by MedPAC are much worse than we had anticipated,” said TMA President Michael Minch, MD. “The costs of running a practice have risen by 24 percent since 2001 and are expected to rise another 19 percent over the next 10 years. Over this same period of time, specialists’ payments will have been cut by 13 percent. I am surprised that so many physicians continue to see Medicare patients under present conditions, and I am sure that number will have to shrink under the proposed rule. Physicians will not be able to continue along this course.”

The TMA supports a Federation of Medicine letter to MedPAC stating its proposal asks too much of physicians and patients, and contains provisions not previously been endorsed by the Commission. Read more and take action at www.tnmed.org/actonSGR.

Take the TMA SGR Survey

Tell us how deep SGR cuts would impact your practice and your patients.

www.surveymonkey.com/s/TMA-SGR2011

Federation Opposes “Drastic” SGR Plan by MedPAC

A proposal by the Medicare Payment Advisory Commission (MedPAC) to repeal the flawed SGR payment formula is well-intentioned but “drastic” its approach.

That from the TMA, which joins national medical societies and allied healthcare groups in opposing the Commission’s new plan to pay for the SGR fix with some $333 billion in provider payment cuts and beneficiary cost increases.

“The cuts approved by MedPAC are much worse than we had anticipated,” said TMA President Michael Minch, MD. “The costs of running a practice have risen by 24 percent since 2001 and are expected to rise another 19 percent over the next 10 years. Over this same period of time, specialists’ payments will have been cut by 13 percent. I am surprised that so many physicians continue to see Medicare patients under present conditions, and I am sure that number will have to shrink under the proposed rule. Physicians will not be able to continue along this course.”

The TMA supports a Federation of Medicine letter to MedPAC stating its proposal asks too much of physicians and patients, and contains provisions not previously been endorsed by the Commission. Read more and take action at www.tnmed.org/actonSGR.

Take the TMA SGR Survey

Tell us how deep SGR cuts would impact your practice and your patients.

www.surveymonkey.com/s/TMA-SGR2011
It’s Election Time: Things You Should Know

The TMA’s annual leadership elections are just around the corner. Now is the time to submit nominations for possible candidates for regional and statewide offices.

By November 14, Component Medical Societies need to certify their Society representative(s) to the Regional Nominating Committee. They should also provide a list of members interested in running for regional and state offices to the Society’s RNC members and to the TMA, to be relayed to the regional and state nominating committees. All election materials can be found online at www.tnmed.org/elections.

ONLINE ELECTION CENTER
The online election center at www.tnmed.org/elections has all the required forms for Regional and Statewide Nominating Committees and candidates, official election policy, a list of regions and contact information.

PLC Nominations Due January 3

Nominations are now being accepted for the TMA Physician Leadership College Class of 2012-13; the deadline to submit applications is Tuesday, January 3.

Open to all members of the TMA, the College meets six times throughout the year, beginning in April 2012. If you are interested in participating in the PLC, please visit www.tnmed.org/leadership-college for more information and an application.

Questions regarding the PLC can be directed to Ashley Cates at 615-460-1671 or ashley.cates@tnmed.org.

Annual Awards: Nominations Due Dec. 16

The TMA is proud to accept nominations for the 2012 Community Service Award, Distinguished Service Award, and the Outstanding Physician Award.

Each nomination should be accompanied by complete information according to the criteria outlined in the nomination packet, available at www.tnmed.org/awards. A checklist is included for each award category and must be submitted at the time of nomination.

All nominations and materials must be submitted electronically, either in a Word document or as a PDF file. Submission instructions are included in the nomination packet.

DEADLINES
• Outstanding Physician Award - December 16, 2011
• Community Service Award - December 16, 2011
• Distinguished Service Award - January 1, 2012

Questions? Please contact Ashley Cates, at ashley.cates@tnmed.org or 800-659-1862.

PLC Graduates Speak

“Physicians are looked upon as the leaders of their practice, but we have little training in this capacity. The TMA PLC was a wonderful experience and taught many aspects of leadership all physicians can employ in their practice.”
— Pete Powell, MD
Class of 2008

“I particularly enjoyed the PLC because of the interaction among the highly accomplished and motivated individuals who shared the common goal of making a favorable difference in health care from both a patient’s and provider’s perspective. The faculty was excellent!”
— Morris Barocas, MD
Class of 2009

“My experience with the TMA PLC has given me the leadership skills and competency to be an effective physician leader in my group and various other organizations that I am involved in. The scope of experiences that the PLC offers has helped me to advance my career as a physician leader in the community and further patient advocacy on a broader scale.”
— Christi Witherspoon, MD
Class of 2011
TMA Public Health Champion: Dr. Marta Wayt

Marta Wayt, DO, FACP, of Kingsport, has been named the TMA Quarterly Public Health Champion.

An internist with Kingsport Medical Associates, Dr. Wayt is known for her fierce devotion to her patients both in the office and in the hospital; beyond her practice, she serves as medical director of Providence Medical Clinic and volunteers with Friends in Need Health Center, both of which provide care to underserved and uninsured residents of upper East Tennessee.

“She helps multiple people in our community,” said Elizabeth Clemens, MD, who nominated Dr. Wayt for the TMA honor. “She has several non-paying patients in her personal clinic—I know as she has taken several from my ER referrals—and works with them to provide care. She works hard to get specialists to aid these patients and others. She is simply a dynamic young woman.”

Dr. Wayt has been a volunteer physician with Friends in Need for several years. Friends in Need provides regionally supported medical, dental and counseling care to the underserved and uninsured in Sullivan, Hawkins and Scott Counties.

“Dr. Marta Wayt is one of (our) extraordinary physicians. She began volunteering as an Internal Medicine physician at Friends In Need in October of 2003,” said FIN Executive Director Mark Smelser, who said during that time she has delivered timely, compassionate care to hundreds of patients. “With Dr. Wayt’s and other area physicians’ commitment to the clinic, patient visits have increased by 114 percent in the last eight years.”

In early 2010, she joined Providence as medical director. Modeled after the Church Hill Free Medical Clinic, Providence offers “compassionate” primary care and spiritual support to the underserved in Sullivan County.

Dr. Wayt received her medical degree from the West Virginia School of Osteopathic Medicine in 2000 and completed her residency training at Mercy Hospital in Pittsburgh. Certified by the American Board of Internal Medicine, she is a Fellow of the American College of Physicians.

Do you know a TMA public health hero who deserves to be in our quarterly spotlight? Submit their name with a brief statement explaining the reason for your nomination to brenda.williams@tnmed.org.

Absent Federal Funds Force More TC Cuts

A lack of hoped-for federal funding has forced TennCare officials to enact another 4.25-percent reimbursement cut for certain services, effective January 1.

The new cuts will again impact nursing homes, MCO administrative rates, transportation providers, lab and x-ray providers, dentists, the PACE program, and home health providers. The newest reductions are on top of a 4.25-percent cut already enacted on these same providers in July, for a total of 8.5-percent in reductions.

“TennCare has tried its best not to cut direct patient care but we believe imaging is direct patient care because it determines the diagnosis in a lot of cases,” said TMA General Counsel Yarnell Beatty, who said many TMA members provide x-ray services. He said the delay in decision-making by officials in Washington is to blame for the timing and late notice on these changes.

For explanation behind TennCare budget cuts, visit www.tn.gov/tenncare/budget12.shtml. For assistance or questions, contact the TMA Legal Department at 800-659-1862.

TMA BOARD APPROVES BUDGET, LEGISLATIVE PKG, WEB APP
(Continued from page 13)

The BOT’s updated HSR position statement can be found at www.tnmmed.org/HSR. Details on ICD-10 training by the TMA can be found at www.tnmmed.org/ICD-10.

OTHER ACTION

The Board also:

• Approved the TMA’s 2012 legislative package as presented by the Legislative Committee;
• Approved continuation of year three of the Association’s strategic plan;
• Approved collaboration with the Tennessee Pharmacists Association to address the state’s status as a leader in overprescribing and overutilization of prescription drugs;
• Approved rollout of a new TMA web application, which gives members mobile access to fellow members, TMA staff and experts, and breaking news important to doctors and patients. The application will be introduced to members later this year; and
• Agreed to support the campaign of Lee Morisy, MD, of Memphis, for the AMA Board of Trustees. Dr. Morisy is the current chairman of the AMA Council on Science and Public Health.
**Give a Thursday for TMA Doctor of the Day**

Each year, TMA members are invited to serve as the Doctor of the Day for the Tennessee General Assembly. This volunteer commitment involves one day of service at Capitol Hill in Nashville during the legislative session. All available service dates for 2012 are Thursdays. On most Thursdays, especially early in session, your responsibilities will end before noon.

As the Doctor of the Day, you will be called on to provide basic medical services to legislators and staff. In addition to providing care when needed, you will have a unique opportunity to interact with legislators on the House and Senate floors – a privilege reserved for very few. The TMA will reimburse you for reasonable related expenses.

Your presence on Capitol Hill shows lawmakers not only your expertise but also your concern for the health of Tennesseans. **NOTE: You must be a TMA member with an active, unrestricted medical license to volunteer.**

**HERE’S YOUR CHANCE!**

This unique opportunity allows you to see the legislative process in action, influence legislators and volunteer your expertise.

To sign up, visit [www.tnmed.org/programs](http://www.tnmed.org/programs) and click on “Doctor of the Day.” You are welcome to volunteer for multiple dates. If you have questions not covered in this information, please contact Renee Amott at 800-659-1862 or renee.amott@tnmed.org.

---

**Survey Vitals Complimentary Subscription to Members**

Survey Vitals is an easy, web-based survey tool that provides real-time patient feedback... a must-have for complying with impending health system reporting requirements.

The TMA is working with Bob Vosburgh of Survey Vitals to offer our members a **three-month complimentary subscription** to the Survey Vitals dashboard. Members will receive emails and future alerts about the complimentary subscription.

Learn more at [www.tnmed.org/patient-survey](http://www.tnmed.org/patient-survey)

For more information, contact Communications Manager Ashley Cates at 800-659-1862 or Ashley.Cates@tnmed.org.
Tennessee General Assembly Convenes in January; IMPACT Needs Your Help Now

By Newton P. Allen, Jr., MD
IMPACT Chairman

It’s hard to believe but the beginning of the next session of the Tennessee General Assembly is right around the corner. It was only six short months ago that the legislature wrapped up the 2011 session, where we saw passage of one of the most important items on the TMA’s agenda, comprehensive tort reform and caps on non-economic damages. This success is due to leadership from Governor Haslam and our friends in the House and Senate.

In 2012, the legislature takes on the important responsibility of drawing new congressional and legislative district lines, a task required every 10 years. This promises to be a time-consuming and high-profile process, so the TMA legislative team will work hard to ensure that our friends in the legislature focus on our legislative agenda and that we have another successful year.

The TMA will be asking the legislature to consider additional legal protections for physicians serving patients under the EMTALA mandate, and to eliminate the possibility of the courts overturning last year’s tort reform win by amending the state constitution to expressly permit the General Assembly to enact caps on non-economic damages.

As always, our success depends on your support. By law, IMPACT will be prohibited from making political contributions to legislators from the time the legislature convenes on January 10 until it adjourns several months later. This gives us effectively until the end of the year to make the contributions necessary to make our voice heard before the legislature begins its work and takes up the TMA’s important agenda. So it is critical to have the full support of our membership and the benefit of a well-funded PAC to make the investments needed before January 10.

Please consider a donation to IMPACT in the next 60 days. For those who have already contributed through your annual dues bill, please consider increasing your level of support. Corporate contributions to IMPACT are now allowed, so this gives you another channel to support the PAC. For those who are not currently supporting IMPACT, now is the ideal opportunity to make your voice heard.

To contribute please visit the IMPACT Website at www.tnimpact.com or send a check to:

IMPACT
2301 21st Avenue South
P.O. Box 120909
Nashville, TN 37212

For more information about IMPACT, visit www.tnimpact.com.

Capitol Hill Club

The IMPACT Board of Trustees recognizes the following IMPACT donors who have become Capitol Hill or Platinum Club members in the past month. We greatly appreciate all IMPACT contributors for their help in assuring that candidates supportive of organized medicine receive generous financial support from IMPACT. To join IMPACT or the Capitol Hill Club, please contact Gary Zelizer at 800-659-1862 or e-mail gary.zelizer@tnmed.org, or log on to www.tnimpact.com.

Newton Allen, Jr., MD, Nashville
Joe Browder, MD, Knoxville
John Culclasure, MD, Nashville
Chris Fleming, MD, Germantown
David Gerkin, MD, Knoxville
Mark Goldfarb, MD, Nashville
Ronald Johnson, MD, Germantown
Robert Kerlan, MD, Germantown
George Lee, III, MD, Nashville
Lee Morisy, MD, Memphis
Edmond Owen, Jr., MD, Memphis
Robert Page, MD, Knoxville
Charles Portera, MD, Chattanooga
John Proctor, MD, Franklin
Perry C. Rothrock, MD, Cordova
Andy Walker, MD, Nashville
John Warner, MD, Nashville
Jeffrey Warren, MD, Memphis
Clarence Watridge, MD, Memphis
Laura Witherspoon, MD, Chattanooga
George Woodbury, Jr., MD, Memphis
Michael Zanolli, MD, Nashville
Six orthopedists with The Campbell Clinic in Memphis have been named among the nation’s “Top Doctors” by U.S. News & World Report. They are: James H. Beaty, Jr., MD; S. Terry Canale, MD; David L. Cannon, MD; James L. Guyton, MD; Andrew J. Murphy, MD; and William C. Warner, Jr., MD. All are members of The Memphis Medical Society.

James C. Fleming, MD, FACS, and Stephen T. Miller, MD, MACP, have been named associate chief medical officers for UT Medical Group, Inc., in Memphis. Dr. Fleming directs the UT Hamilton Eye Institute’s Orbit Center, and chairs the UT Medical Group Finance Committee, and is vice chairman of Ophthalmology and the Philip M. Lewis Professor of Ophthalmology at the University of Tennessee Health Science Center. Dr. Miller is the Robert S. Pearce Chair in Internal Medicine, professor and vice chair of Medicine at UTHSC, and an educational leader at Methodist Le Bonheur Healthcare. Both are members of The Memphis Medical Society.

Ted L. Flickinger, MD, of Maryville, has been elected chairman of the board of directors for the Helen Ross McNabb Center, a community organization offering mental health, substance abuse and social services in 20 counties in East Tennessee. A retired urologist, he also serves as vice president of the board of directors for Blount Memorial Hospital, and is a member of the Blount County Medical Society.

William C. Gibson, MD, of Premier Surgical Associates, PLLC, in Knoxville, has been chosen for the Comprehensive Patient Safety Leadership Fellowship by the American Hospital Association and the National Safety Foundation. A Class of 2010 graduate of the TMA Physician Leadership College, Dr. Gibson now serves on the PLC Steering Committee. He is a member of the Knoxville Academy of Medicine.

Edward D. Kim, MD, of Knoxville, has been elected to the board of directors for the American Society of Reproductive Medicine and appointed to the editorial board of ASRM’s international journal, Fertility and Sterility. He has also been elected to the board of directors for the society for the Study of Male Reproduction and will serve as its president-elect in 2013. A urologist with University Urology, PC, Dr. Kim serves on staff at University of Tennessee Medical Center and is a member of the Knoxville Academy of Medicine.

Edward W. Reed, MD, FACS, of Memphis, has been designed trustee emeritus in honor of his 28 years of service to the Meharry Medical College Board of Trustees. A 1955 alumnus of Meharry, Dr. Reed was the first African-American board-certified general surgeon to practice in Memphis; he was also the first African-American physician to serve on the faculty of UT College of Medicine and have staff privileges at Baptist Memorial Hospital – Memphis. He is a former chairman of the board for the MED, and has served on the boards of various organizations including the University of Tennessee, St. Jude’s Children’s Research Hospital, St. Joseph Hospital, the Tennessee Division of the American Cancer Society and the American Cancer Society. A 2008 recipient of the TMA Outstanding Physician Award, in 2008, Dr. Reed is a member of The Memphis Medical Society.

Walter C. Shea, Jr., MD, was inducted into the Lenoir City Sports Hall of Fame in September. A longtime general practitioner and former medical administrator of Baptist Health Care, Dr. Shea served for years as team physician for the Lenoir City Panthers, handling sideline injuries and emergencies as well as team physicals. He is a former Man of the Year and Rotary Club member, and served as colonel in the Tennessee Defense Force Medical Unit, 304th Battalion. Dr. Shea is also a co-founder and chairman of the Board of Adult Community Training, serving special needs citizens of Lenoir County. Now retired, he is a member of the Knoxville Academy of Medicine.

Are you a member of the TMA who has been recognized for an honor, award, election, appointment, or other noteworthy achievement? Send items for consideration to Member Notes, Tennessee Medicine, 2301 21st Ave, South, PO Box 120909, Nashville, TN, 37212; fax 615-312-1908; e-mail brenda.williams@tnmed.org. High resolution (300 dpi) digital (.jpg, .tif or .eps) or hard copy photos required.
Life with your clearinghouse.

Life with Navicure.

How’s your cash flow? Find out how to get your electronic claims paid 21% faster with Navicure*.

The most technologically advanced clearinghouse solution, now more affordable than ever.

navicure®
Collect more. Stress less.
www.navicure.com • 1-877-409-5828

Tennessee Medical Association members receive $250 off implementation and enrollment on packages starting as low as $79 per provider per month.

“Best In KLAS”
Claims and Clearinghouse Services
2010 Top 20 Best in KLAS Awards: Software & Professional Services
www.KLASResearch.com

*During 2003, the average Navicure client saw an average 21% reduction in days between electronic claim submission date to payer paid date. Before the implementation, they began using Navicure and by the end of their 1st year using Navicure’s solution.
Our Support for TMA Members is Expanding

Making Our Mark Across Tennessee

Now in the Chattanooga area.
XMC is proud to support members of the Tennessee Medical Association by providing cost effective office equipment and electronic document management. As independent business people and exclusive representatives, Xerox of XMC offers you the best of both worlds.

As a corporate partner with the Tennessee Medical Association, you receive the benefits of:

- Consistent negotiated contract pricing on Xerox technology
- Single order contact
- Free technology consultation
- Hardware, software, managed print services, and electronic document management available
- Total Satisfaction Guarantee

XMC Excellence in Office Solutions

Multifunction Machines | Scanners | Copiers | Printers | Electronic Document Management

www.xmcinc.com • 888.814.3114
In June 2009, a local manufacturer came knocking on the door of Fayetteville Medical Associates, concerned about its rising healthcare costs for workers.

“When a local employer approaches you about high medical costs, it gets your attention,” said Fred Ralston, Jr., MD, MACP, an internist and principle in the eight-physician group, who said the company wanted to address some high-cost referral patterns. Dr. Ralston said physicians sat down with the company and insurer, went over the data, and worked to adjust their referrals to more cost-effective hospitals that provided the same or better care. After meeting the needs of the manufacturer and insurer, Ralston reminded them of their own data regarding Fayetteville Medical Associates’ low cost and high quality care. The insurer took the not-so-subtle hint and created an incentive program that still rewards FMA for ongoing cost-effectiveness.

“Our practice is 102 years old and the thread of our history and that of the community is connected,” said Dr. Ralston, adding that in light of current economic conditions, “We want to do everything we can to make sure healthcare costs are not a hindrance to the local economy.”
How Much Is Too Much?

Health care costs are definitely, doggedly on the rise. A 2010 CMS report said healthcare spending grew to a record 17.3-percent of the U.S. economy in 2009 and projected that by 2011, the government would be paying more than half of the nation’s total healthcare tab.

One health policy analyst said the fallacy in the health cost argument is the idea of dollars saved. Healthcare spending will continue to rise for a lot of reasons—baby boomers entering Medicare, health reform, universal coverage, rapidly expanding technology, etc.—thus, he said the realistic goal is not to reduce the amount spent but to control the rate of rising cost.

“I think that’s an important distinction that gets lost, to think we’re going to save all this money,” said David Mirvis, MD, senior health policy fellow at the University of Tennessee’s Howard Baker, Jr. Center for Applied Public Policy and a senior research fellow and healthcare consultant at Fogelman College of Business and Economics at the University of Memphis. “It’s a savings from what might have been, not a savings in terms of dollars in somebody’s pocket.”

To state that we are spending too much implies there is a correct amount we should be spending. Dr. Mirvis said the question then becomes, how much is too much? And who makes that decision?

“Polls show that when we ask if we are spending too much on health care globally, people say yes; but if we ask are we spending too much on your healthcare, the answer is no. It’s a complicated question.”

In that scenario, Dr. Mirvis said the physician’s role in controlling healthcare costs becomes one of not wasting resources, not participating in fraud, presenting more choices to patients that honor both their health and their pocketbooks, and becoming an advocate for quality care.

“When other people impose cost cuts who have got only financial interest in mind and don’t understand the nature of patients and doctors, we have to raise our voices,” he said.

“We have to separate that out in public perception that we are not advocating for our own income but for the patient in terms of protecting quality of care ... and defining quality as evidence-based quality—not just more and not just new, but more effective and appropriate care.”

A Medical Home

On its quest to provide quality, effective care, Fayetteville Medical Associates signed on to become a Patient-Centered Medical Home (PCMH) through Blue Cross BlueShield of Tennessee (BCBST) in early 2010. As an immediate past-president of the American College of Physicians and as chair of its Health and Public Policy Committee, Dr. Ralston said he heard much about the medical home concept and was convinced this was the best emerging way to care for patients in the current healthcare landscape.

This physician-led team approach relies on best practices, communication and technology to provide coordinated care that aims to keep patients healthy, manage their conditions and head off problems before they become more serious.

“ER visits would become fewer if a patient has access after-hours and their non-emergent needs are met. If the care is better over time, inpatient admissions will fall, as well, because of appropriate care. This generates savings through the health...
plan where some of that is shared back to primary care and much of it goes back to the consumers — the persons buying the insurance,” he added.

Amerigroup Tennessee, with 18 of its 500 TennCare primary care practices (caring for 20 percent of its members) participating, ranks 8th nationally for the number of providers engaged in its PCMH pilot program. William Runyon, MD, chief medical officer for the Tennessee plan, said Amerigroup believes the focus on preventive primary care is the path to higher quality, cost-effective care.

“We have a significant level of respected evidence that in areas where you have a greater concentration of primary care providers, you have a significant reduction in medical cost and a dramatic increase in quality,” he said. “This is a model that has the opportunity to address both of these; that was one of the very reasons we launched this strategy.”

The program began in January 2010 as a way to improve collaboration and efficiencies. “We had done about as much as any managed care organization could with regard to quality and cost,” Dr. Runyon explained, adding the insurer knew the arm’s-length, high-level dealings with providers had to change. “We began to design our program to really provide much more robust support, a boots-on-the-ground high level of collaboration.” And he said Amerigroup is already seeing significant improvements with its medical homes in reduced ER visits and hospital admissions, and a corresponding increase in better health outcomes.

**Practicing Lean**

For Prime Care Medical Center, PC, in Selmer, becoming a BlueCross PCHM practice two-and-a-half years ago has improved day-to-day patient care and led to some cost reduction. But other costs are going up and reimbursement is going steadily down, according to Medical Director Jim King, MD, so Prime Care has taken steps to make up the difference.

“Our practice signed up with CMS and received a

**New Specialists’ Network to Improve Care, Reduce Costs**

Whatever the coming “wave” is in health care, eight specialty groups in Nashville want to get ahead of it.

Anesthesia Medical Group, Howell Allen Clinic, Otolaryngology Associates of Tennessee, Premier Radiology, Tennessee Orthopaedic Alliance, Tennessee Women’s Care, PC, The Surgical Clinic and Urology Associates, PC, have formed Health Innovation Specialists (HIS), a network to share and compare data and use it to develop clinical initiatives to deliver high quality, efficient, cost-effective specialty care.

HIS Chair Charles Eckstein, MD, said the move was prompted in part by new health reform emphasis on accountable care organizations, which to date have been focused on primary care. “We felt that there was little attention being given to quality initiatives in the specialty sector despite the significant opportunity for savings.”

Another issue is current insurance quality programs which mainly measure a doctor’s performance based on costs using billing records. A former TMA Board chairman, Dr. Eckstein said concern was prevalent among members during his tenure — and HIS partners wanted to make sure they were evaluated fairly. “All of these groups are committed to being measured on quality; however, quality must include not only costs data but clinical outcomes, as well,” he said.

The network has been established and insurer meetings have gone well, he said; by the first quarter of 2012 the groups hope to firm up the means for data collection, evaluation and reporting to begin the process of getting “ahead of the curve.”

Dr. Eckstein said the self-evaluation may be painful at times but doctors are driven to do their best. “If they see they can do better, they’ll want to do better. We have little doubt in that regard.”

Ultimately, he said with changes in reimbursement and new ways of delivering care on the horizon, the future is about seeing what works and getting rid of what doesn’t. With concurrent evaluation, best practices will result.

“On all those levels you’re going to save time, save money, save the patient recovery time — you save up and down the line,” he said. “Identifying leaders in this regard and emulating their practices will speed the development and adoption of quality-based practice and reimbursement.”

**Dr. Runyon**

**Dr. Eckstein**
significant check for PQRI and ePrescribing incentives. Of course, the five-percent primary care bonus that was passed in the health reform bill has helped our practice significantly,” he said. To help pay for information technology investments and upkeep as well as practice expansion costs, Prime Care has also added ancillary services such as expanded radiology, physical therapy, ultrasound and laboratory services, allergy testing and hospital procedures. To keep the books balanced, they are renegotiating with vendors, controlling utility costs, and staying on top of paperwork required for payment.

With the rise of high-deductible health plans, patients increasingly need help keeping healthcare costs down, too, so Dr. King and his colleagues are paying more attention to that aspect. “We talk with patients now on a regular basis about cost. We want to decide not only which treatment is best, but also which one adds the most value that they can afford,” he said, adding, “The worst pill I can write for a patient is one they can’t or won’t fill.” He said they’re also beginning to utilize group visits by similar diagnosis, as well as phone and electronic consultations (or “e-visits”), which save money for the practice, the patient and the insurer.

Recalculating

Amid the sea change in health care, Dr. King said physicians, especially those in primary care, need to change their paradigm.

“You can’t continue to do like we’ve done in the past and increase the amount of patients you see, services you provide, tests you do, and make that work,” he said. “Besides adding cost to the system, insurers are decreasing the payments for those, so over time that model is going to go away.” Instead, he said doctors need to look at becoming more patient-centered and focus on adding quality and value by maintaining and improving their health.

For one member, those goals are achieved through a direct payment, or cash-only, practice. Yasmine Ali, MD, MSCI, FACC, FACP, opened Nashville Preventive Cardiology, PLLC, earlier this year and decided not to work with insurers.

The daughter of two TMA-member physicians, Dr. Ali had seen the mounting pressures posed by increased regulation and lower reimbursement, both in her parents’ practice and early in her own career. “My passion is cardiac prevention and I clearly saw the need for that but wasn’t sure how to get paid for it under the existing systems of care. I thought, ‘If I’m really going to do this to prevent heart disease and stroke and be able to educate my patients, I’m going to have to do it on my own.’”

Through this practice model, she said she is able to do her part to improve her patients’ health and reduce healthcare costs.

“Because I’m not tied to insurance contracts, I can offer discounts. I work with my patients and other providers to find out about a patient’s financial situation and then I go from there,” she said. “I can give charity care, show compassion, give...
professional courtesy. I am able to offer flat rates. I am in control of how much time I spend with my patient; if it requires 90 minutes, I’m happy to give them that. And because I’m in control of my own schedule and time, I am able to volunteer regularly at Siloam Family Health Center. In my own way I am increasing access and decreasing costs for the uninsured or underinsured who might not otherwise be seen, because they wouldn’t have low- or no-cost access to a specialist.” (Read more about Dr. Ali’s practice model on page 27)

**Bend The Curve**

A former president of the American Academy of Family Physicians and former TMA Board chairman, Dr. King said while in leadership he was constantly telling fellow physicians that the status quo was not sustainable. The TMA can help, he said, by keeping members informed about their options.

“We need to educate members on what the buyers of health care want, and then let’s start to provide that product instead of continuing to do the same thing and just get paid more for it. How many TMA members got PQRI and e-prescribing incentive money? How many of them are working toward meaningful use? We’ve got to get out there and change those numbers.”

Overall, Dr. Ralston said the healthcare expenditure curve continues to rise and “we have to bend the curve.”

“There is an informed estimate that between 30 and 50 percent of what we do in health care does not add value to the equation. There are some clinical conditions where practice in one part of the country is more efficient than in other parts of the country; that’s the kind of thing we need to look at and find a way to at least contain the curve of cost,” he said, adding, “We all have a role in helping our society get the best value for dollars spent on health care.”

**Learn More**

ACP High-Value, Cost-Conscious Care Initiative
www.acponline.org/clinical_information/resources/hvccc.htm

BCBST Patient-Centered Medical Home Program
www.bcbs.com/blueresources/wellness/patient-centered-medical-home/

Video: Introduction to the Patient Centered Medical Home
www.emmisolutions.com/medicalhome/transformed/

U.S. Health Care Costs Explained, Kaiser Family Foundation

**IOM: Insurance Exchanges Will Fail Without Cost Containment**

An October report by the Institute of Medicine, requested by the U.S. Department of Health and Human Services, said the “essential benefits” plans to be offered in insurance exchanges under health reform must balance cost and comprehensiveness — otherwise, these coverage expansions in the health system reform law will fall short. The IOM panel said one way to hold down costs is to emphasize evidence-based medicine as a way to standardize care.
Tame the beast.

Running a practice is getting more complicated — and frustrating. And in your gut, you know traditional software won’t make it simpler. Join the 27,000 providers who use our cloud-based practice management, EHR, and patient communications services to tame the beast.

Put the power of the cloud to work.
800.981.5085 : athenahealth.com/TNMed
There were so many other people in that exam room ... and none of them were my patient.

They were all the “middle men,” the third parties coming between me and my patient, between me and the direct patient care we like so much to talk about these days. They were the third-party payors and the claims processors and the coders and the administrators and the schedulers and the bottom-liners, all trying to figure out how to make doctors more like mechanics and turn a real “profit” — all those so-called interested parties who didn’t even know my patient or her problems but were effectively managing to hinder the delivery of true patient-centered care.

It was a wonder I could even see my patient through this intervening throng, much less take the time actually to talk with her. Then again, why should a doctor need to speak to a patient anymore? Can’t we just look at the chart and read what someone else has written about her, glance at the medication list and vitals someone else has taken, review the results from tests someone else has ordered? And who has time to speak—and, much more importantly, listen—to anything substantive the patient has to say in a 10-minute visit? Ask the patient? Ludicrous.

Yet most risk management courses advise us that those doctors who are best able to communicate with their patients as individuals, giving them the time of day—before, during and after any adverse event—are the least likely to be sued. Perhaps we should add to our malpractice tort reform advocacy the idea of restoring the patient-physician relationship, by reforming systems that undermine it when they steal time from us and our patients in myriad and often insidious ways.

In addition to MCOs and PPOs, we now have ACOs and EHRs and SGRs, piled atop declining reimbursements and increasing frustrations, amid a morass of regulations with questionable potential benefit ... and no end in sight. We have now been reduced to trying to figure out the very meaning of “meaningful” (as in whatever “meaningful use” is supposed to mean). Navigating the maze of modern medicine resembles nothing so much as getting lost in a three-ring circus, for both physicians and patients. Surely it does not have to be this complicated. Surely there is a better way.

While I cannot presume to suggest what the better way might be I can say that, for me, opting out of Medicare and all forms of insurance and beginning a solo direct-payment (also known as “cash only”) practice has turned out to be the right thing to do at this stage of my career, especially given my goals as a preventive cardiologist. Before, when I spent the majority of my time covering the CCU and doing damage control, I had little time or energy left to practice prevention—a good portion of which requires time dedicated to patient education. And on the occasions when I tried to do so under a third-party payment system, the time constraints of the schedule demanded by that system made patient counseling on prevention inadequate at best and impossible at worst.

I established a solo preventive cardiology practice, Nashville Preventive Cardiology, PLLC, and began seeing patients there this past February (2011). With the wonderful assistance of the everhelpful TMA staff, I was able to figure out what I needed to do to opt out of Medicare, after carefully weighing all the options. (As with so many matters involving Medicare, opting out is not without its own hassles.)

And so this experiment of mine has begun. Eight months into it, with total control over my own schedule, I have found the personal satisfaction has far exceeded my expectations. I am able to spend at least 60 minutes with every new patient doing a thorough history and cardiac exam, and spending time to educate my patients on their cardiac risk factors as well as risk-reduction techniques to modify those factors as favorably as possible. I partner with my physician colleagues in the community to provide primary care services and additional diagnostic testing whenever needed. I have no billers, no coders, no collections (as payment is due at the time of service); with this alone I have cut estimated potential overhead by at least 75 percent. I have found my patients to be highly receptive to this way of practicing medicine; they tell me they especially appreciate the time I spend with them and my highly personalized approach.

While this practice model is not for everyone, it is the right one for me right now and is allowing me to continue to see patients and practice medicine with the original passion for patient care that led me to medical school in the first place. For me, I feel I have finally found truly meaningful medicine.

Dr. Ali is president of Nashville Preventive Cardiology, PLLC, and an assistant professor of Clinical Medicine at Vanderbilt University School of Medicine. She currently serves as vice chair of the TMA Young Physician Section and is a YPS delegate to the American Medical Association. Contact her at 615-866-9907 or dr_y2001@yahoo.com.

Dr. Ali’s comments are her own and not necessarily those of the TMA.
Our Members Get It.
From reforming tort laws to recouping insurance claims, your TMA provides countless benefits – worth more than the cost of membership!

SAVINGS
• eHealth/Health Information Technologies
• Free Group Purchasing Program
• ‘Workers’ Comp Insurance
• Document Management Solutions
• Financial Services

SECURITY
• Contract Review Services
• Identity Theft Protection
• Practice Management Resources

PERFECTION
• Patient Satisfaction Survey
• Continuing Education
• Workshops & Seminars
• Physician Leadership College

Make Sure You Don’t Lose It!

Renew your membership online at www.tnmed.org/renew or call the TMA at 800-659-1862

Physician Leadership College
Applications are now being accepted.
The Tennessee Medical Association’s Physician Leadership College is an intensive leadership development program designed to train TMA members in the core aptitudes to excel in leadership positions within organized medicine, medical practice and business.
For more information, visit www.tnmed.org/leadershipcollege

Class of 2013
Application Deadline:
January 3, 2012!
SPECIAL FEATURES

Erosion

By Charles E. Leonard, MD, FAAFP

It is 3:00 p.m., no patients in the office, and I stand at the window pondering the rain as it washes a thin brown stream of mud down the driveway. With Alan Jackson’s prophetic song “There Goes The Little Man” playing in my head, I am reminded of the O’Native American who appeared in those famous litter commercials with a tear in his eye. I, too, grieve over Paradise lost. Let me take you from a mountain unattainable to a mountain conquered, and finally a mountain eroded.

It is 1957 and my parents listen intently as the surgeon tells them their son needs his inguinal hernia repaired. So a curious four-year-old boy is admitted to the only hospital in town, to the only surgeon in town. The surgery nurse, who is also the surgeon’s wife, recognizes something in that little boy and answers his questions, shows him around the hospital and the operating room, and lets him see the surgical instruments.

I was hooked. I wanted to become a doctor and my path was set.

Growing up, I admired the family docs who treated me when I was sick. They made me want to become a family physician. They did lots of fun stuff like delivering babies, seeing hospital patients, and using my favorite subject, science, in the real world. Everyone in the community respected them. Some of these mentors even let me see patients with them. To become one of them seemed insurmountable, yet there was a hunger inside me that wanted to take you from a mountain unattainable to a mountain conquered, and finally a mountain eroded.

First, there was college, then medical school, then family practice residency and finally, private practice starting on July 21, 1981. It was a three-physician group: one general surgeon, one internist and me. This was the only “group” in town. The other physicians were solo. There was one OB/GYN, one other internist, and three other family physicians, bringing the total to eight. Nobody “recruited” me. No bonus, no moving expenses, just the offer to rent an office and two exam rooms, hang out my shingle and have at it. Nevertheless, I had climbed the mountain.

We were busy but not too busy. I delivered babies and saw patients in four nursing homes. The active physicians took turns being on call for the hospital. Some of us even worked night shifts in the emergency room. We were pretty much on call 24/7 unless one of us needed to go out of town or just needed a night out with the wife. In this event, we would ask one of the other physicians to cover for us.

New patients came quickly and within four years, I opened my own solo practice. My home number was listed in the phone book and when I ran into a patient at Wal-Mart, it was “Hi, Doc!” Patients brought me tomatoes from Grainger County or baked pies and cakes for me. When a patient died, I visited the family at the funeral home. This was rural family medicine in the 1980s. It did not last.

The hospital was sold to a larger hospital, which later merged with an even larger hospital system. It began recruiting other doctors until the population of physicians had expanded by a factor of five. Physicians began to form groups and then merge with larger groups. These hospitals and large groups had the financial resources to advertise in our local newspaper. With the county population growing slower than the physician population, this rainstorm significantly eroded my patient list.

It was not long until the hospital also closed its obstetrics department, claiming it was losing money. Traveling to hospitals in neighboring cities to do deliveries became impractical. Hospitalists were hired to take care of the unassigned patients and a full-time emergency room service was contracted by the hospital. Soon the ER began to function as a walk-in clinic of its own. Frequently, reports came to me about patients with minor illnesses or minor injuries being treated there during the time my office was open.

It is raining again.

At about that time came the appellation “provider” instead of doctor. Currently the TriCare Prime website directs patients to pick a “Primary Care Manager.” Wow, I never thought I would long to be called a provider.

Soon walk-in clinics began to spring up. Thinking it would take longer to be seen in my office or that I would be too busy to see them, patients began going to the walk-ins with minor illnesses instead of coming to me. These clinics also did school physicals and, along with pharmacies, began offering flu shots. There is not a lot of profit in flu shots — just enough to make some extra money for Christmas bonuses for my employees. This year TennCare decided that unless a physi-

(Continued on page 32)
As a medical professional, there are many important demands that compete for your time. That’s why we have developed a unique level of banking that offers you convenient access to professional guidance, as well as priority services and exclusive discounts. It’s all part of our Medical Private Banking Group, a team dedicated to serving the needs of the medical industry. We believe it’s your key to finding the financial solutions that fit around every part of your life – both personal and professional.

Visit our new healthcare site at ftb.com/medsolutions for exclusive financial solutions that can simplify your personal & professional life.

To find out how you can benefit call:

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chattanooga</td>
<td>423-757-4251</td>
</tr>
<tr>
<td>TriCities</td>
<td>423-378-7008</td>
</tr>
<tr>
<td></td>
<td>423-461-1231</td>
</tr>
<tr>
<td>Knoxville</td>
<td>865-971-2112</td>
</tr>
<tr>
<td>Memphis</td>
<td>901-681-2524</td>
</tr>
<tr>
<td>Nashville</td>
<td>615-734-6016</td>
</tr>
</tbody>
</table>

Conventional wisdom suggests that health care is “recession-proof,” yet medical practices are as susceptible to economic cycles as other small businesses. There are ways, however, to maintain the health of your practice in light of declining revenues, growing accounts receivable, and tighter cash flows within the practice.

The following eight tips on how to boost revenue and reduce may help you improve the health of your bottom line— even in today’s challenging healthcare environment.

1. **EXERCISE HEALTHY CODING PRACTICES**
   Compliance is a strong force in the healthcare industry today. Upon evaluation of medical records, it is common to find that many providers are under-coding for their services.

   Whether under-coding is due to fear of an audit or lack of education, a coding and billing evaluation should be performed at least annually. Remember, EMR systems are not infallible—it is the provider who is ultimately responsible for the codes used. It is imperative that providers are documenting services according to documentation standards. An annual coding evaluation helps to ensure that all charges are captured and alleviates the tendency to leave money on the table that is rightfully yours.

2. **KEEP AN EYE ON CASH COLLECTIONS**
   Account aging and bad patient debts may increase during a downturn. Pay close attention to collecting co-pays, co-insurance and deductibles up front and be prepared to postpone some patient appointments to ensure that co-payments can be made on the day of service, as stipulated in your insurance provider contracts. A properly-trained medical staff can politely implement these important policies while maintaining patient satisfaction.

3. **MARKET YOUR PRACTICE FROM THE INSIDE OUT**
   The best place to begin your marketing approach just may be with your existing patient base. Training your staff to greet, care for and communicate with your patients can make a world of difference in patient retention. And, of course, patients who have a positive experience in your practice are more likely to share their experience with others.

4. **ADD ANCILLARY SERVICES**
   Ancillary services can provide a substantial payback to a medical practice. There is a right way, however, to approach this potential revenue stream. Carefully review your options and consider the return on investment for the space and resources required to add additional services. If done properly, ancillary services can positively contribute to your bottom line while providing greater convenience to your patients.

5. **NEGOTIATE INSURANCE SAVINGS**
   Some medical liability companies offer discounts simply for taking a risk management course or even for belonging to a specific professional organization. You may also reap discounts for consolidating all of your insurance with a single carrier. Shop around for the best deals that may save you thousands of dollars each year.

6. **REDUCE SUPPLY COSTS THROUGH GROUP PURCHASING**
   Investigate group purchasing organizations (GPOs) to achieve cost savings on office supplies, equipment or medications that you order each month. As part of a GPO, you may be eligible for 10–40-percent discounts on items you order every month.

7. **LEARN HOW MUCH YOUR PRACTICE IS WORTH**
   A Certified Valuation to determine the worth of your practice is crucial, not only if a potential buyer should emerge but in case you decide to seek a practice partner, get a divorce, become disabled, or decide to sell to a hospital or larger medical group. A Certified Valuation is an essential part of your estate plan and can help you realize your professional business goals.

8. **CONSIDER OUTSOURCING**
   For services that do not involve direct patient care, consider an outside provider rather than a full-time employee in areas such as billing, bookkeeping, transcription, payroll or accounting. Outsourcing avoids high fixed expenses such as salary and benefits of employees in these areas, and it permits the expenses for these services to fluctuate along with your patient volume.

(Continued)
Economic recession is difficult for both patients and physicians. Knowing where and how to make changes that will not compromise patient care or your professional standards is the challenge. The good news is there are things you can do to position your practice to thrive, even in a tough environment!

Ms. Gurganious is a senior management consultant and Ms. Petrillo is the director of Marketing with DoctorsManagement, LLC, in Knoxville.

**DoctorsManagement is a TMA Corporate Partner** This information was supplied by DoctorsManagement exclusively and for the benefit of our members. TMA does not accept responsibility for the information provided.

---

Erosion (Continued from page 29)

A few years ago, Cigna formed an arrangement with a reference laboratory to perform all lab tests for its members. No longer could physicians do cholesterol tests and other CLIA-waived tests in the office where results would be available in five minutes. Now all lab work had to be sent out – another shower.

I know what you are thinking. Change is inevitable. Go with the flow. Adapt. A recent article in *Annals of Internal Medicine* written by White House officials encourages small group practices to do just this: “...the health care system will evolve into 1 of 2 forms: organized around hospitals or organized around physician groups.” It said hospital practices and large groups would be the only types of practices that will have the resources to survive in the future. The article also said, “To realize the full benefits of the Affordable Care Act, physicians will need to embrace rather than resist change. The economic forces put in motion by the Act are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups.”

American Academy of Family Physicians President Lori Heim, MD, courageously rebutted this position in *AAFP News Now*. In the same article, Board Chair Ted Epperly, MD, also promised not to abandon small group FPs. While I applaud them for those encouraging words, they have to be evaluated in the shadow of recent efforts by the Academy to promote the White House model of primary care. If the U.S. Surgeon General is the template for this model, then the ideal primary care physician is a salaried government employee. I have to admit—I do envy the insulation from erosion this would provide. Do the small practice baby-boomer FPs have to give up and admit defeat? Is the type of practice that was so attractive to me as a boy gone forever? Dear Lord, I just want it to quit raining. I have already seen enough top-soil run-off into the ditch and I am afraid it may be too late to hand out umbrellas. Terra firma has become terra laxed.

A disturbing article appeared in the Health section of the *New York Times* on April 23, 2011, entitled “Family Physician Can’t Give Away Solo Practice.” In the article, Ronald Sroka, MD, former president of the Maryland Medical Society, described his practice as “...emblematic of a transformation in American medicine.” He went on to say that doctors like him are increasingly being replaced by teams of rotating doctors and nurses. He said the centuries-old intimacy between doctor and the patient is being lost, and patients who visit the doctor are often kept guessing about who will appear in the white coat.

Today, as many medical school graduates consider their future paths, many of them are choosing the “Golden ROAD”: R=Radiology, O=Ophthamology, A=Anesthesiology and D=Dermatology. The salary of a rural solo family physician with 75-percent overhead expenses does not hold a candle to the ROADies. A recent article in *Medical Economics* by James E Sweeney reported the average 2009 FP salary as $163,000 per year. But according to the first chart, 24 percent of FPs, the largest percentage group, earned less than $120,000. And I would estimate that a lot of them are with me in the five-figure, not six-figure, range.

Yet, if I won the Powerball lottery today, I would still be at work in the morning because at this moment, I am fulfilling the dream I had as a four-year-old boy. There is no doubt that patient-centered medical homes, accountable care organizations and hospital-owned practices are growing exponentially. Moreover, some day the practice police may drag me away kicking and screaming. Nevertheless, for now I am King of the Mountain even though it has become more like a hill. I ask myself, “Was it worth it?” The answer echoes back, “Yes.” How many are fortunate enough to capture their dream and keep it for 30 years?

Truly, I have been given a gift from God. Christ says in Matthew not to be concerned about tomorrow. Maybe the erosion will stop, maybe it won’t. Either way, I love what I am doing and I hope my steps have helped some folks along the way.

Dr. Leonard’s comments are his own and not necessarily those of the TMA.
The constant pressure to perform at high levels can lead physicians to problems with chemical dependencies or other addictions and behavioral changes. The consequences of their intensely personal conflicts can extend outward, affecting their patients and communities in ways they never intended.

As I reflect on this...

"As I reflect on this, my 10th year of sobriety, I attribute the successes I have had in practicing medicine the last ten years wholly to changes in my lifestyle since going through treatment. Without those changes, I don’t think I would be alive today, and if I were alive, I don’t think I would be practicing medicine or enjoying my life."

-- J.S., M.D.

Tennessee Medical Foundation

Roland W. Gray, M.D., Medical Director

216 Centerview Drive, Suite 304 • Brentwood, Tennessee 37027 • (615) 467-6411
The good news is they all lead to us.

Turn to The TMA Association Insurance Agency for all your insurance needs.

Physicians have lots of different insurance needs. But knowing where to turn can be confusing. The TMA Association Insurance Agency can help. We provide comprehensive solutions—the full line of services and products you need.

- Employment Practices Liability Insurance
- Specially Designed Building and Contents Package
- Umbrella—for that Extra Protection
- Workers’ Compensation—New Dividend Plan

We now offer a Workers’ Compensation Dividend Plan! We will return premium based on favorable loss experiences. This is our way to reward our “best in class” customers. And if you would like, we can even donate the dividends to the Tennessee Medical Foundation.

Full line of coverage, less premium due to affordable rates—you can’t argue with that.

Bundle in the personalized service you can expect from The TMA Association Insurance Agency, and we know you're headed in the right direction.

Contact Us Today
Chattanooga 888.616.7873    Nashville 800.347.1109
Jackson 888.981.6888    Memphis 800.544.1681    Email TMA@assoc-admin.com

TMAinsurance.com—for details on all available plans.
ABSTRACT

Background: Potentially avoidable hospitalizations are inpatient admissions for certain conditions, called Ambulatory Care Sensitive Conditions (ACSCs), which can potentially be prevented by effective outpatient treatment of individuals who actively participate in their own care and engage in responsible personal behavior. Changes in the rates of ACSC hospitalizations over time may signal an improvement or deterioration in the quality and effectiveness of ambulatory care. These long-term trends may also suggest changes in the underlying factors such as lifestyle choices and dietary practices of individuals and families.

Objective: This study presents data from the Tennessee Hospital Discharge Datasets on changes in ACSC hospitalizations as a percent of all hospitalizations for 1998-2006.

Methods: Retrospective analysis of administrative data based on the UB-92 claims forms submitted by all short-term acute-care hospitals in Tennessee.

Results: Total ACSC hospitalizations in Tennessee increased by 4.2 percent between 1998 and 2006, while the total costs for ACSC hospitalizations decreased by 1.8 percent in constant 2006 dollars. In comparison, total admissions for all conditions increased by 15 percent during 1998-2006 while total hospital costs for all conditions increased by 21 percent. The rate of increase in ACSC hospitalization varied according to patient’s race, insurance type, and whether the patient’s health plan is managed care or fee-for-service. ACSC patients admitted through an emergency department outnumbered their counterparts who were not admitted through an emergency department by a factor of more than two throughout 1998–2006.

Conclusions: Our analysis of long-term trends of ACSC hospitalizations in Tennessee reveals a mixed bag of good news and bad news. In 1998-2006, ACSC hospitalizations rose at a much lower rate than overall hospitalizations for all conditions. Meanwhile, the costs of ACSC hospitalization in 2006 constant dollars decreased while the costs of overall hospitalizations increased. Minority groups such as blacks and patients insured under TennCare did not experience much decline in ACSC hospitalizations, especially in the rates of chronic ambulatory-care sensitive conditions, when compared with their white and commercially-insured counterparts. Patients whose care was managed experienced smaller declines in ACSC hospitalizations than those not under managed care. Finally, the number of ACSC hospitalizations admitted through an ED outnumbered those admitted through the regular hospital admission department during the study period, and the gap between the two sources of admissions grew larger over time.

BACKGROUND

Researchers have recently focused on hospitalizations that can potentially be avoided as a source of information to measure and track health care access to ambulatory care. 1-3 These hospitalizations are inpatient admissions for certain conditions, called Ambulatory Care Sensitive Conditions (ACSCs), that can potentially be prevented when clinicians deliver timely and effective outpatient treatment to individuals who actively participate in their own care, follow a healthy lifestyle, and engage in responsible personal behavior. 4 Nationally, 4.4 million inpatient admissions to U.S. hospitals in 2004 involved treatment for one or more of these ACSCs, resulting in a total cost of more than $29 billion – one out of every 10 dollars of total hospital expenditures. 5 High rates of hospitalizations for these conditions are important to clinicians and health care decision makers because they suggest resources wasted as well as opportunities for improving health system efficiency by delivering timely and effective primary care in the ambulatory setting. Changes in the rates of ACSC hospitalizations over time may signal an improvement or deterioration in the quality and effectiveness of ambulatory care. These long-term trends may also suggest changes in the underlying factors such as life style choices and dietary practices of individuals and families that shape the health status of the general population or specific population segments.
This study presents data from the Tennessee Hospital Discharge Datasets on changes in ACS hospitalizations as a percent of all hospitalizations for 1998-2006. It used the revised definitions of ACSs released by the Agency for Healthcare Research and Quality (AHRQ) in 2007 to develop hospitalization rates for selected chronic and acute ACS conditions for adults ages 18 and over. This updated version of ACS definitions as described in the AHRQ’s new Prevention Quality Indicators (PQIs) has moved two pediatric conditions, pediatric asthma and pediatric gastroenteritis, to a new and separate set of quality indicators for the pediatric population. The 12 PQIs for adult populations considered in this brief include:

**Label (PQI No.)**

**Chronic PQI**
- Diabetes (PQI 1)
- Diabetes, short-term complications (PQI 12)
- Diabetes, long-term complications (PQI 13)
- Uncontrolled diabetes (PQI 14)
- Lower extremity amputations among patients with diabetes (PQI 16)

**Circulatory Diseases**
- Hypertension (PQI 7)
- Congestive heart failure (PQI 8)
- Angina without procedure (PQI 13)

**Chronic Respiratory Diseases**
- Chronic obstructive pulmonary disease (PQI 5)
- Adult asthma (PQI 15)

**Acute PQI**
- Dehydration (PQI 10)
- Bacterial pneumonia (PQI 11)
- Urinary infections (PQI 12)

*PQI = Prevention Quality Indicator

**DATA AND METHODS**

**Data source.** Tennessee law (Tennessee Code Annotated (TCA), Section 68-1-108) requires that every licensed hospital report all claims data found on the UB-04 Form to the Tennessee Department of Health. Since 1997, the Division of Health Statistics in the Office of Policy Planning and Assessment of the Tennessee Department of Health has established a data system, the Hospital Discharge Planning System (HDDS), to collect, compile and disseminate hospital discharge data annually. The data used in this study contain excerpts from the 2005 HDDS dataset that covers the data period from January 1, 1998 through December 31, 2006.

Cost data for inpatient hospitalization were not available from the Tennessee Discharge Database used in this study. They were estimated by deflating the dollar amounts of billable discharges that were reported by the HDDS Datasets by a cost-to-charge ratio calculated for each hospital based on the cost and discharge data reported in the 2005 edition of the Tennessee Joint Annual Report of Hospitals.

**Study population.** The study population is restricted to adult patients (ages 18 and over) discharged from non-federal short-stay hospitals licensed in Tennessee, including general medical and surgical hospitals, women’s or OB/GYN hospitals, and pediatric hospitals. Excluded are patients discharged from long-term, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Also excluded, following the guidelines for using the AHRQ Quality Indicators, are patients with a major diagnostic code of pregnancy, childbirth, or puerperium.
DATA AND METHODS
In 2006, Tennessee hospitals admitted approximately 110,000 adults for ambulatory-care sensitive conditions at a total cost of more than $624 million, converted by authors from reported hospital charges using a calculated cost-to-charge ratio. Over time, total ACSC hospitalizations in Tennessee increased by 4.2 percent between 1998 and 2006, from 105,431 admissions to 109,852 admissions. During the same period, total costs (measured in 2006 constant dollars) for ACSC hospitalizations decreased by 1.8 percent, from $639 million to $624 million. In comparison, total admissions for all conditions increased by 15 percent between 1998 and 2006 in Tennessee while total hospital costs for all admitting conditions increased by 21 percent. The slower growth of ACSC hospitalizations has over time resulted in a declining trend in ACSC hospitalizations as a percent of all admissions in Tennessee, falling from 17.5 percent in 1998 to 15.9 percent in 2006, a decrease of 1.6 points (or an almost 10-percent decline) in eight years (Figure 1).

Chronic vs. acute conditions. The Table shows that chronic ACSC hospitalizations as a percent of all hospitalizations fell by 1.1 percentage points (or a 10-percent decline) between 1998 and 2006 while the percentage of acute ACSC hospitalizations fell less, by 0.6 percentage points (an eight-percent decline) during the same period. A closer examination of the individual categories of ACSC conditions in Table 1 shows a pattern of disturbing trends. For example, ACSC hospitalizations for diabetes as a percent of all hospitalizations did not decrease; it actually increased by 0.1 percentage points from 1.7 percent in 1998 to 1.8 percent in 2006 (a four-percent and statistically significant increase). Similarly, ACSC hospitalizations for hypertension and adult asthma also experienced steady increases, causing the proportion of potentially preventable hospitalizations for hypertension and adult asthma to all hospitalizations to increase between 1998 and 2006. ACSC hospitalizations for urinary tract infection, an acute condition, also experienced similar increases.

Gender differences. Both men and women experienced steady declines in non-maternal ACSC hospitalizations as a percent of total hospitalizations between 1998 and 2006 (Figure 2), with declines by women slightly outpacing declines by men. Women consistently had higher ACSC hospitalization rates than men during 1998 – 2006 and the gap remained relatively stable over time.

Racial variations. Among the major racial and ethnic groups, as shown in Figure 3, white patients experienced the most decline in ACSC hospitalizations as a percent of all hospitalizations (a decline of 2.4 percentage points, from 17.8 percent in 1998 to 15.4 percent in 2006, or a 13-percent decline over time), followed by Hispanic patients (a decline of 1.3 percentage points or a 12-percent decline) and those in the “other” racial/ethnic group (1.2 percentage points or a decline of 10 percent). Black patients, in contrast, experienced an increase in the percent of ACSC hospitalizations, rising from 18.9 percent in 1998 to 19.4 percent in 2006 (a statistically significant increase of 2.92 percent).

Variation by insurance. Among the four major third-party payers, Medicare patients consistently led in ACSC hospitalizations as a percent of all hospitalizations while those
insured by commercial health plans (BCBS commercial plans included) consistently had the lowest percentages (Figure 4). Between 1998 and 2006, both Medicare and commercial patients experienced declines in the percentage of ACSC hospitalizations, with Medicare patients experiencing more impressive declines than commercial patients. TennCare/Medicaid patients saw a slight decline in the percentage of ACSC hospitalizations in early 2000s but the decline had slowed to a halt in more recent years. Self-pay/ uninsured patients followed a similar pattern up to 2003, but the ACSC hospitalizations as a percent of all hospitalizations for this group of patients who have no insurance coverage had experienced an uptick since 2003.

Influence of managed care. Both managed care and non-managed care patients experienced a modest decline in ACSC hospitalizations relative to all hospitalizations (Figure 5). For the period 1998–2006, managed care patients consistently experienced lower percentages of ACSC hospitalizations than non-managed care patients. But it is worth noting that managed care plans did not deliver more impressive declines in ACSC hospitalizations as a percent of all hospitalizations to live up to the expectation of a better managed form of healthcare delivery.

The role of ER. Some of the ACSC hospitalizations are planned, or scheduled, hospitalizations, while others were admitted through an emergency department and, by implication, unplanned. Figure 6 compares the ACSC hospitalizations as a percent of all hospitalizations of those who were admitted through a hospital emergency department with those not admitted through an emergency department. The patterns of change of the two groups of ACSC patients differed in two significant ways for the period 1998 to 2006. First, ACSC patients admitted through an emergency department outnumbered their counterparts who were not admitted through an emergency department by a factor of more than two throughout 1998–2006. Second, the gap between the two groups grew larger, with those admitted through an ER experiencing a slight rising trend while those not admitted through an ER a pronounced declining trend.

DISCUSSION AND CONCLUSION
Our analysis of long-term trends of ACSC hospitalizations in Tennessee reveals a mixed bag of good news and bad news. The first piece of good news is that ACSC hospitalizations, while still rising, rose at a much lower rate than overall hospitalizations for all conditions (4.2 percent vs. 15 percent) during 1998–2006. With Tennessee’s adult population ages 18 and older increasing by 12 percent during this period, the 4.2-percent increase in ACSC hospitalizations was modest by comparison. It is not clear how much of this favorable trend reflects a gradual improvement in the underlying health behavior and health status of the general population and how much reflects the improvement in access to primary care. More research is needed to understand the sources of this declining trend, which has important implications to both the health of Tennesseans and their access to health care.

Another bright spot in the trend data is the steady decline in the cost of ACSC hospitalizations. During 1998–2006, while the costs of overall hospitalizations increased by 21 percent in 2006 constant dollars, the costs for ACSC hospitalizations declined by 1.8 percent. Most hospital financial data available publicly are based on hospital charges and are mostly reported in current dollars unadjusted for inflation. Our analysis converted hospital charges into costs based on a set of cost-to-charge ratios calculated from the Joint Annual Report of Hospitals in Tennessee. Over the study period, hospitals in Tennessee inflated their charges in part to offset the increases in consumer prices and in part to position themselves for better reimbursements from third-party payers – a practice that has become increasingly popular across the country. Our trend analysis reinforces the need to adjust the reported hospital charges for both general inflation and hospitals’ tendency to inflate their charges over the actual costs when conducting cost analysis.

Our sub-group analyses reveal several disturbing trends. Minority groups such as blacks did not experience the same declining trends in ACSC hospitalizations, especially in the rates of chronic ambulatory-care sensitive conditions, as their white counterparts. Similarly, patients insured by TennCare (Tennessee’s managed care Medicaid program) did not fare as well as Medicare and commercially-insured patients. Finally, our findings on managed care and admissions through the ED warrant closer attention by health officials and practitioners. Patients whose care was managed had a lower likelihood to experience potentially avoidable hospitalization during the study period but patients whose care was not managed experienced greater decline in ACSC hospitalizations as a percent of all hospitalizations. Finally, the number of ACSC hospitalizations admitted through an ED outnumbered those admitted through the regular hospital ad-

(Continued on page 45)
Your Compass in the EHR Selection Process

The Vendor Standards Program (VSP) leads you to vetted EHR vendors, exclusive member discounts and practice-friendly terms/conditions.

VSP Partners Give TMA Members:

- Discount pricing
- TMA’s negotiated terms and conditions on industry best practices & training
- Interoperability with Tennessee’s Health Information Exchange Network
- Rights retention to all clinical data
- Transparency in software purchase quotes
- Assignment of licenses due to practice purchase, merger, acquisition, buy-out or name change
- Additional licenses if needed, provided at initial preferred pricing
- And more!

To learn more, contact
Angie Madden, CHC, CAPM
Director of eHealth Services
Angie.Madden@tnmed.org
800-659-1862

www.tnmed.org/vsp
AMAF Mission Accomplished Through the TMAA

By Dottie Pennington, TMAA AMAF Vice President

The mission of the AMAF is to improve the health of Americans through philanthropic support of quality programs in public health and medical education. The Foundation serves as the philanthropic arm of the AMA. Since 1950, the Foundation has distributed $80 million in gifts to medical schools; guaranteed over $96 million in loans that have benefited more than 40,000 medical students, interns, and residents; and supported numerous research projects through its grants program. Of these funds, $3.7 million have returned to Tennessee in one of the forms listed above.

The TMAA continues to be deeply committed to fundraising for the Foundation and its success lies in its grassroots efforts. In 2010 the Alliance raised over $50,000 with the Holiday Sharing Card Project. These monies can be designated for scholarships at a medical school of one’s choice, for the Healthy Living Grant Program or for the Development Fund. In 2010 the TMAA designated these funds for Tennessee medical schools in the following amounts (listed alphabetically):

1. East Tennessee State University, James H. Quillen College of Medicine, Johnson City - $3,400
2. Meharry Medical College, School of Medicine, Nashville - $11,807.25
3. University of Tennessee Health Science Center (UTHSC), College of Medicine, Chattanooga - $14,513.75
4. UTHSC, College of Medicine, Knoxville - $6,657.35
5. UTHSC, College of Medicine, Memphis - $14,436
6. University of Tennessee Medical Education, Jackson - $220
7. University of Tennessee Medical Education, Nashville - $364
8. Vanderbilt University School of Medicine, Nashville - $6,460

These are impressive numbers and we can congratulate ourselves. As we like to boast, Tennessee has led the nation for more than 30 years in Sharing Card contributions to the Foundation (see the artwork for this year’s Holiday Sharing Card on this page). Fortunately for the medical students, AMAF support does not stop there. In addition to our medical school gifts, the AMAF offers 12 Minority Scholars Awards ($10,000 each); 18 Physicians of Tomorrow Awards ($10,000 each); and one Arthur N. Wilson, MD Scholarship ($5000).

AMAF HEALTHY LIVING GRANT PROGRAM

The second major division of the Foundation is the AMAF Healthy Living Grant Program (formerly the Fund for Better Health). These funds support vital grassroots efforts to promote healthy lifestyles education and awareness in these areas:

1. Nutrition and physical fitness
2. Alcohol, substance abuse and smoking prevention
3. Violence prevention (domestic violence, suicide prevention, internet safety, bullying)

There is also a special grant called “The Dolores Chandra Fund for Better Health Grant” for medical student and resident affiliated groups. Mrs. Chandra, the late wife of TMA member Channappa Chandra, MD, of Hixson, was a vibrant member and officer in TMAA and AMAA before her untimely death in a car accident; she is fondly remembered by all who knew her.

For membership information, contact Robin Hutchins at (865) 693-5997 or rhutch1029@gmail.com; or TMAA Executive Assistant Judy Ginsberg at 615-460-1651, 800-659-1862 (toll free) or tmaa@tnmed.org.
FOR THE RECORD

These grants can supply critical funding to jumpstart a project, affect change quickly, increase visibility for a project/organization, encourage collaboration and make a lasting difference in a community.

DEVELOPMENT FUND

The AMAF Development Fund is an unrestricted fund that allows the Foundation to respond quickly to issues as they arise or provide support in areas of greatest need. It can function as an undesignated emergency fund and has been used in the aftermath of devastating natural disasters. The funds are used to help serve the medical community in the affected areas by making emergency grants available to physician practices damaged or disrupted by the storm’s destruction.

The Foundation serves as a rich resource for scholarships, grants and emergencies. For more information on how it may meet a specific need you may have, visit www.amaalliance.org.

NEW MEMBERS

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY
John B. Allen, MD, Chattanooga
Timothy M. Ashburn, MD, Smithville
John H. Ashcraft, DO, Chattanooga
Neetu Bali, MD, Chattanooga
Thomas Barros, DO, Hixson
Nanette K. Bentley, MD, Chattanooga
Krish Bhadra, MD, Chattanooga
Gabriel E. Bruffy-Holmes, MD, Chattanooga
Anna R. P. Carlson, MD, Chattanooga
Erume D. Chapman-Jackson, MD, Chattanooga
Jeffrey D. Clinicscales, MD, Chattanooga
Paul W. Courtwright, MD, Chattanooga
Bryce A. Cunningham, MD, Chattanooga
Karisten R. Djernes, MD, Chattanooga
Nicholas M. Drahush, MD, Chattanooga
Devan Griner, MD, Chattanooga
Kendra E. Hawkins, MD, Chattanooga
Miss Hina, MD, Chattanooga
Cole J. Houston, MD, Chattanooga
John C. Huggins, MD, Ooltewah
John P. Hungerford, MD, Signal Mountain
John A. Jarrell, IV, MD, Chattanooga
Scott M. John, MD, Chattanooga
Natalie L. Johnson, DO, Hixson
Michael A. Kagen, MD, Chattanooga
Neelima Katragunta, MD, Chattanooga
Aaron D. Kline, MD, Chattanooga
Jonathan A. Lawrence, MD, Chattanooga
Alexander C. Lemons, MD, Chattanooga
John M. Lewis, DO, Chattanooga
Genevieve A. Maass, MD, Chattanooga
Bradford L. Mitchell, MD, Chattanooga
Richard D. Moody, MD, Chattanooga
Zainab Nayeri, MD, Chattanooga
Mr. Greg Nieckula, Signal Mountain
Sean M. Owen, MD, Chattanooga
Christopher D. Pankiw, MD, Soddy Daisy
Derek Patterson, MD, Chattanooga
Steven M. Peterson, MD, Chattanooga
Tommy J. Petros, MD, Chattanooga
James W. Ragins, MD, Chattanooga
Jessica K. Reynolds, MD, Rossville
Sunanda N. Sadanandan, DO, Chattanooga
Sarita K. Sapkota, MD, Chattanooga
Metta A. Shafer, DO, Chattanooga
Elise S. Sims, MD, Ooltewah
Brian S. Smith, MD, Ooltewah
Joshua D. Stevens, MD, Chattanooga
Diana A. Tamboli, MD, Chattanooga
Steven M. Thomas, MD, Chattanooga
Jerry D. Walkirk, Jr., MD, Chattanooga
Amy E. Walthour, MD, Rossville
William C. Whitmire, MD, Lookout Mountain
Joshua P. Winter, MD, Chattanooga

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE
Joseph M. Okolo, MD, Jackson

GILES COUNTY MEDICAL SOCIETY
Terry A. Wynn, MD, Pulaski

THE MEMPHIS MEDICAL SOCIETY
Sandra L. Arnold, MD, Memphis
Bettina H. Ault, MD, Memphis
Bindiya Bagga, MD, Memphis
P. Joan Chesney, MD, Memphis
Harris L. Cohen, MD, FACP, Memphis
Melody J. Cunningham, MD, Memphis
Noel M. Delos-Santos, MD, Lakeland
Alicia M. Diaz-Thomas, MD, Memphis
Theodore M. Eison, MD, Memphis
Ikechukwu U. Emerenwaonu, MD, Memphis
Alvaro R. Encinas, MD, Memphis
B. Keith English, MD, Memphis
John K. Eshun, MD, Memphis
Ignacio F. Fernandez-Nieves, MD, Memphis
Robert J. Ferry, MD, Memphis
Mayte I. Figueroa, MD, Memphis
Stephen P. Fulton, MD, Memphis
Dana W. Giel, MD, Memphis
Steven P. Goldberg, MD, Memphis
Roberto R. Gonzalez, MD, Memphis
Mr. Robert D. Griffith, Knoxville
Katherine M. Gyves-Ray, MD, Memphis
Brent K. Haberman, MD, Memphis
Debra L. Hanna, MD, Cordova
Marion E. Harre, MD, Memphis
John R. Hill, MD, Memphis
Masanori Igarashi, MD, Memphis
Valerie P. Jameson, MD, Memphis
Ryan C. Jones, MD, Cordova
Vijaya M. Joshi, MD, Memphis
Dai Kimura, MD, Memphis
Christopher J. Knott-Craig, MD, Memphis
David A. Kube, MD, Memphis
Karen L. Lakin, MD, Memphis
Linda F. Lazar, MD, Memphis
Henrique M. Lederman, MD, PhD, Memphis
Laurie E. L. Imsand, MD, Memphis

(Continued)
NEW MEMBERS
(Continued)
Dukhee B. Lee, MD, Memphis
Florentina Litra, MD, Memphis
Charles B. MacDonald, MD, Memphis
Mr. Michael Massaro, Memphis
Mary Mazel, MD, Memphis
Amy L. McGregor, MD, Memphis
Jennifer D. McLeay, MD, Memphis
Kathryn A. McVicar, MD, Memphis
Ruby Melha, MD, Memphis
Christie E. Michael, MD, Memphis
Robin L. Morgan, MD, Holly Springs
Deborah D. Nelson, MD, Memphis
Peggy A. O’Cain, MD, Memphis
Frederick B. Palmer, MD, Memphis
Louis S. Parvey, MD, Memphis
Freedom E. Perkins, Jr., MD, Memphis
Stephen D. Pishko, MD, Memphis
Eniko K. Pivnick, MD, Memphis
Gerald J. Presbury, MD, Memphis
Ms. Rachel Marie Rose, Memphis
Robert A. Schounmacher, MD, Memphis
Andreas Schwingshackl, MD, Memphis
Zachary B. Self, MD, Memphis
Georgette R. Sevier, MD, Memphis
Namrata Shah, MD, Memphis
Samir Shah, MD, Memphis
Sunil K. Sinha, MD, Memphis
Stephanie K. Slagle, MD, Memphis
Chandrea Smothers, MD, Memphis
Thomas T. Spentzas, MD, Memphis
Saumini Srinivasan, MD, Memphis
James K. Stamps, MD, Memphis
Rosemary S. Stocks, MD, Memphis
Dennis C. Stokes, MD, Memphis
Stephanie A. Storgjon, MD, Memphis
Arthur M. Townsend, IV, MD, Germantown
James D. Tutor, MD, Memphis
Katherine C. Van Poppel, MD, Memphis
Benjamin R. Waller, III, MD, Memphis
Jewell C. Ward, MD, PhD, Memphis
Glen T. Wetzel, MD, PhD, Memphis
James W. Whelless, MD, Memphis
Tony M. Whitaker, MD, Memphis
Matthew T. Whitehead, MD, Memphis
Robert S. Wilroy, MD, Memphis
Robert J. Wyatt, MD, Memphis
George Young, MD, Memphis

NASVILLE ACADEMY OF MEDICINE
Shilpa R. Carlson, DO, Nashville
Ranjan Chanda, MD, Nashville
John J. Dreyzehner, MD, Nashville
Nia M. Foderingham, MD, Nashville
Paul J. Gentuso, MD, Nashville
Christopher L. Fill, MD, Nashville
Douglas B. Johnson, MD, Nashville
Xianling Liu, MD, Smyrna
Mark R. Nelson, MD, Nashville
John S. Pirolo, MD, Nashville

SULLIVAN COUNTY MEDICAL SOCIETY
Charles R. Rice, MD, Kingsport
Pitchar Theerathorn, MD, Kingsport

TMA DIRECT
Scott E. DesJarlais, MD, Jasper

WASHINGTON-UNICOI-JOHNSON COUNTY MEDICAL ASSOCIATION
Haytham F. Adada, MD, Jonesborough
Mr. Matthew E. Bailey, Elizabethton
Mr. William D. Bickers, Johnson City

IN MEMORIAM
ETNA LITTLE PALMER, MD, age 95. Died November 19, 2010. Graduate of Bowman-Gray School of Medicine, Wake Forest. Member of Roane-Anderson County Medical Society.

RAZA A. DILAWARI, MD, age 64. Died September 18, 2011. Graduate of King Edward Medical College. Member of The Memphis Medical Society.

CARL C. GARDNER, MD, age 95. Died September 29, 2011. Graduate of Harvard Medical School. Member of Maury County Medical Society.

FRANK JACKSON OSBORN, MD, age 76. Died October 14, 2011. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

AMA PHYSICIAN RECOGNITION AWARD
Physicians who earn the American Medical Association (AMA) Physician’s Recognition Award (PRA) have been recognized by the AMA for their commitment to patient care and lifelong learning through continuing medical education (CME). The Tennessee Medical Association would like to commend our members who have earned the AMA PRA recently by demonstrating that they earned an average of at least 50 CME credits per year. Congratulations to the following:

Henry S. Jennings, III, MD, FACP, Nashville
John J. Warner, MD, Nashville
TRENDS IN POTENTIALLY AVOIDABLE HOSPITALIZATIONS AMONG ADULTS IN TENNESSEE, 1998-2006

(Continued from page 38)

mission department during the study period; over time the gap between the two sources of admissions grew larger. 

References:

Dr. Chang is with the Department of Economics and the Methodist Le Bonheur Center for Healthcare Economics, The University of Memphis, Memphis, TN. Dr. Troyer is associate professor and chair of Economics and an adjunct associate professor in the Department of Public Health Sciences, University of North Carolina at Charlotte, Charlotte, NC.

For reprints contact Dr. Chang at the Fogelman College of Business and Economics, The University of Memphis, Memphis, TN 38152, phone: 901-756-1513, email: cchang@memphis.edu.
INSTRUCTIONS FOR AUTHORS

Manuscript Preparation – Manuscripts should be submitted to the Editor, David G. Gerkin, MD, 2301 21st Avenue South, Nashville, TN 37212. A cover letter should identify one author as correspondent and should include his complete address, phone, and e-mail. Manuscripts, as well as legends, tables, and references, must be typed, double-spaced on 8 1/2 x 11 in. white paper. Pages should be numbered. Along with the typed manuscript, submit an IBM compatible 3-1/2” high-density diskette containing the manuscript. The transmittal letter should identify the format used. Another option is you may send the manuscript via e-mail to brenda.williams@tnmed.org. If there are photos, e-mail them in TIF or PDF format along with the article.

Responsibility – The author is responsible for all statements made in his work. Accepted manuscripts become the permanent property of Tennessee Medicine.

Copyright – Authors submitting manuscripts or other material for publication, as a condition of acceptance, shall execute a conveyance transferring copyright ownership of such material to Tennessee Medicine. No contribution will be published unless such a conveyance is made.

References – References should be limited to 10 for all papers. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of first three authors followed by et al, complete title of article cited, name of journal abbreviated according to Index Medicus, volume number, first and last pages, and year of publication. Example: Olsen JH, Boice JE, Seersholm N, et al: Cancer in parents of children with cancer. N Engl J Med 333:1594-1599, 1995.

Illustrated Material – Illustrations should accompany the e-mailed article in a TIF or PDF format. If you are mailing the article and diskette, the illustrations should be 5 x 7 in. glossy photos, identified on the back with the author’s name, the figure number, and the word “top,” and must be accompanied by descriptive legends typed at the end of the paper. Tables should be typed on separate sheets, be numbered, and have adequately descriptive titles. Each illustration and table must be cited in numerically consecutive order in the text. Materials taken from other sources must be accompanied by a written statement from both the author and publisher giving Tennessee Medicine permission to reproduce them. Photos of identifiable patients should be accompanied by a signed release.

Reprints – Order forms with a table covering costs will be sent to the correspondent author before publication.

CAREER OPPORTUNITY

ADVERTISING

Please return this page, with ad text typed and double-spaced, for all career opportunity advertising. Send to:

Beth McDaniels
Tennessee Medicine
2301 21st Avenue South, P.O. Box 120909
Nashville, Tennessee 37212-0909
Phone: (615) 385-2100, Fax: (615) 312-1958

Rates are $100 for the first 50 words ($50 for TMA members); 25 cents for each individual word. Count as one word all single words, two initials of a name, single numbers, groups of numbers, hyphenated words, and abbreviations.

Advertisers may utilize a box number for confidentiality, if desired, in care of Tennessee Medicine, P.O. Box 120909, Nashville, TN 37212-0909. Using this box in an ad will add eight (8) words to the total count.

The deadline is the 10th of the month preceding the desired first month of publication, and will be subject to approval. Each listing will be removed after its first publication unless otherwise instructed.

Please type your ad exactly as it should appear or e-mail your ad to Beth McDaniels at beth.mcDaniels@tnmed.org and send your check with a hard copy to her attention. You may call in with credit card information for payment, if needed.

LIST OF ADVERTISERS

Athena Health, Inc. ....................................................26
BlueCross/BlueShield of Tennessee............................6
DoctorsManagement, LLC........................................12
First Tennessee Bank ................................................30
Nashville Preventive Cardiology ..............................11
Navicure ..............................................................19
State Volunteer Mutual Insurance Company ............48
Tennessee Medical Foundation .................................33
Tennessee Society for Laser Medicine and Surgery, Inc. ....4
The TMA Association Insurance Agency, Inc. ............34
TMA ICD-10/5010 Seminars .................................8
TMA Membership Services .................................28
TMA Physician Leadership College .....................28
TMA Physician Services, Inc. ..............................2, 47
TMA Vendor Standards Program ..........................39
Two Point, Inc. .....................................................46
XMC, Inc. ..........................................................20
You insure your life and your health. But what about your identity?

TMA’s Identity Theft Program Helps You Combat Identity Theft
Each year, three out of ten Americans have their identities stolen. It’s the fastest growing crime in America. And the consequences can take a devastating toll — on your finances, reputation, time and emotions.

Let ID Theft Assist Be On Alert For You — 24 hours a day.
ID Theft Assist offers you the most comprehensive coverage plan available today. For just $91 a year (single or family), you are provided valuable help when you need it most. Coverage includes:

- E-mail alert credit monitoring
- Real-time credit report
- ID Theft Affidavit submission
- Report fraud to creditor
- Forward criminal report to creditors
- Credit & charge card replacement
- Cancel checks/ATM cards
- Report fraud to Social Security Administration
- Assist with identification replacement
- Postal inspector notification
- Creditor fraud department notification
- Place fraud alerts with credit reporting agencies
- Provide ID Theft Response Kit
- Cash advance
- Free initial legal consultation
- Unlimited phone emotional support

For more information or to enroll, please go to www.TMAPhysicianServices.com

ID Theft Assist
For program questions
1-866-MY-ID-911

TMA PHYSICIAN SERVICES INC.
I don’t just have insurance.

I own the company.

Michael A. McAdoo, M.D.
Milan Medical Center
Milan, TN
Family Practice

Medical Professional Liability Insurance

“Like me, you’ve probably noticed some professional liability insurance carriers recently offering physicians what seem to be lower rates. But when I took a closer look at what they had to offer, I realized they simply couldn’t match SVMIC in terms of value and service. And SVMIC gives me the peace of mind that comes when you’re covered by a company with a stellar record of over thirty years of service and the financial stability of an “A” rating or better since 1984. At SVMIC, I know it’s not just one person I rely on... there are 165 professionals who work for me. And, since SVMIC is owned by you, me, and over 14,000 other physicians across the Southeast, we know our best interests will always come first.”

Mutual Interests. Mutually Insured.

Contact Randy Weaver or Susan Decamus to reach SVMIC or call 1-800-342-7239. www.svmic.com

SVMIC is exclusively endorsed by the Tennessee Medical Association and its component societies.