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Vince Lombardi, the famous former coach of the champion Green Bay Packers football team, often spoke of teamwork: “The achievements of an organization are the results of the combined efforts of each individual.” He also spoke about leadership: “Leaders are made, they are not born. They are made by hard effort, which is the price which all of us must pay to achieve any goal that is worthwhile.” Teamwork and leadership must become part of the lexicon when discussing medical homes and team-based medical care as part of the current and future state of medical care in Tennessee.

The State of Virginia has passed legislation for team-based medical care. The Medical Society of Virginia worked extensively with the leaders from the Virginia Council of Nurse Practitioners for a year and a half to draft this legislation. This law establishes a more consultative and collaborative approach between physicians and nurse practitioners (NP) while ensuring the physician remains the leader and manager of the patient-centered healthcare team. It does not give nurse practitioners independent practice because the NP may only practice as part of a patient care team.

The patient care team and patient care team physician are defined as follows: “Patient care team” means a multidisciplinary team of healthcare providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients. “Patient care team physician” means a physician who is actively licensed to practice medicine in Virginia and who provides management and leadership in the care of patients as part of a patient care team.

The new Virginia law also expands the number of nurse practitioners who can participate in a patient care team from four to six per physician, at the discretion of the team care physician. It gives nurse practitioners additional flexibility in treating patients in free clinics and nursing homes. The law also provides opportunities for collaboration and consultation among nurse practitioners and patient care team physicians through telemedicine, and includes periodic review of patient charts or electronic health records in the practice of patient healthcare teams and may include visits to the site where health care is delivered in the manner and frequency determined by the patient care team.

Each member of a patient care team has specific responsibilities related to the care of the patient or patients and provides healthcare services within the scope of his or her usual professional practice. Nurse practitioners practicing as part of a patient care team maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. Physicians on patient care teams may require that a nurse practitioner be covered by a professional liability insurance policy with limits equal to the current medical malpractice cap.

It would behoove the State of Tennessee to emulate our neighbors to the northeast in beginning dialog between the Tennessee Medical Association and the Tennessee Nurses Association so that we can have effective team-based medical care in our state. Your TMA Legislative Committee under the leadership of Dr. Charles White, Jr., your TMA Practice Management and Quality Committee under the leadership of Dr. Ben Johnson, and your TMA Professional Relations Committee under the leadership of Dr. Ron Kirkland are ready and willing to work with their counterparts at the Tennessee Nurses Association on this type of coordinated care.

Vince Lombardi is often misquoted as saying, “Winning isn’t everything, it’s the only thing.” What he actually said was, “Winning is not a sometime thing, it is an all time thing.” Winning is an all-time thing at the TMA. Your staff and leaders are interested in patient care teams in Tennessee. Nurses are vital to the success of this type of care. Physicians have paid the price through hard effort to achieve their professional status. For all Tennesseans to win, physicians must be the leaders of patient-centered healthcare teams.

Share your thoughts with Dr. Robinson at president@tnmed.org.
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“Loss of Use,” Unused & Expired Drugs — A Terrible Waste

By David G. Gerkin, MD
Editor

For years, the expiration date of drugs has been a complex issue. The problem is increasing with the large number of drugs available, the increasing cost of all pharmaceuticals except for a select group of generic drugs, and the availability of drugs used only in smaller patient populations, described as “orphan drugs.”

Recently a new crisis in drug availability has occurred and is creating problems, particularly in drugs used in anesthesia cases and a few other categories. When these drugs reach expiration dates either set by the pharmaceutical companies or many states, a terrible “loss of use” occurs and struggle of opinion begins, even with specific guidelines and laws on direct use.

I was surprised to realize there are no policies for expiration dates on many products. As far as other products are concerned, as long as a date is not tampered with or there is not an attempt to mislead the consumer about a product’s quality, there are no hard and fast rules about pulling items from the shelves.

Last year, I took a look in our medicine cabinet at the bottles of prescribed medicines we no longer use or the dosage has changed. Fortunately, we are on only a few drugs but even with the small number, the “loss of use” is significant when I calculate the cost of those close to expiration or have already expired. I was aghast. When I extrapolated the number and cost to many people who use a large number of prescribed drugs, it is a tragedy of waste.

There are a number of different reasons medications are subject to such complex decisions. Even though I often feel discouraged trying to influence regulatory and legislative imposed issues and as a result experience some apathy, I am going to “strike out” at the cause and outline some possible solutions.

These drugs represent three possibilities for loss of use if no longer needed for the problem they were prescribed. First, they are not expired but legally, at least in most states, I am not supposed to give the drugs to someone needing the same drugs and dosage. Second, as might happen in a nursing home or similar circumstances, a drug is no longer needed and has an expiration date less than a year and in most cases cannot be returned for credit or restocking, especially with less than six months left before expiration. Even if some companies accept returns, it is at a considerably discounted price and usually the drugs are lost for use. Third, the drugs have expired and in many instances end up the toilet and into our water sources, often a few days after the expiration date if one follows the “rule.” I read somewhere that between $80 and $400 million of unexpired but no-longer-used drugs is wasted. A nursing home director once said even with “proper disposal” of expired medications, “I never go fishing the day after we dispose of our drugs.”

Now what does “expired drug” actually mean? This is a difficult definition. E-How, a website of health topics, lists the Food and Drug Administration (FDA) drug expiration rules more succinctly than what one can find buried in volumes of information on the FDA website. The Federal Food, Drug, and Cosmetic Act gives the FDA the power to regulate drugs. The laws regulating expiration dates and other aspects of medical drugs protect consumers from ineffective drugs. Their definition can be somewhat ambiguous: “Drug expiration dates are meant to reflect the date at which the drug’s potency begins to diminish. The drug does not usually become harmful after the expiration date listed on the box or bottle, but rapid degradation of certain drugs, such as insulin or liquid antibiotics, is possible. Any drug that contains an organic compound is also susceptible to decay. However, most drugs in pill form remain effective beyond the expiration date. The purpose of this expiration date is to inform consumers about the potency and effectiveness of the drug at the time of purchase. The FDA mandates that all drug companies test the expiration process of their drugs. A closed-container system is used by these companies to study how the drug ages. Scientists monitor the rate at which the drug remains chemically potent. The closed-container environment must mimic the ideal storage areas the drug should be placed in, usually a cool, dry area.”
The overall problem is that many drugs labeled as “do not use after …” are not expired but have less shelf life than many state regulations allow and thus, are lost for use. Finally, the drug companies rarely retest their drugs at the time of labeled expiration to see if they could be extended. Why? I am not sure but have some ideas!

Of course, further use of drugs that are not expired, as addressed above, has great potential value but by far the largest waste is in drugs defined as expired. When evaluating expired drugs or loss of effectiveness, the ones most likely to be a problem near the listed expiration date are liquid drugs. These tend to evaporate if opened and crystallize if not. In addition, some drugs such as eye drops can have sterility issues. These are examples of what I think are usually justified expiration dates.

The FDA does grant some exemptions. Any drug that uses a company’s previous stock of tested chemicals can accelerate the testing process. This saves the company time and money.

Now, I have described the various reasons for “loss of use” of these valuable and expensive drugs and recognize the laws and regulatory issues, but realize there might be some hope for changes in procedures leading to the prevention of some of the waste.

First, there is the use of the actual expiration date. When your prescription is filled, pills are transferred from the pharmacy’s stock bottle to a labeled prescription bottle. The stock bottle bears an expiration date but the bottle dispensed generally does not, so there’s no way to know the expiration date of your pills. In many states and it is true in Tennessee, the “do not use” date is one year after the prescription is filled. This is often related to the fact that the USP (United States Pharmacopeia) would set an expiration date of one year from the date your pills were dispensed (unless expiration date of the manufacturer’s stock bottle is less than a year, then an earlier date would apply.) But there is a practical answer to that since the state law could be changed to reflect the actual expiration if they are stored properly. Drug products must pass FDA-mandated tests to guarantee stability for the duration of the chosen expiration period. The drug must retain at least 90-percent potency through that time period. Many drugs considered expired would meet that criterion.

In 1985, the U.S. military asked the FDA to determine whether the shelf life of its inventory of drug products could be extended, since military officials faced the possibility of having to replace their billion-dollar drug stockpile as expiration dates approached. The FDA found that most drugs stored in original, unopened containers were safe and effective for several years past their set expiration dates. Of note is that 90 percent of the drugs tested were effective, and this was after 15 years of properly controlled storage. Another opportunity to promote saving and use is a more frequent and proper use of the Shelf Life Extension Program (SLER), an FDA-approved program that determines continued efficacy, which could save millions of dollars.

A further opportunity for savings goes back to the terrible loss at facilities such as nursing homes and other long-term care facilities that order drugs. Some states have established a “give away” program that, under some restrictions, allows unused medication to be distributed to indigent or disadvantaged patients safely. Initially the greatest challenge came from pharmacists and regulatory agencies but drug companies remained relatively neutral. Unfortunately, many have not adopted that process, and I think it should be the standard for all!

A great article by Steven Luxenberg in the Washington Post in November 2002, summarizes the vagaries on this issue by the FDA guidelines and rules. He states that initially, the FDA issued a statement in 1980 “often cited as the main obstacle to action, said in part: ‘It could be a dangerous practice for pharmacists to accept and return to stock the unused portions of prescriptions that are returned by patrons because he would no longer have any assurance of the strength, quality, purity or identity of the articles.’ Pharmacists call that language unambiguous. In a Feb. 25, 2000, letter to the AMA, the FDA relented just enough to allow the creative thinkers a chance. In a subsequent letter in August, the agency stressed that it still had concerns about safety, and about the potential for drugs to be diverted and then sold [illegally] on the gray market. If specific criteria were met – primarily, if nursing homes could prove that they had handled the drugs properly and that the medication was in its unbroken, original packaging, the FDA had no objection to allowing states to decide for themselves what to do.”

Last, about the drugs that are in my medicine cabinet, stored properly and not expired, they rarely are wasted based on a personal decision. I must clarify I am not recommending any specific action to anyone but is a personal decision. I am sure I have crossed some “lines” in my treatise and affirm the views are only mine only, but I am passionate about this terrible cost and “loss of use.”

Steve Luxenburg’s article added, “…there are ‘no villains’ in this story.” I agree and recognize that the FDA and the states simply want to protect the public and prevent drug diversion. Pharmacists have their rules and guidelines established for patient safety, but I think many of the possibilities I elucidated above ensure that the risks are small enough to make this terrible “loss of use” something we can address.
What could be more basic than handwashing? Might Sir William Shakespeare (1564-1616) have known of the excess maternal mortality of his era prior to our contemporary hand-washing era when he wrote for Titania to endorse, “And so she was with child, but she, being mortal, did die of it?”

While serving as chief of medicine of our 121st Evacuation Hospital during my Far East deployment, I stepped between two of our military medical corpsman/laboratory technologists to stop them from fisticuffs as one endorsed while examining a peripheral blood smear through the microscope, “I see Plasmodium Vivax,” while the other, examining the same peripheral blood smear on the same patient, endorsed, “I see Plasmodium Falciparum!” I restored their collegiality by my looking through each microscope and endorsing, “Both of you are correct. This represents a mixed infection of these two separate and distinct malaria parasites.” With that observation, my laboratory technologists became once again best friends. Dare we wonder what might well have happened if I had not been comfortable in looking through a microscope?

Further during my medical treatment and care of my fellow military veterans, I might well see patients having both folic acid deficiency resulting from alcohol consumption without adequate nutritious meals, and iron deficiency from blood loss from alcoholic gastritis with vomiting. Their resulting anemia would be dimorphic (double-formed); that is, when I look through the microscope examining their peripheral blood smear I would see two separate and distinct populations of red blood cells:

1. Macrocytic hyperchromic red cells from their folic acid deficiency.
2. Microcytic hypochromic red cells from their iron deficiency.

… which our laboratory computer might well average to fully normal laboratory values: MCV 90; MCH 30; MCHC 30. Might looking through the microscope be the most reasonable way to resolve this seeming computer glitch?

Further, the computer may be somewhat challenged to distinguish between a normal white blood cell and a nucleated red blood cell. Again, might looking through the microscope be the most reasonable way to resolve this seeming computer glitch?

Do we need to give our patients what they want or what we, as reasonable and prudent providers, determine what they need?”
I obtained the history of his gradual onset of his partial expressive aphasia. A search for his treatable condition(s) led us to curable Meningioma with gradual resolution of his partial expressive aphasia.

Our electronic (computerized) medical record (EHR) is here to stay! While our EHR may well benefit some aspects of quality patient care, dare we wonder why my generation made the decision to perform much of laboratory testing by computer while, at the same time, we either knew or should have known that our licensure (USMLE III) examinations and our board examinations seem to be written by senior gray-haired physicians who may well be much like me, acting as though our ward-laboratories—now long gone—containing at the least a microscope, a centrifuge, Gram Stains, Ziehl-Nielsen Stains and Wright’s Stains, were still present and in use both in patient care and in the training of our medical students and resident house officers? Further, why is microscopic examination of the peripheral blood and the urine (centrifuged) no longer considered part and parcel of the medical physical diagnostic examination of our patients? How did my generation get us here?

My fault! My bad! Mea culpa! How could I be that wrong?

References:
1. Sir William Shakespeare: A Midsummer Night’s Dream; quote from Titania, immortal, indestructible Queen of the Night, re: the maternal post-partum death of her human friend/companion—prior to our contemporary hand-washing era.
2. Reticulocyte, red blood cell precursor.
4. Latin: Admission of having made a mistake.

Board certified in internal medicine and cardiovascular disease, Dr. Grossman is a mentor for U.S. Medical Licensure Examination III and American Board of Internal Medicine candidates. A retired colonel in the U.S. Army Medical Corps, Dr. Grossman is a member of the American College of Physicians and the Washington-Unicoi-Johnson County Medical Association. He is also a book reviewer for Tennessee Medicine. Contact Dr. Grossman at drjosh@embargmail.com.

The TMA welcomes but is not responsible for opinions expressed in this forum.
Ask TMA

A FORUM FOR QUESTIONS, ANSWERS AND COMMENTS

ACA “SUNSHINE ACT” & CONTROLLED SUBSTANCE DATABASE

Q: I was told that there is a new law that requires every pharmaceutical company to report any payment that is made to me. Is this true? Do I have to make a report of every payment I receive from a pharmaceutical company?

A: This is a mixed answer. Yes, the law exists, but no action is required by physicians; the reports must be made by drug companies (or GPOs).

The Affordable Care Act contained a section regarding drug company payments to physicians and hospitals. The Department of Health and Human Services published its final rule on the implementation of this requirement on February 8, 2013, available at www.gpo.gov/fdsys/pkg/FR-2013-02-08/pdf/2013-02572.pdf. There are two public reports that might impact physicians. First, drug companies manufacturing drugs that are paid for by Medicare, Medicaid or CHIP must annually report to the Secretary of HHS certain “payments or other transfers of value” to physicians and teaching hospitals. Second, the Act also requires drug companies and “group purchasing organizations” (GPOs) to report certain information regarding the ownership or investment interests held by physicians or the immediate family members of physicians in such entities.

The purpose of these laws is to discourage the development of inappropriate relationships between drug companies and physicians and help prevent potentially unnecessary health care costs that can arise from such conflicts of interest.

Data collection will begin on August 1, 2013 and must be reported by March 31, 2014. There will be no retroactive reporting.

Again, the important thing for physicians to know is that the reporting requirements belong to the drug company or other reporting entity, not to the physician. No drug company can force physicians to submit a report or even furnish any information. But do not be surprised if this information is used by the media because the reports will be public information.

A more detailed review of the final rule by TMA General Counsel, Yarnell Beatty may be found online at www.tnmmed.org/rule-summary-section-6002-of-affordable-care-act.aspx.

Q: My practice administrator attended a local meeting and was told that I have to query the Controlled Substance Monitoring Database before issuing a prescription. If true, this will have a huge impact on how I schedule my day and is another administrative burden that gets in the way of patient care.

A: The Tennessee General Assembly passed a bill in 2012 that requires prescribers or a prescriber’s extender to query the Controlled Substance Monitoring Database (CSMD) before issuing a controlled substance prescription for an opioid or a benzodiazepine. It must be checked annually if the opioid or benzodiazepine remains a part of the treatment. A prescriber may designate other licensed professionals and up to two unlicensed persons in the practice as healthcare practitioner extenders, and allow an extender to query the CSMD on his/her behalf. Each extender must register with the CSMD and receive a unique username and password. The TMA fought vigorously to have the ability for two unlicensed persons in the office to be able to query the database for a physician to help alleviate the burden of the requirements that this new law places on physicians.

A report to law enforcement must be made when a physician queries the database and has actual knowledge that a patient has knowingly, willfully and with intent to deceive obtained or attempted to obtain a controlled substance. Please see our Law Guide topic titled Doctor Shopping Guidance at www.tnmmed.org/lawguide for the details of reporting and a form that may be used to make the report. The law also enumerates some exceptions to the query requirement. These exceptions, as well as instructions on how to register for the CSMD, are found in our Law Guide topic titled Controlled Substance Database. If you have any questions, please contact the Legal Department at becky.morrissey@tnmed.org or 800-659-1862.

Member login is required to access the Law Guide. If you need help with your login, contact the TMA at 800-659-1862.
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- Up to 8 Hours CME
- President’s Inauguration & Dinner
- House of Delegates
- Awards Luncheon
- Social & Networking Events

Register online at www.tnmed.org/medtenn2013 or scan here:
Douglas J. Springer, M.D., FACP, FACG, of Kingsport, has been chosen president-elect of the Tennessee Medical Association, and will serve as president of the Association for 2014-2015. He will succeed Christopher Young, M.D., of Chattanooga, who will be installed as president at the TMA's annual meeting, MedTenn 2013. Practicing with Gastroenterology Associates in Kingsport, Dr. Springer is board-certified in internal medicine. A native of Canada, he is a graduate of University of Calgary Faculty of Medicine.

TMA physician leadership elections were held online from February 1-28. Final results were certified by the TMA Election Committee, comprised of TMA President Wiley Robinson, M.D., Immediate Past-President F. Michael Minch, M.D., and current President-elect Dr. Young. All new officers and committee members will be installed during the TMA annual meeting, MedTenn 2013, April 5-7, in Franklin, TN.

ELECTION RESULTS
TMA members also elected the following physicians:

Board of Trustees
Region 1 - Keith Anderson, M.D., Memphis
Region 3 - Pete Powell, M.D., Franklin
Region 6 - Nita Shumaker, M.D., Hixson
Region 8 - Tim Gardner, M.D., Johnson City

Judicial Council
Region 2 – Susan Lowry, M.D., Martin
Region 4 – Ron Overfield, M.D., Nashville
Region 6 – Eugene Ryan, M.D., Chattanooga
Region 8 – Fred Mishkin, M.D., Kingsport

Starting May 1, Medicare participation or enrollment will be required for physicians who refer or order services for Medicare patients, unless they have a valid opt-out affidavit on file.

That from the Centers for Medicare and Medicaid Services (CMS) which said it will deny claims submitted on or after May 1 that include the name and National Provider Identifier (NPI) of a physician who referred or ordered services for a Medicare patient but who is not enrolled.

CMS had originally planned to implement this requirement in 2010 but the American Medical Association succeeded in getting it delayed for several years, during which CMS has worked to ensure that physicians are enrolled. The AMA and the Tennessee Medical Association continue working to keep members apprised of Medicare requirements, including the upcoming two-percent Medicare reimbursement cut for services rendered on or after April 1.

For more information, contact the TMA at 800-659-1862.
TMA Launches ICD-10 Roadshow

The TMA is launching Phase 2 of its ICD-10 education program with the ICD-10 Roadshow, which will appear at locations across the state in May.

“Practices have to prepare for this transition to avoid disruption in patient care and reimbursement,” said TMA Practice Solutions Director Angie Madden, who emphasized the October 1, 2014 implementation deadline is quickly approaching.

“There is now a firm implementation date per CMS and practices are now at a time when they have to start their education plan for staff and clinical providers, look at IT systems that will need upgrades and start the process of their transition,” she said.

The program is sponsored by BlueCross Blue Shield of Tennessee and Emdeon. Attendees will hear THIMA experts talk about the coding and documentation compliance issues; BCBST, United Healthcare and Emdeon discuss testing timelines, dual processing procedures and how to minimize payment delays now that they all have had time to develop their approach; national expert, author and contributor to Talk Ten Tuesdays Denny Flint will help practices actually leave with a workable approach to get started on implementation.

Locations:
May 7 – Memphis, Longinotti Auditorium, Saint Francis Memphis
May 8 – Nashville, Owen Continuing Education Center, Baptist Hospital
May 21 – Kingsport, Meadowview Marriott
May 22 – Knoxville, Knoxville Marriott
May 23 – Chattanooga, BCBST Headquarters

Topics:
• Roles & Responsibilities of Physicians & Staff
• How to Develop an Education & Transition Plan
• Understanding Documentation & Compliance Mandates
• Choosing Implementation Tools
• Payor Readiness

Who should attend?
• Physicians & Other Providers
• Practice Managers & Administrators
• Coding & Billing Specialists
• IT Consultants
• Clearinghouse & Revenue Cycle Management
• Hospital Ambulatory Personnel

Rx Database: Got Questions or Issues?

Required queries of the state’s Controlled Substance Monitoring Database before prescribing opiates or benzodiazepines began on April 1. Tennessee physicians who still have not registered themselves or their staff agents for the CSMD need to do so, and are being asked to report any issues or concerns to the CSMD administrator or to the TMA.

The TMA continues to work behind the scenes to seek adjustments and give feedback to state officials on issues that arise with the CSMD.

PROBLEMS?
The TMA has heard from some members who have had trouble or confusion about registering for the database; in addition to registering themselves, physicians are also able to register their licensed staff and up to two unlicensed staff members as designated agents to check the database on their behalf. Please read our March “Ask TMA” article dealing with these issues, available at www.tnmed.org/tennessee-medicine-magazine/editorials/#!/page/11, and our current “Ask TMA” article in this issue.

Further questions about registration or using or checking the database can be addressed to the Tennessee Board of Pharmacy CSMD administrator at CSMD.admin@tn.gov or 615-253-1305, or the TMA at 800-659-1862.
Member News

TMA Analyzes ACA “Sunshine Rule” for Members

In its effort to keep members apprised of changes in health care and particularly rules, regulations and laws affecting the practice of medicine and patient care, the TMA has completed an analysis of the final rule on pharmaceutical gifts and payments to physicians under the Affordable Care Act.

Entitled, “Drug Company Payments to Physicians and Hospitals Final Rule: What Physicians Need to Know,” the TMA Legal Department has outlined the requirements in the Sunshine Act related to the reporting of pharmaceutical gifts or payments and certain financial relationships involving physicians.


The purpose of these medical accountability laws is to discourage the development of inappropriate relationships between drug companies and physicians and help prevent potentially unnecessary healthcare costs that can arise from such conflicts of interest.

For details or more information on physician advocacy and assistance offered by the TMA, call 800-659-1862.

BMCs Spark Concern About Patient Referrals for Imaging

The Tennessee Medical Association is asking members to report concerns about benefit management companies (BMCs) affecting patient referrals for imaging services.

Colleagues at the Texas Medical Association have said BMCs like MedSolutions have begun to pressure physicians to join their networks if they want to continue providing imaging services to members of Aetna, CIGNA and several other plans. The TMA has also heard the BMCs have called patients directly, informing them of other in-network imaging facilities that will cost less than the in-network facility they were referred to by their physician.

If you have experienced similar concerns about benefit management companies, please notify the TMA Legal Department at yamell.beatty@tnmed.org. Please provide the name of the BMC, the health plan(s) involved, and the nature of your practice’s concern.

MEET
Finance Committee Chairman
Dr. Pete Powell

PERSONAL
Official Title/Position: Assistant CMO
Company/Years: Vanderbilt Health Williamson, 17 years
Practice Interests/Specialties: Internal Medicine/Pediatrics
Most Important Accomplishment: My children.
Family: Wife Carmen, and two daughters, 8 and 11.
Something Not Widely Known About You: I was in the inaugural class of the TMA Physician Leadership College
Currently Reading: Board review

COMMITTEE
Years as Chair: 2
Why I Agreed to Step Into a Leadership Role: During these times of tremendous changes in health care I felt it important to get involved and protect our patients and our profession.
Goals/Philosophy as Committee Chair: Work collaboratively with all committees to develop a unified organization that is strong financially and by membership.
Most Important Committee Accomplishments: developing a balanced budget in difficult economic times
Importance of the TMA/Committee: The TMA is the lone place in Tennessee where physicians can express a significant voice to the issues at hand. The TMA protects its physicians and their profession and enhances the care of all of Tennessee patients.
PITCH 2013 A SUCCESS!

Physicians from Chattanooga huddle before beginning their day of lobbying.

TMA leaders meet with Speaker Beth Harwell. (L-R): Speaker Harwell, TMA President Dr. Wiley Robinson, President-elect Dr. Chris Young, Nashville Academy of Medicine President Dr. Michel McDonald, (far right) IMPACT Board Chairman Dr. Newton Allen.

Lt. Governor Ron Ramsey (left) meets with physicians from east and upper east Tennessee in a private session.

IMPACT Chairman Dr. Newton Allen urges PITCH attendees to support medicine’s political action committee.
We had a great turnout for PITCH, the TMA’s annual policy briefing and lobby day, at our State Capitol in Nashville. Over 120 participants met with their local lawmakers to strengthen relationships and discuss major issues affecting the profession such as youth concussions, motorcycle helmet repeal, scope of practice, reimbursement, EMTALA, and administrative hassles and burdens on practices and patient care.

Thank you to all who participated! If you didn’t attend, we hope to see you next year. In the meantime, get involved through Doctor’s Day on the Hill, sign up for grassroots action or contribute to IMPACT. Learn more at www.tnmed.org/govt-relations.
TMA Well-Represented at AMPAC Candidate Workshop

By Jim Wilson, Manager
AMPAC Political Education Programs

AMPAC conducted its annual Candidate Workshop on February 15-17, in Washington, DC. Thirty-six physicians, students and spouses from all over the country came to the Workshop to learn what it takes to run a competitive campaign for public office, and hopefully follow in the footsteps of the 13 recent Workshop graduates who won elections in 2012.

The February Workshop began with a keynote address from U.S. Representative (and 2008 Workshop alumnus) Phil Roe, MD (R-1) who also spent the first session with the attendees and talked about his experiences as a physician, candidate and Congressman. While most of his Congressional colleagues were home on recess, Dr. Roe gave four hours of his time on a Friday night to his colleagues, and AMPAC is extremely grateful!

The Volunteer State and the TMA, as has become an annual custom, was well represented at the Workshop, with three physician participants, in addition to Dr. Roe:

- Richard Briggs, MD, Knoxville
- Manish Sethi, MD, Nashville
- Turney Williams, MD, Johnson City

DETAILS
One of AMPAC’s flagship Political Education Programs, the Workshop is intended for physicians, spouses, medical students and state society staff who are considering a run for public office. It packs all the essential elements of a political campaign (from Alderman to Congressman) into a two-day program.

The Workshop starts with an overview of the comprehensive campaign plan, and then progresses through each of the elements of a competitive campaign:

- Political polling
- Campaign organization and structure
- Campaign message
- Direct mail
- Internet and social media
- TV and radio ads
- Press relations
- Public speaking
- And last, but by no means least … Fundraising

Spots are still available for the 2013 Campaign School, held April 17-21, at the Ritz Carlton Pentagon City in Arlington, VA. AMPAC covers all costs for AMA members, except for transportation to the DC area. AMA member spouses are also welcome to apply.

INTERESTED?
For more information, visit www.ampaonline.org/political-education, e-mail politicaleducation@ama-assn.org, call 202-789-7465, or call TMA Government Affairs at 800-659-1862.
Dr. Mitch Mutter of the Tennessee Department of Health talks with Dr. Seth Kaufman, a pain management physician at The West Clinic – Memphis, following one of the state’s Controlled Substance Symposia in March.

TMA Practice Solutions and eHealth Director Angie Madden receives a 2013 Champion Award from the Tennessee Health Information Management Association. (L-R): THIMA President Kyle McElroy, Ms. Madden, and THIMA Exec. Dir. Wanda McKnight.

TMA leaders visited with U.S. Senators Bob Corker and Lamar Alexander as part of the AMA National Advocacy Conference in mid-February. (L-R): Drs. Jesse Ehrenfeld, Nashville; Don Franklin, Chattanooga; David Gerkin, Knoxville; TMA President Wiley T. Robinson, Memphis; President-elect Chris Young, Chattanooga; and Mark Anderson, Chattanooga.
MEMBER NOTES

Two TMA members are among new officers elected by the medical staff at Athens Regional Medical Center for 2013. **David R. Childress,** MD, a family physician with Athens Family Practice, is the new chief of staff. **Joseph C. Lauterbach, MD, FACOG,** a specialist in OB/GYN and pelvic surgery with Athens Women’s Clinic, is the immediate past chief of staff. Both are members of the McMinn County Medical Society.

**David M. Larsen, MD,** of Jackson, was recently honored as 2012 Man of the Year by the Exchange Club for the work he has done for the Jackson community. A board-certified family medicine specialist, his achievements include opening the Northside Medical Clinic, where he practiced for 25 years; serving on six mission trips to Nicaragua; and opening the Faith Health Center, providing healthcare by volunteer physicians to uninsured patients. Dr. Larsen is a member of Consolidated Medical Assembly of West Tennessee.

**Brent R. Moody, MD,** of Nashville, has been re-appointed as chair of the American College of Mohs Surgery’s Public Policy Committee. The College represents over 1,000 fellowship-trained skin cancer surgeons. The Public Policy Committee is responsible for oversight of the College’s legislative and regulatory initiatives at the national level. Dr. Moody is medical director of the Skin Cancer & Surgery Center, PLC. A board-certified, fellowship-trained dermatologist specializing in Mohs Micrographic Surgery (for the treatment of skin cancer) and general dermatological surgery, Dr. Moody is a former director of Cosmetic Dermatologic Surgery and assistant professor of medicine at Vanderbilt University. Dr. Moody is a member of the Nashville Academy of Medicine.

**Samuel R. Schroerlucke, MD,** was recently named physician of the month by Saint Francis Hospital-Bartlett. The award is given based on comments from patients, families and staff at Saint Francis, Dr. Dr. Schroerlucke is with Tabor Orthopedics in Memphis, where he specializes in complex spinal reconstructions and minimally invasive spinal surgery. He has presented and published numerous research projects on topics such as early onset scoliosis, adult spinal deformities and minimally invasive spinal techniques. He is a member of the American Academy of Orthopedic Surgery, North American Spine Society, an associate member of the Scoliosis Research Society and a member of The Memphis Medical Society.

**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.**

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George M. Testerman, Jr., MD, Kingsport
John J. Warner, MD, Nashville
Sameh Ward, MD, Blountville

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**TMA ELECTIONS...**

(Continued from page 13)

**AMA Delegation**
Richard DePersio, MD, Knoxville
Chris Fleming, MD, Germantown
Donald Franklin, Jr., MD, Chattanooga
John Ingram, III, MD, Alcoa
James King, MD, Selmer
Robert Kirkpatrick, MD, Memphis
Lee Morisy, MD, Memphis
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Tennessee’s physician and medical groups are increasingly becoming more involved in care coordination models in an effort to improve tracking of patient data and quality outcomes, while lowering healthcare costs.
It is part of a nationwide trend that has been ongoing in some states for several years. While not as far along perhaps compared to other states’ efforts, the number of physicians participating in accountable care organizations (ACOs), patient-centered medical homes (PCMHs) and other innovative strategies is on the rise.

In Middle Tennessee, an ACO formed last year by Saint Thomas Health – MissionPoint Health Partners – announced on March 5 that it was entering a four-year partnership with BlueCross BlueShield of Tennessee.

The new agreement, which goes into effect in January 2014, focuses on realizing four core objectives: enhancing the health status of Middle Tennessee consumers; reducing healthcare costs; improving the patient experience; and enriching the lives of caregivers.

MissionPoint, a non-profit organization founded by Saint Thomas Health and a group of dedicated physicians, provides numerous services to members, including health coaching, home visits, preventive health services and strategies for managing a member’s individual health needs. Launched in January 2012, MissionPoint has serviced more than 50,000 members in Middle Tennessee.

Through its new BCBST partnership, the ACO is boldly predicting it can reach more than 560,000 members.

“We are excited to partner with BlueCross BlueShield of Tennessee in offering a new product to the community, expanding our efforts in continuously improving quality outcomes and lowering costs,” said Jason Dinger, CEO of MissionPoint Health Partners. “MissionPoint truly is a new platform for healthcare delivery. We’ve been extremely pleased with the response from patients, physicians and the business community. Now, working with BlueCross, we have the opportunity to provide our unique approach to health care to more individuals and communities.”

The announcement is emblematic of the direction medical care is heading, not only in Tennessee but across the nation. The Patient Protection and Affordable Care Act (ACA) signed into law by President Obama in March 2010 includes a network of subsidies, tax credits and mandates designed to decrease the number of uninsured in the U.S.

The ACA also loosened up Medicare payments, thereby allowing a restructuring of fee-for-service payments to follow a bundled payment system. ACOs were initially conceived to link provider payments to the outcomes of Medicare beneficiaries.

Tennessee took advantage of this particular provision when in May 2012 it was announced that BlueCross BlueShield reached agreements with Vanderbilt University Medical Center, Tennessee Orthopaedic Alliance, Campbell Clinic and the Knoxville Orthopaedic Clinic on a new bundled payment system that focuses on patient care, quality and outcomes.

Working directly with the practices, BlueCross’ bundled payments will provide a set payment amount for the entire episode of care for total knee and hip replacements, including the surgery and physical therapy. The partnership kicked off October 1, 2012.

Tom Lundquist, MD – then vice president of performance measurement and improvement of health services at BCBST – called the bundled pay agreement a big step in the right direction in changing the way medical care is paid for.

“This is the right time for innovation,” he said, in a May 2012 BCBST news release about the agreement. “It requires real commitment to take that first step because this program is a fundamental rethinking of the entire episode of care. We’re fortunate to have these partners who recognize the long-term benefit of getting in on development from the beginning in this important quality initiative.”

Dr. Lundquist is still involved in Tennessee care coordination, but from a different angle. He is now president and CEO of AnewCare ACO Collaborative, LLC, where he leads clinical integration efforts between Anew, Mountain States Health Alliance, and several physician groups throughout the state.

AnewCare is an ACO model geared to help physicians lead health system redesign and improve quality and efficiency. It’s designed to help providers go directly to market through CrestPoint Health Plan, as well as other payers. CrestPoint Health holds the distinction of being the only provider-sponsored health plan in Tennessee, providing Medicare Advantage plans for more than 16,000 members.
Lundquist joined AnewCare in May 2012, and later that summer, the company was picked by the Centers for Medicare & Medicaid Services to serve under its Medicare Shared Savings program. There are seven such Shared Savings ACOs in Tennessee. Under the program, providers have the latitude to receive shared savings that stem from improved outcomes for patients.

“My feeling is that ACOs in concept make a lot of sense for providers to lead the effort in transforming health care,” Lundquist said.

CMS has attempted to ratchet up ACO activity since the Affordable Care Act was adopted, also developing the Advanced Payment ACOs, of which there are two in Tennessee. Under this model, doctors receive an upfront payment based on the number of patients they have.

“Because of the cost [of health care] relative to the overall gross domestic product, we’ve seen the federal government step up over the past several years and change how they pay for health care,” Lundquist said.

Besides the ACOs formed in conjunction with CMS, there are also several commercially-backed programs. Organizations participating in these include BlueCross and BlueShield of Tennessee and Saint Thomas Health (which is based in Nashville).

In addition to the ACO activity in Tennessee, there are roughly 420 clinicians or practice sites in Tennessee that are recognized by the National Committee for Quality Assurance as patient-centered medical homes.

While the labels differ, the bottom line is that Tennessee physicians are increasingly rallying behind coordinated care.

“We all recognize where things need to go,” said Richard Lachiver, MD, chief medical officer at Amerigroup. “The challenge isn’t that we all agree that philosophically this is where we need to go. I think it’s fair to say the biggest challenge we face is the pace and sequencing with how to get there. And that’s where you see the differences between providers and MCOs, and so on.”

Amerigroup is dedicated to the TennCare program that covers mothers and children eligible for Medicaid’s Temporary Assistance to Needy Families (TANF) program and people with long-term illnesses and disabilities eligible for Medicaid’s Supplemental Security Income (SSI) program.

Dr. Lachiver recently joined Amerigroup after being with Nashville-based Healthways for several years, where he worked with providers in Hawaii on fine-tuning medical home strategies.

“We’re talking fundamentally about some consistent ideas and features,” he said. “I learned a lot about what works practically and we’ve made some progress here at TennCare.”

TennCare utilizes a patient-centered medical home model through which beneficiaries are matched with a primary care physician to provide coordinated care.

In the Western part of the state, Methodist Le Bonheur Healthcare in Memphis is contracting with BlueCross BlueShield of Tennessee as part of a five-year arrangement to advance new care and payment models. The new accountable care model – called “Network S” – was announced last summer, and went into effect January 1.

Methodist Le Bonheur replaces Baptist Memorial Healthcare System as the provider of choice in the program, although Baptist continues to participate in TennCare Select networks.
Each organization in Network S has committed resources towards the development of an ACO that will serve Memphians and others in the region. Both Methodist and BlueCross will be financially accountable for performance-based measures to ensure quality and reduce costs.

“We’ve always been committed to offering the best outcomes for patients, but this new agreement means we’re all working together in innovative ways to accomplish our goals,” said Gary Shorb, president and CEO of Methodist, in an August 2012 news release about the partnership. “The industry is shifting away from traditional payment methodologies and we’re excited to be at the forefront of this change. We believe the model we develop can set the highest quality standard and deliver outstanding outcomes for patients while still being affordable.”

The ACO partnership with Methodist is the first for BlueCross in Tennessee.

Vanderbilt University Medical Center, meanwhile, received an $18 million CMS grant in June 2012 to work on improving chronic disease management for patients with high blood pressure, heart failure and diabetes. The funding goes toward supporting the implementation and evaluation of MyHealthTeam (MHT), a model of team-based care that couples collaborative healthcare teams with health information technology to improve control of high-risk, high-cost conditions.

While other states may have more data generated or models more fully developed, stakeholders believe Tennessee providers are well on their way toward becoming a strong market for care coordination.

“The physician culture sometimes gets in its own way, and we have got to think about how to participate rather than stall out,” Dr. Lundquist said.

Dr. Lachiver said as long as the physician community sticks to some core basic principles – such as ensuring care coordination generates real-time information – then patient-centered medical homes, ACOs and other innovative methods should be successful.

Mr. Garcia is a freelance writer covering the healthcare industry in Tennessee.
When it comes to taking care of their health and managing their medical treatment, Tennesseans overwhelmingly prefer that a team of medical professionals, led by a trained physician, oversee their needs, a new statewide poll has confirmed.

“Polling found that Tennesseans prefer strongly that a physician oversee and manage their health care, both personally and for their families,” said Steven Ethridge of the Memphis-based polling firm Ethridge and Associates. “We found very compelling results stating, in no uncertain terms, that the vast majority of Tennesseans trust their doctors to lead the healthcare team.” He added.

Ethridge’s firm conducted the poll in January 2013 on behalf of the Tennessee Medical Association. The poll surveyed more than 800 Tennesseans and has a margin of error of 3.5 percent.

92 percent of respondents strongly agreed or somewhat agreed that physicians should have primary responsibility for leading and coordinating a patient’s health care.

When asked whether they would prefer a physician or nurse practitioner to have primary responsibility for the diagnosis and management for their health care, 82 percent strongly agreed or somewhat agreed that a physician should be in that role.

When it comes to prescriptions for complex drugs, including those with a risk for abuse or dependence, 73 percent of respondents strongly or somewhat preferred getting those from a physician.

97 percent strongly or somewhat agreed that physicians and nurses need to work together in a coordinated manner to ensure that patients get the care they need.

86 percent strongly or somewhat agreed that nurses, while helpful and important to the healthcare team, should assist a physician who should be in the lead role.

When Tennesseans consider the education and training of healthcare professionals, 87 percent strongly or somewhat agreed that physicians are the most qualified to diagnose both common and complex medical conditions.
The public clearly shares the view that sound health care takes a team, and that physicians should continue to lead these dedicated technicians, assistants, specialists and nurses. The poll underscores what Tennesseans have long believed: That physician-led health care makes sound medical sense.

The TMA agrees with Tennesseans. It takes a team to deliver great health care, a team of dedicated professionals and specialists, a team focused on patient wellness and peace of mind, a team with a well-trained physician in the lead.

“We’d never suggest that we can go it alone,” said TMA President Wiley Robinson, MD. “Allied health professionals are crucial to helping diagnose patients and finding the best treatment plans to get them well.”

In the long run, proper initial diagnosis and treatment are going to save money, not to mention time, discomfort and suffering. Physicians bring an unparalleled perspective to that process, based on more than 10,000 hours of clinical education and training from four years of medical school and three to seven years of residency training.

The results of the survey, partially funded through a grant from the American Medical Association, demonstrates that Tennesseans clearly believe in the need for a strong physician-led team to provide healthcare services in the future. And with a physician’s experience and training comes the ability to anticipate and discern the widest range of possibilities.

The medical world is a complicated, rapidly changing arena of scientific discovery. Done right, it is coupled with sound judgment and the wisdom that comes from applying thousands of hours of training to a professional lifetime of delivering care.

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his material highlights certain sections of the HealthSpring Provider Services Agreement contract that are particularly important or easily misread. The TMA stresses that providers should read all sections of the agreement as they are all binding.

ARTICLE II: OBLIGATIONS OF HEALTHSPRING

1. Member Identification. HealthSpring agrees to use its “best efforts” in providing current eligibility information on Members, which could be interpreted in many different ways. Providers are strongly encouraged to check each patient’s eligibility before treatment regardless of HealthSpring’s “best efforts.” HealthSpring may deny payments for treatment provided to ineligible patients.


   i. The TMA encourages all physicians to read the HealthSpring Manual in its entirety before signing this contract as it is referenced several times throughout the agreement. The 2013 Manual can be found on the HealthSpring website at www.healthspring.com/DownFile.Aspx?fileid=2082.

ARTICLE III: OBLIGATIONS OF PROVIDER

1. Credentialing. Provider should be aware of selection criteria, application process, credentialing process, and office site evaluations as discussed in the Manual (p. 17). Also, Provider should read and understand his rights (p. 18).

2. Administrative Policies and Procedures. HealthSpring states in its Manual (p. 12) that it will give Provider notice of updates to policies. However, Providers are responsible for reviewing policy updates in the Manual and for complying with these changes on receipt of these notices. HealthSpring will withhold payments if not.

3. Admissions. Provider agrees to admit patient only to HealthSpring affiliated hospitals. Providers should check with all hospitals where they hold privileges and know which, if any, are HealthSpring participating hospitals. If Provider admits patients to a non-participating hospital, he risks not being reimbursed.

4. Change of PCP Panel (PCPs Only). Provider is required to accept any and all HealthSpring patients who choose him as PCP. The important part of this section, though, is in the third sentence. It states that Provider may only close his panel to new HealthSpring patients if he also closes his panel to all new patients in other health plans. It implies that the only way a physician can close his panel to HealthSpring patients is if he is retiring, because the provision requires closure of panel to all health plans, not just Medicare Advantage plans.

5. Provider Requests for a Member to Transfer to the Care of Another Provider. This section applies only to Primary Care Physicians (PCPs). Provider agrees to fill out and submit to HealthSpring the Physician Requests Transfer of Member from Panel form (p. 78 of Manual) if Provider decides to terminate the patient/physician relationship. Provider must show that the Member has failed to follow the standards of Provider’s practice, which has resulted in a disruption of the patient/physician relationship. Provider will have to continue to treat patient until transfer is granted.

6. Non-Solicitation of Members. Provider agrees not to persuade HealthSpring Members to join another Medicare Advantage plan for one year after termination of this agreement. This includes any published statements from Provider regarding any disapproval of HealthSpring’s practices.

ARTICLE IV: REIMBURSEMENT FOR PROVISION OF COVERED SERVICES

1. Provider Statement and Claims Submission. Provider agrees to accept the lesser of billed charges or compensation described in Exhibit A. (See “Exhibit A” section for further explanation.) Note that a clean claim does not include those filed after 120 days from date of service (See Section 1.5 of PSA). According to this provision, Provider has 180 days from receipt of EOB to file appeal. Review appeals process in Manual (p. 24). Read them carefully before signing.

2. Cost-Sharing and Coordination of Benefits (COB). Review the guidelines in the Manual for collecting COB payments from Members when HealthSpring is the primary or secondary payer, as the processes differ (p. 23).
ARTICLE V: TERM AND TERMINATION

Dispute Resolution. Provider agrees to arbitration in Davidson County with HealthSpring regarding any issue occurring during the term of the contract, even if the issue is disputed after the contract is terminated. It also requires the non-prevailing party to bear all costs, fees, and expenses of the arbitration.

EXHIBIT A: FEE-FOR-SERVICE PROVIDER, PCP PROVIDER, MEDICARE ADVANTAGE MEMBERSHIP

1. This part of the contract gives Provider three options for receiving additional compensation as a HealthSpring “Enhanced Partnership” Provider: Platinum, Silver, and Bronze. They are self-explanatory but essentially prohibit Provider from treating new patients from any other Medicare Advantage plan (except the Silver option, which allows Provider to treat patients in only one other plan). This could be problematic, especially for Providers in rural areas where physicians are few.

2. Additionally, Provider agrees to refund to HealthSpring all additional compensation paid under the three options in the event HealthSpring determines Provider is not in compliance with any provisions of the agreement.

   i. Note: HealthSpring has assured the TMA that the Enhanced Partnership agreement is merely an option for providers to receive additional compensation. Providers may still contract with HealthSpring without this additional agreement, and thus would be allowed to see patients from other Medicare Advantage plans.

EXHIBIT B: MEDICARE ADVANTAGE TERMS AND CONDITIONS OF PARTICIPATION

1. This exhibit includes provisions that all Medicare Advantage plans are required by law to include in each provider agreement.

2. Prompt Payment. This section refers to the claims payment and denial timelines laid out in Section 4.2 of the PSA.

3. Advance Directives. The Manual provides a Disclosure Statement for Medical Powers of Attorney for Members to complete (p. 69). Also, HealthSpring’s policy states it will conduct periodic reviews of Provider’s medical records to confirm that the required Advance Directive documentation exists (p. 8).

4. Medicare as Secondary Payor. This section acknowledges the different processes Provider is required to follow if HealthSpring is not the primary payer. Read Section 4.3 of the PSA and section III.b. of this review for more information on COB payments.

For questions about this analysis, contact Ms. Dageforde, TMA assistant general counsel, at katie.dageforde@tnmed.org. For other managed care contracts or contract amendments they wish the TMA Legal Department to provide a similar analysis for, please contact Yarnell Beatty at yarnell.beatty@tnmed.org.

*DISCLAIMER: This material and discussion of these issues should not be construed as legal advice or representation by the TMA in your practice’s attempts to negotiate the terms of any HealthSpring or any other Medicare Advantage contract. It does not constitute an attorney-client relationship between you or any TMA employee. This unwarranted material is provided only for informational purposes so you can better understand the terms of the contract. Should you require legal advice or representation, you should contact your personal attorney, or if you do not have one, the TMA has a relationship with a law firm that has expertise in this area and offers TMA members representation at a discounted hourly rate. For more information, contact Yarnell Beatty, TMA General Counsel, yarnell.beatty@tnmed.org. The TMA cannot advise you whether or not to sign a contract with HealthSpring or any other managed care company.
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J.S., M.D.

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Anticonvulsant Hyper-sensitivity Syndrome (AHS): A Case Report

By Bradley R. Keel, DO, and Catherine L. Payne, MD

OBJECTIVE
Recognize this rare but serious drug reaction and its treatment.

ABSTRACT
Anticonvulsant Hypersensitivity Syndrome (AHS) is a rare complication of common drugs used today. It is unusual in that it occurs later than most other drug reactions, about two to six weeks after initiation of the offending agent. It also has a hereditary background unlike most other drug reactions. This reaction is caused by the aromatic amines and causes hepatitis, skin rash, fever, and other systemic organ involvement can occur. The reaction is rare but often fatal, thus the observer should be acutely aware of this in the months following initiation of the agents.

INTRODUCTION
Anticonvulsant Hypersensitivity Syndrome (AHS) is a rare complication from anticonvulsant or antiepileptic therapy with drugs that contain aromatic compounds which include carbamazepine, phenobarbital and phenytoin. Diagnosis is made by a triad of symptoms which include rash, fever, and systemic involvement. This syndrome may occur anytime after the initiation of these offending drugs but usually appears two to six weeks after initiation of therapy, this differentiates AHS from other drug eruptive skin rashes.

CASE REPORT
A 40-year-old African-American female presented to an emergency department with complaints of nausea, vomiting and right upper quadrant abdominal pain, as well as a rash. The rash had preceded the abdominal complaints by one week but was attributed to a change in soap. When she was seen in the emergency department two days before admission, she was given prednisone for her rash and discharged. The patient then developed abdominal pain associated with nausea and vomiting. Further history revealed the patient had been started on phenytoin four weeks before admission for new onset seizures. Her past medical history is also significant for human immunodeficiency virus disease (HIV) diagnosed five years earlier; her last CD4 count was 347. Physical examination revealed a fever of 102°F blood pressure 93/57, respiratory rate 20, and oxygen saturation of 100%. Her abdomen was tender in the right upper quadrant without hepatomegaly, guarding or rebound. She had a non-desquamating, maculopapular rash over her entire body, including her palms and soles. The rest of physical exam was normal. Lab abnormalities included aspartate aminotransferase 270 U/L, alanine amino-

### Table 1. Liver function tests trended over admission.

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transferase 245 U/L, serum sodium 123 mmol/L, albumin 2.3, total protein 5.3, alkaline phosphatase 88, total bilirubin 0.3, INR 1.16, and lipase 4. Her blood indices were initially normal — including eosinophils — but she ultimately became anemic during her admission.

She was admitted and monitored while phenytoin was discontinued and levetiracetam was begun. During her admission her liver-associated enzymes were monitored daily. For the first two days her liver enzymes were stable; she then had a sharp rise on day four of admission and over the next day, both her AST and ALT had doubled, then sharply declined over the last three days of her admission (Table 1).

She was discharged after eight days and her transaminases were trending down predictably. Her nausea and vomiting subsided and her abdominal pain resolved by day six. Her rash ultimately began to desquamate and slough off (Figures 1-3).

**DISCUSSION**

Anticonvulsant Hypersensitivity Syndrome (AHS) is a rare complication from anticonvulsant or antiepileptic therapy with drugs that contain aromatic compounds, such as carbamazepine, phenobarbital and phenytoin. These reactions are idiosyncratic and occur one in every 1,000 to 10,000 cases. Unfortunately they carry a high mortality rate of 10 percent, mostly related to secondary infections. The prevalence is most likely higher but is underreported due to confusion with other more common reactions, like drug eruptions and allergic reactions.

The exact mechanism is unknown. Theories include a deficiency or abnormality of epoxide hydroxylase which detoxifies the aromatic amine anticonvulsants, reactivation of herpes-type virus, or an association with certain HLA subtypes. ²

Drug related eosinophilia and systemic symptoms (DRESS), another name for AHS, implies systemic consequences and characteristic abnormalities. These systemic symptoms include rash and fevers but may be associated with hepatitis, arthralgias, lymphadenopathy or hematological dyscrasias. Diagnosis is made by a triad of symptoms which include rash, fever and systemic involvement. There are scoring systems that can be used to aid in diagnosis: the RegiSCAR inclusion criteria for DRESS is an example of one of them (Table 2).

This syndrome may occur anytime after the initiation of an offending drug but usually appears two to six weeks after initiation of therapy, which differentiates AHS from other drug eruptive skin rashes. ¹ Although rare, AHS is a serious side effect of commonly used anticonvulsants. Recognition requires knowledge of these side effects and prompt discontinuation of the offending drug. Other treatments are mostly supportive, including antihistamines and steroids. As in our case, the liver is the most common affected internal organ, with 51 percent of patients having some

(Continued on page 38)
Glucose Monitoring As an Impediment to Improving Glycemic Control: A Case Report

By Aimee G. Russell, DO; Lei Chen, MD; Kelli Jones, CDE, RN; and Alan N. Peiris, MD (Lon), FRCP (Lon)

ABSTRACT
Diabetes mellitus is increasing in frequency and is associated with disabling acute and chronic complications. There is evidence to indicate that excellent glucose control may retard the development and/or progression of these complications. In order to optimize diabetic control, patients are encouraged to monitor their glucose frequently. We describe a patient who provided inaccurate glucose monitoring results, delaying effective management of his progressively increasing glycosylated hemoglobin level. The diagnostic clue to his erroneous glucose monitoring results was the lack of intra-day variation in this patient on insulin therapy. Moreover, glucose records within the patient’s glucometer pointed to a much less frequent glucose monitoring than the written data provided by the patient. The glucometer was accurate when used by the patient under direct observation. It remains unclear whether this patient deliberately misled his providers or if the erroneous data reflected underlying cognitive dysfunction. Providers are encouraged to approximate average blood sugars based on glycosylated hemoglobin values and compare this to home monitoring results provided by the patient. Primary providers should also expect a certain degree of variability when reviewing home blood sugar values with their patients (on insulin therapy) and consider further investigation should the numbers lack such variation. Clinicians are urged to inspect the actual glucose readings on the patient’s glucometer as well as inspecting written glucose records. Observing the patient’s technique and accuracy when using their personal glucometer should also be considered.

INTRODUCTION
Type 2 diabetes is increasing at an alarming rate globally.1 It is a costly disease and evidence indicates excellent glucose control may reduce the onset and progression of diabetic complications. In order to optimize a given diabetic regimen, it is traditional to request that the patient provide QID glucose monitoring results, especially if they are taking insulin. As such, glucose self-monitoring is the cornerstone of contemporary treatment of diabetes mellitus.2 It allows rapid and effective correction of blood sugar levels if they deviate from the set target range.

While self-monitored glucose recordings provide first-hand information on glycemic control, the accuracy and reliability of the data set need to be scrutinized prior to intervention. Failure to do so may lead to false impressions and cause delay of appropriate treatment or initiation of inappropriate management in addressing blood glucose levels. We report a patient with uncontrolled diabetes in whom interventions were delayed by apparently improve glucose values. Closers inspection revealed glucose data to be inaccurate with minimal intra-day glucose variations.

CASE HISTORY
The patient is a 62-year-old military veteran with past medical history of poorly controlled diabetes mellitus type 2 (diagnosed in 2003 with the most recent HgbA1c of 13.9%). The patient also had diabetic neuropathy, vitamin D deficiency, dyslipidemia, major depression, and anxiety. Patient was an obese male in no acute distress with blood pressure of 120/72mmHg, pulse 76bpm, respirations 16, height 72 inches and weight 229.5lbs. Physical Examination was normal apart from reduced pedal pulses and diminished sensation to monofilament testing bilaterally.

Laboratory investigations revealed: hgbA1c: 13.9% [4.6 – 6.4 %]; CBC was normal except for mildly decreased platelets of 136,000 and an MCV of 81.3L [83.5-96.8L].

A complete metabolic panel revealed: Blood Urea Nitrogen: 16mg/dl and Creatinine: 0.8mg/dl; AST 26 units/L, ALT 369 units/L and Alkaline Phosphatase 89 units/L. Recent Fasting Lipid Panel was remarkable for Triglycerides of 461mg/dl and Direct LDL of 118mg/dl. Vitamin B-12: 369pg/mL.

PATIENT COURSE
Diabetic regimen at time of evaluation consisted of: glargine insulin 28 units subcutaneously Q am and 64 units subcutaneously HS, aspart insulin 68 units subcutaneously TID with meals, sliding Scale Insulin AC/HS, metformin 1000mg PO BID and pioglitazone 45mg PO Q day. HgbA1c at the initial visit was 9.5%. The patient underwent changes in glargine and aspart insulin dosages as well as a trial of U-500 insulin, without improvement in glycemic control. During the recent referral, the patient was re-introduced to glargine (10 units HS) and aspart (5 units TID with meals) in conjunction with a sliding scale of insulin. His Hemoglobin A1c was 13.6% with the presence of polydipsia, polyphagia, polyuria and signs/symptoms of neuropathy.

Glargine and aspart were increased and the patient was instructed to check blood glucose levels four times daily and call with results in two weeks. During the scheduled three-
month follow-up, the patient provided glucose readings that were without much daily fluctuation. The patient’s glucometer records indicated BID testing despite the patient providing QID written glucose records. He was able to use and demonstrate accurate use of glucometer under direct observation. The patient was noted to have moderate cerebral dysfunction on neuropsychological testing. A CT head without contrast revealed small nonspecific cerebral white matter hypodensities compatible with chronic ischemic micro-vascular disease and calcific intracranial atherosclerosis.

**DISCUSSION**

This case illustrates a rare complication of glucose monitoring. The patient provided inaccurate glucose monitoring results which impeded efforts to rapidly resolve his hyperglycemia. Suspicion of inaccurate glucose readings initially arose when his home glucose monitoring results demonstrated a lack of intra-day variability. Further, inspection of his actual glucose monitoring device only revealed twice-daily glucose checks, whereas the patient was providing us with four-times daily values. The patient questioned the accuracy of his glucometer; however, meter use by the patient under direct observation indicated comparable accuracy to the clinic meter.

Self-glucose monitoring is not without its challenges. Questions regarding accurate readings must be of concern. Accuracy may be limited due to many factors such as: strip storage, aging, environmental issues such as temperature, and/or patient aspects such as improper coding or incorrect handling. Another key point is that the patient’s HgbA1c was significantly higher than his home blood glucose results, which averaged approximately 220mg/dL. Based on traditional formulas, our patient’s average blood glucose reading would have been approximately 418 mg/dL. In rare instances where HgbA1c may not be accurate, a serum fructosamine may assist in assessing glycemic control.

Potential discrepancies between a patient’s glucose records and his HgbA1c should alert providers to search for alternate explanations, especially in the setting of unusually uniform glucose results in patients on insulin. Many of this patient’s glucose readings were within five percent of the average glucose value. To our knowledge, there are no clearly defined parameters regarding expected variability in glucose values in diabetic patients on insulin. However, the lack of variation among his blood glucose values and the fact that his home glucose readings did not reflect his HgbA1c or glucose monitoring results raised the question of data inaccuracy. It is difficult to ascertain if the patient was simply falsifying the data or the readings were a result of an underlying progressive cognitive dysfunction that impacted transfer of glucometer readings to a written format.

**CONCLUSION**

We urge clinicians to critically evaluate home glucose monitoring results. One expects a certain degree of variability of glucose values in diabetic patients on insulin and lack of such variability should leave one asking, “Are the glucose numbers too good to be true?”

**References**


Dr. Russell and Chen are residents in the Internal Medicine program at East Tennessee State University, Johnson City, TN; Ms. Jones is the Diabetes Clinic manager at Mountain Home VAMC in Mountain Home, TN; Dr. Petris is chief of Endocrinology at Mountain Home VAMC and professor of Medicine at ETSU.

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**ANTICONVULSANT HYPERSENSITIVITY SYNDROME (AHS): A CASE REPORT**

(Continued from page 36)

type of liver involvement. People with AHS should be advised to avoid the offending drug and all other aromatic anticonvulsants. The patient also needs to be advised to inform their relatives of this reaction because of the genetic and familial predisposition.

**CONCLUSION**

This syndrome is easily identifiable when a careful history is taken. Clinicians should become more aware of this syndrome and be more watchful for its occurrence. It occurs later than other drug reactions and only an accurate history may lead you to it as a diagnosis.

**References**


Dr. Keel is a resident and Dr. Payne is associate program director in the Department of Internal Medicine, University of Tennessee College of Medicine, Chattanooga. Contact Dr. Keel at 975 East Third Street, PO Box 54, Chattanooga, TN 37403; phone: 423-778-2998; email: bradley-keel@gmail.com.
Case Report and Review of the Literature: Spontaneous Aortobronchial Fistula

By Gabriel A. Zaietta, MD; Abhijit A. Raval, MD; Liliana Murillo, MD; Jay Mehta, MD, FCCP; Ryland P. Byrd, Jr., MD; and Thomas M. Roy, MD

ABSTRACT
Blastomycosis rarely presents in pregnancy. Pregnancy is a state of partial immunodeficiency that predisposes to blastomycosis infection, especially in endemic areas. Blastomycosis in pregnancy has been reported in a few female patients and their offspring. We are reporting a 32-year-old pregnant patient at 34 weeks of gestation who presented with a lung mass. The cytopathological exam of the biopsy taken by fine needle aspiration showed evidence of Blastomycosis organisms. She received Liposomal Amphotericin B and was followed closely until delivery. The placenta was examined and did not show evidence of infection in the fetus. Healthcare professionals in endemic areas such as Tennessee should be aware of blastomycosis in pregnancy.

INTRODUCTION
Aortobronchial fistula (ABF) is an anomalous communication between the aorta and a segment of the tracheobronchial tree. Due to high mortality, non-specific symptomatology and lack of specificity of diagnostic tests, a high index of suspicion is critical. Spontaneous ABF is a very rare cause of hemoptyysis.

CASE REPORT
A 75-year-old Caucasian man with a history of hypertension, hyperlipidemia, duodenal ulcer and abdominal aortic aneurysm presented to the emergency room after an episode of “spitting up” a small amount of red blood. The patient was seen and discharged home but returned four days later when he was hospitalized with a provisional diagnosis of upper gastrointestinal bleeding. He had three episodes of “vomiting/spitting” red blood, generalized weakness and lightheadedness. The patient was found to be orthostatic and the physical exam was remarkable for mild tenderness in the epigastrium without rebound. Hem occult was positive. Chest x-ray (Figure 1) showed left hemi-diaphragm elevation (present in previous films) but no infiltrate, pleural effusion or nodules. Left periilar prominence was identified. A CT of the chest was requested. An early consultation with the patient suffered an episode of hemoptyysis, (approximately 100 cc), followed four hours later by an incident of massive hemoptyysis estimated in 700 cc. The patient suffered a cardiac arrest and could not be resuscitated. The autopsy showed a saccular atherosclerotic aneurysm of the descending thoracic aorta, measuring 8.0 x 7.0 x 5.0 cm, adjacent to the left lower lobe, eroding into the left lower lobe and forming an aortobronchial parenchymal fistula (Figures 2, 3).

DISCUSSION
Aortobronchial Fistula (ABF) is uncommon but lethal if not treated promptly, as it causes a massive hemoptysis in 100 percent of the cases. It results from an anomalous communication between the aorta and the tracheobronchial tree.

Girardet, et al., were the first to describe an aortobronchial fistula secondary to TB in 1914. In 1924, Boyd, et al., reviewed 4,000 autopsy reports of thoracic aortic aneurysms and found 3.7-percent occurrence of aortopulmonary fistula (aortobronchial and aortopulmonary artery fistulas).1 In 1934, Keefer and Mallory reported six cases of ABF in a series of autopsies, five of them associated with thoracic aortic aneurysm and one with...
Syphilis. In 1947, Jones performed the first successful surgical repair of an ABF on an 11-year-old girl who had undergone ligation of a patent ductus arteriosus two years before.

ABFs arise as a complication of an aneurysm or pseudo aneurysm, attributed to several etiologic processes. Theories to explain fistula formation include local infection or mechanical stress causing the formation of a pseudo aneurism. Compression of the tracheobronchial tree usually produces pulmonary collapse and infection that enhance the pathological process. Prior to 1960, the most common infectious causes were tuberculosis, syphilis and fungal infections. Since then, most cases have occurred on the setting of atherosclerosis.

Intermittent hemoptysis followed by massive hemoptysis is the most common symptom, occurring in 95 percent of the patients. Massive hemoptysis is characterized by the expectoration of 300–400 ml of blood during a 24-hour period. Incidence of massive hemoptysis is 50 percent. Unfortunately, a massive episode is sometimes the first and only manifestation of the disease. Other signs and symptoms of ABF are dyspnea, cough, chest or back pain, pulmonary rales or hypoxia.

Routine radiological imaging technique as CT, MRA or angiogram can be employed but sensitivity and specificity is low. Bronchoscopy can identify the source of the bleeding, but the fistulous tract might not be readily visible and the procedure might produce a dislodgement of the clot and massive hemoptysis.

It is concluded that timely diagnosis and surgical intervention can be lifesaving. Unfortunately, the correct diagnosis of ABF is established premortem in only 54 percent of the cases. Prior to the use of stenting techniques, surgeons performed open procedures via thoracotomy or sternotomy. The usual approach was through a left thoracotomy, where the aortic end of the fistula could be corrected by patch closure, direct repair, grafting or subclavian artery flap repair. Current endovascular techniques offer a safer, more rapid procedure for repairing

FIGURE 2. Lung and trachea from post. View with aortic pseudoaneurysm rupturing in left lung bronchus.
a life-threatening aortobronchial fistula, especially in patients whose operative risk during an open procedure would be prohibitively high. However, the long-term efficacy of this approach has yet to be defined. In our review of the literature of 36 cases published in 19 articles (Table), we attempted to further clarify associations of ABF. Review of the cases showed the average age of presentation was 68.4 years old (range 47-86). ABF was found most frequently in men (69 percent) and the most common symptoms were hemoptysis, dyspnea and chest pain. The usual risk factors were atherosclerosis, aortic dissection, aortic aneurysm and hypertension. Only one patient had TB with a possible association to the ABF. On physical exam, some patients presented with a loud continuous precordial murmur, hypotension or coarse crackles, but in most cases the findings were not reported. In general, diagnosis was suspected on CT of the chest and later confirmed by aortography. ABFs were most commonly found between distal descending aorta and left main bronchus or between distal descending aorta and left lower lobe; this is because aortic aneurysms or pseudo aneurysms develop most frequently in the descending portion (86 percent of the cases). Most of these cases underwent successful surgical repair with aneurysm resection and patch or endovascular stent graft placement.

From our literature review, we found 21 out of 36 patients (58 percent) had their ABF repaired in a timely basis with endovascular technique, resulting in significant impact on mortality (90 percent survival). Two of the 36
patients did not undergo surgery (one of them refused and the second one suffered an acute fatal hemoptysis) and did not survive. Overall, an 81-percent survival rate was identified when combining endovascular and conventional procedures.8-12

**CONCLUSION**

Although ABF is a rare condition, our case demonstrates the relevance of a careful differential diagnosis and a high degree of suspicion in patients with unexplained hemoptysis. In a case of hemoptysis of large quantity (>100cc) when the etiology is unknown and ABF is not excluded, surgical intervention should be considered. Endovascular technique, which is safer and quicker than the conventional one, should be employed more frequently, as it effectively reduces mortality.13, 14

**References:**


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Making a Case for the TMAA

By Heidi Dulebohn, President-elect

Please allow me to introduce myself: my name is Heidi Dulebohn and I am humbled to serve as the TMAA President-elect. Thank you for allowing us this space to voice our opinions in the coming year. Our goal is to work in concert with the TMA as a strong voice for medicine and medical families in Tennessee.

I am a member of the Washington-Unicoi-Johnson County Medical Alliance in Johnson City. My husband, Scott, a TMA member and neurosurgeon, our two dogs and I have been in the Tri-Cities for the past seven happy years. We moved to East Tennessee from Northern Minnesota, where I was very active in the Lake Superior Medical Society Alliance, (LSMSA).

When Scott made the decision to move to Johnson City—a place where he had wanted to live for 15 years, I cautiously agreed. His closest friends were practicing medicine in the area and he wished to join them. As wonderful as this was for my husband, it was not as great for me. I was leaving my friends, my job, and numerous volunteer organizations I was involved with. One of the hardest groups to leave was the LSMSA.

Once we were settled in Johnson City, I reached out to find the medical alliance. After I began attending meetings and getting to know the members, the transition to Tennessee seemed easy. I had something big in common with these members—a lifestyle. The one constant in our dynamic medical family lives, is our common “language.” It is this commonality that sets our group apart.

Today, there is more and more competition for our “free time.” I have been asked, “Why should I join, or even remain a member of the medical alliance?” I respond with the obvious reason of helping others in your community lead healthier lives and add, “What other group offers you such a sense of understanding, empathy and caring by others in very similar situations as yourself?” This sometimes unspoken sense of understanding can touch you when you need it most. Recently, I had major surgery and was moved to tears by the warm out-pouring of concern and support from the members of my Alliance.

This is why it is my goal, my hope and my commitment to strengthen all of our Alliances across this great state of Volunteers.

We want every TMA member’s spouse to join us, and every TMAA’s spouse to join the TMA! Together the TMA/TMAA can move mountains for a healthier Tennessee.

Thank you for your confidence in me. I look forward to meeting each of you in the coming year! Please contact me today at heidi.dulebohn@mac.com. +

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