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—Greg Rowbatham, M.D.
**Presidency’s Comments**

**Erosion: A Sign of the Times**

By Douglas Springer, MD, FACP, FACG | President

Erosion is defined as “a gradual loss of” something. Our individuality is eroding. We need the voice of solidarity. Just when you hoped that everything could stay the same, it ends up changing, and for many, not for the better. Change is difficult to embrace because it brings uncertainties. It also brings opportunities for improvement. There are several truisms in medicine today: silos are unacceptable, quality/outcomes/cost are imperative, fee-for-service is going to be replaced with a variation of bundled payments or some form of payment reform, a large part of each state budget is medicine, it is increasingly difficult to go it alone, it is better to be in some group to exercise influence, the legislature is now using the TMA as its ultimate resource for medical consultation, and different elements of medicine are talking frequently to solve the larger issues of the entire “house of medicine in Tennessee.” TMA is more influential in this role than at any other time in our state. The money that is available to pay for programs is not going to get larger (the pie will remain the same size) and medicine is going to have to accommodate and work smarter. It is hard for me to believe that most medical professionals can work any harder by squeezing more things in, or working longer hours. Thus, collaboration with the other components of medicine is going to be increasingly important. Witness the recent statement of TMA and TAPA forging the concept of “team.” Physicians in TMA are going to have to be acutely aware of their environment to adequately prepare their practices for the future and TMA is going to do its part to bring you this important information and act as a consistent resource for your practice whether you are solo, integrated, employed by a healthcare system or not integrated, not employed by a health system.

By reducing silos, we can focus on what is important, rather than petty individual agendas. What is most important is the health of our citizens, your patients specifically. With increasing alignment the process of fragmentation is reduced. It can simplify governance and decision making. There can be changes in budget and reducing redundancy of conflict. One main agenda, with a patient-centered focus, can emerge. A lot of wasted energy and duplication are built into silos. Silos interfere with forging decisions. Common goals can move forward more easily and the “voice of solidarity” can surface. This can be a metaphor for change management. Managing change should be deliberate. In TMA, we are creating guiding coalitions made up of people who have expertise, creditability, and are powerful. We are highlighting central themes, creating guiding coalitions, and creating system-level “teams” that are multidisciplinary, managed as a unit, and inclusive. Thus, we are creating a “unit dynamic.” We are always on the lookout for the damage that can come from complacency and ownership of turf (parochialism). In this context we intend to get buy in and keep a forward focus. We intend to implement and sustain “the wins.” We need the assistance of every physician in Tennessee, not just a few. TMA’s momentum cannot be sustained without the necessary dollars from membership and use of TMA services. It is time to get “on board.” Waiting for a time when your salary may go up is not tenable for several reasons. The first, your salary may never go up. Secondly, if you do not participate now, the “wins” may not able to be defended and subsequently lost. Lastly, the future for Medicine in Tennessee as a strong unit will never occur. Now is the time to make a difference.

Finally, I want you to give some thought to our healthcare systems and hospitals, as part of “know your environment.” The old mantra of “they have lots of money and can look after themselves” is a dead idea. If you think your practice has it bad, you ought to take a close look at hospitals’ finance. We are now in this game together for two reasons. Many physicians are now employed by hospitals and the hospitals’ financial health is going to partly revolve around physician health. Even non-integrated doctors need to work with hospitals in order to aid the processes to allow for reduction in expenditures and to improve as much as possible the financial stability of your local hospital. In this way, hospitals should start to support TMA by having their employed medical staff as members.

This should be a budget “must do” and be looked upon as an insurance policy. This will bring the added knowledge of what the problems the employed doctors are experiencing, and add another layer of expertise to our team. In the spirit of knowing your environment, I would invite you to become aware of the hospitals’ plight in the reform era. They have dealt with reductions that have been massive and continue to accumulate. They are dealing with quality reporting requirements, value-based purchasing, readmission reduction programs, hospital-acquired conditions, Meaningful Use requirements, Medicare Shared Savings, PQRs, lack of Medicaid expansion, high-deductible health plans, uninsured, GMEs, and none of these things are expected to generate anything other than giant internal effort, and possible losses. Obviously, the more cooperation hospitals receive from their respective medical staffs, the healthier your local system will be in the future. I would invite you to go to your local facility and ask that they give your staff a quarterly lecture on current local conditions and the financial impact in dollar amounts with all of these programs with local flavor.

As always, comments and suggestions are welcome. It is an honor to serve as your president.

*Share your thoughts with Dr. Springer at president@tnmed.org.*
More Tennesseans Have Access To Prescription Savings

Statewide Prescription Assistance Program Offers a Prescription to High Healthcare Costs

The Centers for Disease Control reports that Americans spend more on prescription drugs than people in any other country: some $45 billion in out-of-pocket dollars in the last year alone. With that in mind, the Tennessee Drug Card is reminding physicians that their patients who aren’t insured or who take prescription drugs that aren’t covered by their health insurance plans, can use the Tennessee Drug Card to obtain discounts of up to 80 percent off the retail price for brand and generic FDA-approved medications.

Another unique component of the program is their preferred pharmacy option. Tennessee Drug Card has chosen CVS Pharmacy as their preferred pharmacy so that residents who don’t have access to a computer and can’t obtain a hard card, can visit any CVS Pharmacy to have their prescriptions processed through Tennessee Drug Card. Residents can simply reference “Tennessee Drug Card” to have their prescription processed through the program. Tennessee Drug Card is accepted at over 56,000 participating regional and national pharmacies.

Tennessee Drug Card has been working closely with Tennessee Medical Association, as well as numerous clinics and hospitals around the state to distribute free discount prescription cards to all Tennesseans so that all residents will have access to this free program. Tennessee Drug Card was launched to help the uninsured and underinsured residents afford their prescription medications. The program can also be used by people that have health insurance coverage with no prescription benefits, which is common in many health savings accounts (HSA) and high deductible health plans.

Tennessee Drug Card has helped residents save over $36 million since its inception in 2007. You can help by encouraging your patients to print a free Tennessee Drug Card at www.tennesseedrugcard.com. Tennessee Drug Card is also available as an app for iPhone and Android. You can search “Free Rx iCard” in the app store. Any physicians who are interested in ordering free cards for their clinic/hospital can email Natalie Meyer, Program Director, at Natalie@tennesseedrugcard.com.

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**TMA’s current vision** is to help its members receive a great return on their career investment in medicine. Most often when people talk about ROI, they speak in terms of financial gains or profits. While this is a goal, it is not the only goal that we seek for our members. Achieving and maintaining the autonomy to practice medicine your way, in the environment of your choice, and truly maximizing your enjoyment of your chosen profession completes our vision.

The Physicians Foundation recently completed its second national survey on physician satisfaction, and the numbers are disturbing.

- While general morale of physicians has increased somewhat in the last two years, more than half of our colleagues still have a negative outlook with regard to the state of the medical profession.
- Physicians spend on average 20% of their practice time on non-clinical work.
- 39% say they will accelerate retirement plans.
- 8 in 10 consider themselves at capacity or overextended.
- 69% believe their clinical autonomy is sometimes or often limited and their care decisions compromised.

When you no longer truly enjoy what you are doing, going to work each day can weigh heavy on your mind, affecting how you treat patients and colleagues. TMA has a multi-touch strategy to help its members increase their personal satisfaction, protect their autonomy, and prosper in today’s changing work environment.

Right now, TMA is helping members by:

- Reducing the hassles and burdens in practice.
- Building new physician leaders.
- Training physicians and staff on new payment models.
- Advocating for fairness, transparency and funding.

The number-one lament from physicians is the crushing volume of bureaucracy. TMA works daily in the trenches with state officials, insurance executives and regulatory boards to represent the plight of physicians.

As our healthcare system continues to churn, there is a greater need for physicians to step up and lead in the boardroom as much as they do in the exam rooms. This is a different skill set that physicians are not accustomed to or trained in. Through TMA’s leadership institute, we are providing these new skills to prepare physicians to lead in this healthcare evolution, to define and protect good medicine and preserve the doctor-patient relationship.

Our participation in discussions with healthcare systems, the state and other stakeholders regarding standards to govern the developing episodes-of-care is as critical as having a voice in the mechanisms currently being tested in new pay-for-quality programs. And while half of physicians who completed the survey feel that ICD-10 will cause severe administrative disruptions in their practice, we don’t anticipate another delay and have training programs ready to prepare our members for this next stage of coding for care provided. This is not an option if you want to be paid properly for services rendered.

Our pervasive advocacy efforts have led to a huge reduction in liability lawsuits and liability insurance costs. Presently, we are engaged in the country’s first legislative effort to make insurance companies abide by the payment terms of contracts. Your dues fund these efforts and we can offer even more resources and achieve greater advocacy wins with the support of all the physicians. Ask your colleagues to join TMA, so we can make medicine more enjoyable, nobler, and more rewarding.

When you enjoy what you do, you never work a day in your life!

*Share your thoughts with Mr. Miller at russ.miller@tnmed.org.*
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Every time I’m faced with writing about something that because of the calendar will happen six weeks or so hence, I have to comment that my crystal ball has gone hazy, and that much of what you’ll find in this column will turn out to be sheer fiction, taken off the top of my head instead of from within it. Some of it will have been resolved one way or another by the time you read about it, rendering it moot. Despite the notably sorry record of forecasters generally, you might nevertheless think that my elevator stops short of the top floor. I can only say that you are about as likely to get something out of this as you are from consulting those who depend on that for their livelihood (which I don’t), with their slick publications touting their triumphs while ignoring their debacles. The problem with both is in figuring out when that is.

As I prepared to leave for my usual walk this morning I was greeted by an intense pattering on the roof reminiscent of a hail storm, accompanied by the screeching, chirping sound of large numbers of birds outside. On opening the door I found the turnaround littered with a mass of starlings that extended up into the branches of a huge, overhanging oak tree. A continuous shower of small acorns, loosened by the fluttering wings of the birds, was pelting down from the tree onto the leaf-strewn pavement and the adjacent roof. My presence dislodged the feathered mass, which screeched away toward less disturbed venues, leaving me to proceed on my walk in more or less reconstituted silence.

My thoughts as I walked along the perimeter of my block on this cool, gray morning were far removed from fluttering starlings and falling acorns, and even from the brisk wind that stirred some of the still clinging leaves to loosen their hold and flutter to the ground, but not so far, either, that such things didn’t intermingle with the deeper thoughts, and sometimes surface. The entire ambience of the neighborhood is continually being altered by the presence or absence of the sun, by its position in the sky, and by the winds, rain, and falling leaves. On this gloomy morning the palette was pastel, and the canvas glowed soft and warm with autumn’s glory. To my left rose a dogwood clad in soft maroon, superimposed on and set off by a somewhat larger, deep green magnolia looming just behind it.

Towering a little farther back, and dwarfing even the magnolia, a huge golden maple gave that corner of my view a layered effect. As I proceeded along the way, the trees gradually assumed individual status once again as the layering diminished, only to be lost as the two smaller trees became slowly but inexorably eclipsed by the maple’s golden mass. Overhead a steady stream of migrating small birds was flying in formation, harbingers of the stark days to come.

Just ahead of me one street over—the street on which I live—a patch of open gray sky was suddenly transformed in my mind’s eye into the deep blue black of night, and I found myself transported into a vision indelibly imprinted on my memory from a winter long past. In the center of the open space hung a crescent moon, caught precisely between the horns of which shone the evening star like a brilliant jewel set in a dagger’s hilt. It was called up from the depths by a debate into which I had been drawn recently by one of the participants as an innocent but not entirely disinterested bystander, as to whether or not a waning moon could be called a crescent moon, since the derivation of the word crescent is the same as that of crescendo, and means “growing.” The debate was saved from acrimony only by its being an exchange between friends, and that whatever the outcome of the argument it would be supremely inconsequential, since it is after all a crescent moon to all but the most pedantic (who also (Continued on p. 13)
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DEATH OF A PROFESSION:
IS MODERN MEDICINE
A PROFESSION IN
TERMINAL AGONY?

By Jackson E. Butterworth, Jr., MD, FACS

Historically, the profession of medicine in Western Civilization has been one of the important contributors to societal development. Currently we see too many responsibilities of the profession of medicine that have been ceded to interests outside the “learned profession.” Much has been received by society in the form of clinical expertise, personal integrity, confidentiality, and reliable commitment from medicine. Compassionate care has been at the forefront of the physician’s armamentarium. In today’s environment we observe a loss of independence and freedom of patient management in many areas. The surrender of these discretions has occurred incrementally in the form of Ling Chi or “Death by a Thousand Cuts.” The industries of insurance, pharmacy, and governmental bureaucracy have captured many of medicine’s former responsibilities. One can determine that medicine as a profession is in an agonial state and in need of intensive care.

Retaining the professionalism of historic medicine too often has been subordinated to economic pursuit. Heather Reid of Morningside College advises, “The rewards of men’s professions may be more tangible than the rewards of Socrates’ mission, but by pursuing their professions to the exclusion of developing their souls, they find themselves with skills, money, and popular esteem but no sense of moral direction by which to guide the use of their practical expertise.” The goals toward which professionals apply their skills ideally would be a product not of technical training but of the personal cultivation of moral aretē.

Business and governmental agencies have become paramount in healthcare and the physician has lost much of the relationship with his patient regarding fees and allowable treatment. Government and businesses determine the “value” of both the physician’s services and the correctness of his recommendations. Indeed the physician’s management and advice are frequently withheld or altered by third party systems. In 2014, the physician has become virtually an employee of the system.

Government has administered many of the cuts that have been inflicted on the system. Through payment schedules, regulations, oversight, and restriction of practice, government polices encroach on the former jurisdiction of the profession. Reduced payment fees accompanying a large Medicare population create economic pressures on the practitioner, which are followed closely by private payer insurances. This fosters economically driven practice patterns.

Another of the cuts relates to technology. Machines and technicians perform many of the longstanding functions of physicians, placing a distance between patients and physicians.

The evolution of physician education brings another injury to medicine. Physician-operated schools propagated the knowledge and the culture of medical practice since the time of Hippocrates and Aristotle. Today, boards of regents and non-medical boards of advisors manage the medical schools. While still included, physicians do not hold the fiscal authority, giving students the message of a secondary status of medicine in the hierarchy of administration.

Computerization of one’s medical practice could be another such cut. All too often, computer-generated patient information obscures meaningful use of the medical record. While computerization offers access of information to medical practitioners, it places another interface between patients and physicians.

Current societal culture mandates significant changes in the young physician’s practice. During their training, professional time is partitioned to provide life away from medicine and available to the family and self. Formerly, time dedication was equated with a strong work ethic within the profession. Shift work and time-off for family activities, while justifiable, reduces this concentration. Physicians are lured into group and hospital employment by the siren-like melody of “practice your profession and leave the business to us.” Independent practices are infrequently sought and independence is lost.

The undermining of professional values and independence may be inevitable in today’s scientific and legal environment. Arnold Relman in the JAMA points out, “At jeopardy in today’s society is the loss of the ‘soul’ of medical professionalism which is the ethical foundation for putting patients’ needs ahead of personal gain, dealing with patients honestly, competently, and compassionately in the interest of the public trust.”

The current Ling Chi suffered by the profession is not likely to be healed or reversed in total. However, opportunities remain for today’s professionals to assert themselves, retaining those qualities that prior generations held dear. State and national medical societies must act to teach the principles of professionalism. Programs to teach practicing physicians and their associates the value of retaining “professionalism” rather than “trade” practices should be promoted. Professional organizations must instruct all caregivers by outlining appropriate ethics, morals, and the hierarchy of the new structure of medical practice. Experienced teams should assist physicians in contracting with hospital systems, allowing discretion for doctors to use best medical
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judgment in patient management, including time with patients. Standards that honor compassion, privacy, and a right of the physician to advocate for his or her patients must be placed into these contracts asserting professional independence.

Changes in the medical profession are real and require adjustment from standards of past decades. By citing and maintaining the traditional values of compassionate patient care and placing patients at the forefront of the profession’s credo, adjustments can be made to advance medical professionalism in our new century. Attention and action from within the profession hopefully will treat injuries currently received and restore it to the status formerly enjoyed.

FOR WHAT IT’S WORTH, HAPPY 1998  (Continued from p. 9)

in their heart of hearts almost certainly think of it that way, and doubtless call it that, too, unless they are simply being deliberately difficult; after all, if you didn’t call it a crescent moon, what would you call it?) Whether the moon at the particular moment of our viewing it in its first or fourth quarter is a detail lost on, and indeed of no interest to, most of us. It is enough that we are able to appreciate the glorious crescent moon, undiminished by pedantic disputations.

Contemplating Nature and all her variations and vagaries is infinitely more satisfying than cogitating about all those other things, too often alarming or potentially disastrous, one is expected to ponder at this time of year. Things such as the state of the world, for instance. With Saddam Hussein running amok again, we shall perhaps be or by the time you read this already have been embroiled in a shooting, or at least a bombing, war. Maybe the world will have been incinerated, either by Saddam or by meteorites. Who knows? Certainly not I. Or maybe the stock market will have entered a free fall, and fortunes, and even worse, lifetime savings, wiped out. Alternatively, maybe not. Maybe instead the economy and individual fortunes will continue growing.

Mankind seems bent on destroying the universe in so far as it is within his capacity to do so. That in attempting to extract every iota of valuable or even just useful material from the earth, the present generation will leave nothing for its progeny that is either valuable, useful, or beautiful seems to bother our tycoons and legislators not at all. Governments and businesses live only for the short term, without regard for the future, with needs that might or might not emerge. Those entities simply consider only the “might not” aspect as important, if indeed they consider the question at all.

Even more uncertain is the medical climate. It is subject to the whims of administrators, lawmakers, and businessmen, which are often far removed from the interests and needs of patients and their doctors. Even as the scientific possibilities for good and often critical patient care continue improving, the cost continues escalating, and many of the new modalities are precluded by the economics of patient care entities and insurance programs. Will that improve? Or will the fortunes of the patient deteriorate further? I can’t say, and so I shan’t hazard a guess.

Man’s inhumanity to man continues unabated. Any change involves no more than a refocusing of it. Slave owners were roundly and justifiably criticized for their insensitivity in separating members of families. And yet when at the end of his junior year a university student from New Zealand left his parents, who have taken out U. S. citizenship papers, in Nashville to visit his former home during the summer vacation, he was refused a return visa because he had reached his 21st birthday and the U.S. vice consul in New Zealand would not believe his sworn statement that he intended to return to New Zealand after graduation. Under the quota system he must go to the end of the line and await his turn, which might be two or three years off.

Lastly, but not necessarily in that order, is the matter of your New Year’s resolutions. Did you make any? As a matter of principle I never do. That way I am not faced with the problem of trying not to break them, which resolution makers regularly do, often before the day is out. I dislike making promises, even to myself, that I’m unlikely to keep. I’ll not embarrass you by asking what you do, and you may do as you please, since you will anyway. It isn’t a bad idea to take stock once in a while, though, and maybe New Year’s Day is a good time for that, unless you have a hangover. When you reach the age of eating your dessert first, though, oftener is better.

To finish off this very informative piece, I shall leave you my thought for the day—maybe even the year, or longer. Motivational speakers often advise you, “Don’t sweat the small stuff!” One such speaker went on to say that after her husband had heard her mention a lot of things he thought were pretty big stuff; he asked her what she thought the big stuff was, anyway. She said, “I told him, ‘You’re born. You die. Everything in between is small stuff.’”

For what it’s worth, Happy New Year.
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PAYER ACCOUNTABILITY PUSH TO CONTINUE IN 2015 SESSION

A big part of TMA’s ongoing advocacy is leveling the playing field with health plans. Sometimes it means acting as an intermediary to help resolve specific disputes between physicians and payers. Other times it means going head to head with the entire industry on Capitol Hill.

Insurance companies have the size and budgets to carry a lot of influence with state lawmakers and regulatory authorities, but TMA’s lobbyists are not afraid to take on major issues, especially when it directly affects members’ livelihoods. Such is the case with TMA’s fight for more reasonable health insurance network contracts.

How it Began

TMA’s legislative staff fielded an increasing number of calls from frustrated members about payers abruptly and arbitrarily changing their reimbursement rates. Health plans routinely write contracts that allow them to lower payment at any time, for any reason, and they have been wielding this leverage for years. When doctors don’t agree with a modification, the payer often threatens to drop them from the network, forcing patients to find a new physician or pay higher “out-of-network” fees.

Typical network contracts protect health plans – and only health plans – by assuring that they have no legal obligation to maintain the original payment amount through the full term. The provisions actually make it legal for payers to cut physicians’ reimbursement in the middle of a contract period.

In no other industry would two parties agree to such a lopsided contract, but insurers have had the upper hand for so long that this strong-armed business practice has become rampant in Tennessee and across the U.S., especially for independent physicians and smaller groups. The TMA listened to members and made it a priority to bring some stability and predictability to the marketplace through innovative, yet common sense legislation.

Progress to Date

TMA’s lobbyists drafted a bill in 2014 that would establish reasonable standards by which health insurance companies conduct business. Simply put, the Healthcare Provider Stability Act (SB2427/HB2303) would require health plans to honor network contract provisions throughout the full contract term and stop one-sided, “take-it-or-leave-it” rate cuts that disrupt patient care.

Senator Bo Watson of Hixson and Representative Jon Lundberg of Bristol sponsored the bill, lined up more than 30 co-sponsors and pushed it through several legislative committees in both chambers. The momentum caught the insurance company by surprise, left it to resort to unfounded arguments and forced it to do something it previously refused to do: Come to the table to discuss a compromise.

Toward the end of the legislative session, Sen. Watson and Rep. Lundberg charged all involved parties, including TMA and representatives from the state’s largest health plans, to meet throughout the summer and fall with the goal of returning with a new bill for the 2015 session, one that satisfies physicians and is still palatable for the payers.

Looking Ahead

Regardless of whether the meetings ultimately produce a compromise, TMA will introduce a new bill in the upcoming session of the General Assembly to give medical practices around the state relief from a frustrating – and in some cases financially devastating – business practice.

Payers need to be held accountable for the agreements they make with healthcare providers and stick to an agreement, once it is in place, for at least 12 months before they make changes that affect agreed upon reimbursement. It is among TMA’s top legislative priorities for 2015 and, if it passes, will be the first law of its kind in the U.S.

It will streamline the administrative process for all parties involved, reduce unnecessary reimbursement hassles, enhance relationships between healthcare providers and insurers and, most important, safeguard patient care.

TENNESSEE MEDICINE | Winter 2014 | tnmed.org 15
In July, the Tennessee Board of Medical Examiners put into effect a requirement for all prescribers who hold a current DEA license and who prescribe controlled substances to complete a minimum of two hours of prescribing CME credit. This left little time for physicians to comply when renewing their Tennessee medical licenses next year. Licensees who are scheduled to renew in 2015 must complete the new requirement by December 31, 2014.

The Tennessee Medical Association is sponsoring a statewide continuing education program to help physicians and other authorized prescribers satisfy the newly enacted requirement for two hours of CME on appropriate treatment of chronic pain. The course is open to all physicians and any other professional licensed prescribers. TMA members get a special discounted rate of $99. Non-members can take the course for $199.

Participants will engage in a comprehensive review of Tennessee’s efforts to combat prescription drug misuse, a summary of Tennessee’s Chronic Pain Guidelines and a discussion of requirements for Pain Medicine Specialists in Tennessee. Physicians can also gain an understanding of how to prevent prescription drug abuse among women and protect babies from Neonatal Abstinence Syndrome, and apply best practices to meet new Controlled Substance Monitoring Database requirements.

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EBOLA PREPARATION EASES CONCERNS

As concern about the possible spread of Ebola sweeps the nation, hospitals, physicians, nurses and other healthcare workers continue to prepare for such an event in Tennessee. David Seaberg, MD, FACEP, Dean of University of Tennessee College of Medicine, believes that, “The threat of Ebola in the U.S. is very different from the reality in West Africa; however, it is vitally important for healthcare providers to prepare for a worst-case scenario.”

“With the combination of Tennessee Department of Health, medical associations such as TMA and TNA, the Tennessee College of Emergency Physicians, and the Tennessee Hospital Association, there has been a tremendous amount of research on this disease in just the past several months.” As a result of this, appropriate steps that physicians in Tennessee should take to protect their patients can be implemented. “I am confident that every ER Department across the state can triage questions and screen patients based on travel history and symptoms and are able to follow particularly strict guidelines in isolating the patient in a negative pressure room and in restricting who is dealing with the patient.”

The most up-to-date guidelines and resources regarding Ebola will continue to be posted on TMA’s website for members to access and use. Members are encouraged, however, to get proper training on the use of personal protective equipment, particularly in ER settings. “In the case of the two nurses in Texas, the disease was spread from inadequate use of personal protective equipment. Here at Erlanger, we do have a well-trained triage, and a cart full with emergency personal protective equipment. Special training has gone into effect for all staff to know how to use this equipment. The same is happening in ERs everywhere. I feel confident that our state is properly adequate and able to cope with Ebola, especially within the ER departments across the state.”

David C. Seaberg, MD, FACEP, is the past-president of the Tennessee College of Emergency Physicians and Dean of University of Tennessee College of Medicine in Chattanooga. He is a recognized national leader for the American College of Emergency Physicians.
**Dr. William Schaffner**, an infectious disease specialist and public health advocate, is the first recipient of an award named in his honor. The inaugural William Schaffner, MD Award was presented to Dr. Schaffner, Chair of the Department of Preventative Medicine at Vanderbilt University, during the Tennessee Public Health Association’s annual awards luncheon in September. The Tennessee Public Health Association and the Tennessee Medical Association have created the joint award to recognize individuals who demonstrate extraordinary efforts in the advancement of public health in Tennessee. In the future, it will be given at a joint ceremony of the associations.

Dr. Schaffner’s career has touched the public in many ways, from creating new infectious diseases science, translating the science into progressive health policy and communicating these advances to the public via the news media. He established Nashville’s first major hospital infection control program, was a member of the American Hospital Association committee that provided guidelines for hospitals to care for AIDS patients safely and effectively, and worked with a trainee to provide the first documentation that child car restraints profoundly reduced infant and child injuries and deaths in car crashes. Tennessee was the first state to mandate the use of child restraint seats in cars.

“Dr. Schaffner has made countless contributions to the fields of science, medicine and public health. But perhaps his most important, yet least known impact is reflected in the many individuals to whom he has served as a gifted teacher and mentor, patiently and logically introducing them to the intricacies of epidemiology, infectious disease control and public health,” said TPHA Executive Director Doris Spain.

A strong advocate of collaboration between academic medical centers and public health institutions, Dr. Schaffner has consulted with the Tennessee Department of Health in teaching, collaborating on policy and responding to infectious disease outbreaks for more than four decades.

“I am both humbled and gratified by this distinctive recognition,” Dr. Schaffner said of the award. “We all strive to develop healthier communities for all who live in Tennessee, and I look forward to celebrating the good works of future awardees.”

A graduate of Cornell University Medical College, he serves as a professor and Chair of the Department of Preventative Medicine and professor of medicine in the Division of Infectious Diseases at Vanderbilt University School of Medicine. He continues to be a strong proponent of collaboration between academic medical centers and public health institutions.
MEMBERS IN THE NEWS

Yasmine S. Ali, MD, MSci, FACC, FACP, of Nashville, has become the Obesity Expert and author for the popular website www.obesity.about.com. Dr. Ali is a preventive cardiologist and clinical lipidologist, and is President of Nashville Preventive Cardiology, PLLC. She currently serves on the TMA's Public Health Committee.

Charles L. Campbell, MD, FACC, of Chattanooga, has been named chief of cardiology for UT Erlanger Cardiology. Dr. Campbell is board certified in cardiovascular disease and internal medicine and is a graduate of Michigan State University.

Allan J. Cohen, MD, FACE, of Memphis, was recently named to the advisory board of the American Board of Clinical Endocrinologists to help develop the 2014-2015 national diabetes treatment guidelines. Serving more than 30 years as an endocrinologist, Dr. Cohen is the medical director at BMG-The Endocrine Clinic.

Charles W. Cox, MD, of Jackson, was the recipient of the 2014 Ralph Johnson Humanitarian of the Year award, presented yearly by the Downtown Dogs Group. Dr. Cox is retired from practice as an Otolaryngologist, but remains a prominent member of the Tennessee Medical Association.

Troy E. Sybert, MD, of Kingsport, has been selected by the Tennessee Hospital Association to be a member of the Symposium for Leaders in Healthcare Quality. Dr. Sybert currently serves Wellmont as the chief quality officer since 2012 and is a graduate of the University of Texas Southwestern Medical Center.+

Do you know a TMA member who has made a great career move, received a big honor or gives to the community in a significant way? Please let us know! Submit your story to crystal.hogg@tnmed.org.

CHECK OUT TMA’S NEW WEBSITE!

We are excited to announce that TMA’s website redesign is live at tnmed.org.

The new site features a brand new look and feel, simplified navigation, improved performance, responsive design for mobile compatibility, and more robust members-only content.

We hope you’ll enjoy exploring the new site.

Moving forward, we will continuously enhance it with more content, new features, better functionality and other improvements. Our goals are to deliver the best possible online experience for our members, put the resources of TMA at your fingertips 24/7, and use the website effectively to bring in new physicians as members.

Tell us what you think. We want your feedback. Send comments to communications@tnmed.org.
BIG DATA.  
BIG CHANGES.  
WHAT’S THE BIG IDEA?

An interview with Troy Sybert, MD, MPH
TECHNOLOGY IS CAUSING A SEISMIC SHIFT in vast amounts of data to both on the macro level, such as in the form of ACOs, and on the micro level, changing the very fabric of traditional medicine in the way physicians practice. The grand challenge as data evolves is how to mine the data, through technology, to create quality care for patients in the clinical setting and align reimbursements with value-based payment models already being implemented across the U.S.

As data moves and evolves, healthcare systems at the macro and physicians at the micro level are all scrambling to survive. Most as a whole lack adaptability, a trait that is necessary for survival. Healthcare systems continue to struggle as large entities find ways to adapt and some physicians resist the change. Troy Sybert, MD, MPH, Executive Vice President and Chief Medical Officer of Capella Healthcare, suggests that “if physicians would sit down and digest what ‘big data’ really is, it wouldn’t be such a concern, but a welcomed asset.”

The medical field is still in an immature state with respect to its ability to reconstruct and mine the data in a way that it needs. Google, as an example, in just a few short years was able to overhaul online advertising and marketing based on consumers’ web surfing patterns.

“Computers bring a three-dimensional view of data to the table in our present day and age,” he said. And this isn’t such a bad thing. Computers are much better at handling data than people are, and bring another element that allows physicians in the clinical setting to apply data across populations of care.

“Once we are able to get computers to do what we want them to do and to spit data out in a certain way, it allows us to more effectively treat a population of hypertension patients, or allows us to look at the data and determine that one diabetic drug causes interactions with another drug. A lot of this can be done without lengthy research trials,” he continued. “Because we are still in the developing stages of mining data, however, ‘big data’ can present some hurdles as it is implemented and understood.”

One such hurdle is workflow revolution. EMRs and other technology enables and actually requires a re-engineering of clinical workflow. Dr. Sybert argues that, “the healthcare system at the macro level underestimated the amount of engineering that should go along with integrating health data with a traditional workflow.” Physicians who have been in practice for 20 years or more have treated patients well using traditional means, and then all of a sudden, everything changes. As a result, some physicians become resistant rather than embracing the change, so that when new technologies such as EMRs are pushed on them through regulatory mandates, those physicians (and hospitals) implement the bare minimum to just get by, without tapping into the potential benefits of the technology, and data.

“Meaningful use was never meant to be a guide for deploying an electronic medical record; EMRs should be meant to improve a
patient’s experience,” Dr. Sybert said. Modern physicians have to develop expertise in areas that previous generations of physicians never had to learn, primarily revolving around technology and data.

“At one of my previous jobs, which is no different than a lot of healthcare systems, we were tracking a minimum of 69 different quality metrics on a micro level. That was only scratching the surface of things that healthcare systems at a macro level are accountable for and currently should be tracking,” Dr. Sybert explains. “It is increasingly common for physicians to spend a lot of their time just keeping up with health IT, tracking clinical regulatory guidelines, new pay-for-performance programs, and even new laws and regulations such as narcotic databases.”

“It has become a huge learning curve in our field, even a monumental hurdle for smaller practices,” he adds. On a micro level for any physician, things like hypertensive medications are always changing from year to year. Throw in narcotic databases for physicians who have little expertise in technology, and “it becomes a real incompetence with physicians who have not been computer savvy to utilize technologies like EMRs and information exchanges that require them to access portals from other databases,” Dr. Sybert said.

In short, it becomes overwhelming.

**PAYERS**

Big data affects Tennessee physicians not just in their clinical decision making and day-to-day business practices; it is also directly tied to their reimbursement. Healthcare payers store and analyze a significant portion of data not only relevant to claims, but also data based on population and services rendered. Data-driven ACOs and other coordinated care payment models enable payers to group patient populations of care into specific categories, evaluate providers on quality and value, and further transition from traditional fee-for-service payment models.

“As we transition from fee-for-service to value-based purchasing models, the payment models begin to get very difficult to understand,” Dr. Sybert said. “Providers and payers have to agree on the data, and it has to be filled with integrity, both at the macro and micro levels.” Some physicians complain that new payer requirements take time away from patient care, and they are spending too much time on administrative tasks when they should be interacting with patients. “Physicians went into practice to treat patients. Now they get caught up in the middle. It becomes incumbent upon healthcare leadership and administration to understand how to facilitate that patient-clinical experience with physicians.”

As fee-for-service and reward for productivity becomes less important and reward for delivering the right kind of care becomes more important, “the challenge becomes how we reward positive behavior from a capitalistic mindset. Healthcare systems and physicians alike will have to shift not only behaviors, but thinking,” he explained. “It is not about how many patients a physician sees in a day anymore, but how well that physician delivers care to the patients who are seen.”

The big stumbling block for many payers will be the inability to harness and cost-effectively analyze these vast data stores. Payers need solutions to mine the data and use it to reduce fraud, manage care for their covered lives, and continue engaging consumers to take more responsibility for their own healthcare choices, and payment.

The data available to physicians, hospitals, and health plans in a sense is forcing much-needed care coordination, greater transparency and accountability. It creates opportunities for physicians to deliver evidence-based medicine to drive efficiency and, most importantly, better patient outcomes. “Mining the data in the way that it needs to be mined for improving quality care is just around the corner,” Sybert concluded. “We are obligated to evolve our healthcare systems to be better (not necessarily more profitable) so our kids can have longer and healthier lives. An unwillingness to adapt and a short-sighted vision will surely derail that goal.”
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Since the introduction of electronic cigarettes in 2003 to the world marketplace, their use has exploded. Currently, e-cigarettes have 20% of the nicotine product market. The current model of the e-cigarette was invented and taken to market by Chinese pharmacist Hon Lik in 2003, entering the United States market in 2007. Previous attempts at a smokeless non-tobacco cigarette, patented in 1965, were never accepted.

The FDA initially attempted to regulate the e-cigarettes as drug-delivery devices, defined under federal law as items “intended to affect the structure or any function of the body.” E-cigarette company NJoy sued the agency, arguing that the nicotine-containing devices were similar to tobacco products which had not been under FDA regulation. A federal appeals court ruled in December 2010 that the agency lacked authority over e-cigarettes, finding they offer only the recreational benefits of a regular cigarette. That legal decision allowed sales of e-cigarettes to proceed but did not address the safety of the products. President Obama signed the Family Smoking Prevention and Tobacco Control Act in 2009. In spring of this same year, the FDA proposed extending the act to include e-cigarettes, pipe tobacco, cigars, hookah water pipes, nicotine gels, and dissolvable forms of nicotine.

Since 2009, the FDA has not regulated recreational nicotine products. Manufacturers have no requirement for consumer protection. Thus, there are no warning labels, no child-resistant packaging and significant media advertising. Television advertisements for cigarettes have been banned in our country since 1971, but in the past few years, supposedly healthier, battery-powered alternatives are seen in numerous prime-time programs. Electronic cigarettes had significant airtime during the 2014 Super Bowl and remain frequent products of late-night talk show advertising.

Electronic Nicotine Delivery Systems, “e-cigarettes,” are being marketed as healthy options for nicotine, using scientific data that does not validate this position. Long-term consequences of e-cigarette use have not been determined. Tom Frieden, MD, Director of the Centers for Disease Control and Prevention, states that, “The increased use of e-cigarettes by teens is deeply troubling. Nicotine is a highly addictive drug. Many teens who start with e-cigarettes may be condemned to struggling with a lifelong addiction to nicotine and conventional cigarettes.” Emerging data points to certain trending, even with e-cigarettes only being available for five years.

Opponents of e-cigarettes express concern that manufacturers may be targeting teenagers or even children, cultivating a new generation of tobacco users. Kits are available online to make your own e-cigarettes, and offer flavors such as cotton candy, bubble gum, and “Mountain Dew-type,” along with the more traditional flavors of coffee, brandy, even a white chocolate. Though not federally regulated, some states have enacted age limits to try to curb sales to children. The FDA reviewed “tobacco products” in October and considered e-cigarettes an agenda item.

Proponents of e-cigarettes proselytize that the user is limiting the risks for harm, inhaling vapor, not smoke. A study presented at the 2013 European Respiratory Annual Congress found significant airway resistance and decreased oxygen saturation.
Dear Doctors and Healthcare professionals,

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What does GYM3 stand for?
G = Garadi (means “Exercise” in Kannada language of Karnataka, India)
Y = Yoga at home
M = Meditation at home.
M = Manaε (“Home” in Kannada).

Our Health depends on 3 things:
1. What we BREATHE
2. What we DRINK
3. What we EAT.

So, we can do:
- Garadi – Exercise at home
- Yoga at home
- Meditation at home.

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Best Wishes

Om Shanthi

C. K. Hiranya Gowda MD, FACS
As 2015 kicks off, healthcare is poised to see a plethora of changes and providers will need a scorecard to keep up. January 1, 2014 saw almost 550 new, changed and deleted codes in AMA’s CPT codes. The number is larger than in previous years and particularly impacts services in the family practice, internal medicine, cardiovascular, gastrology, pathology/ laboratory, and radiology areas. Seven changes were made to the evaluation and management (E/M) section, the most often reported codes in the service-oriented code set. These CPT changes as well as the new ICD-10 code-set scheduled to take effect October 1, 2015 will make for trying times for all providers regardless if practice or hospital-based.

Many practices are still skeptical about whether the conversion to the new ICD-10 code set will actually happen come October. Although previous deadlines were moved “to allow insurance companies and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready,” the U.S. Department of Health and Human Services has dubbed further delay of ICD-10 a myth. They have announced “no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2015.”

So where does that leave providers and their practices? Many practices, after the delay in 2014, have put the brakes on ICD-10 training and testing for several reasons. One, they adopted the wait-and-see attitude. Two, they exhausted their financial resources in getting ready for the first conversion date and their budget didn’t allow for the additional costs involved with the delay. Three, they were ready for the October 1, 2014 deadline, and they just stopped where they were.

If your practice is in the wait-and-see mode, this is not a great place to be. CMS has made it clear the conversion will take place in 2015. Unfortunately, too many practices fall into this category but with some simple steps, a practice can get back on track for a smooth conversion.

First, talk to your practice management vendor and find out where they are in the transition to ICD-10. Most should be ready to roll, which is good, but testing is a must. CMS is still seeking practices to volunteer for testing. It is never too soon to test the practice management system and EHR to make sure the transition will go smoothly.

Secondly, plan financially for that rainy day, which may be the month of October in the coming year. Many experts are indicating that practices need to have at least two or three months of cash on hand, in the event that claims are slow to be processed. A practice cannot afford to be ill-prepared should revenue stream slow to a trickle. With everyone converting at once, claims will, more than likely, be delayed in processing. The premise of the initial conversion delay was to ensure that carriers as well as providers would be ready, but the reality is some will not be ready. At this point, it is still unclear if all carriers will be required to convert to ICD-10.

Lastly, but certainly not the least, start reviewing clinical documentation. The “buzz words” this past year have been “Clinical Documentation Improvement.” Improvement in documentation will never be wasted time, even if we see ICD-10 delayed again. The changes that we see in ICD-10 affecting provider documentation are things such as laterality (right or left) and sequelae (first episode or subsequent). Many diagnosis codes now have bundled codes, so specificity is key. The specificity changes in the code set will require providers to be clear and concise in their documentation. Such words as “and” may need to be replaced with terms such as “with” and “due to” to accommodate for these new combination codes.

Other trends we should see this year are the proliferation of different methodologies for payment. We have heard about many providers who are leaving the traditional fee-for-service models and venturing into patient-centered medical homes, accountable care organizations and shared savings plans. Improved documentation is vital for providers who may wish to change their payment model and be successful in doing so. Patient care affects the reimbursement rates within the new models. Therefore, better documentation and capturing of patient data will allow a provider to be successful with one of these new emerging payment models.

Insurance carriers that ventured into new arenas of payment such as Medicare Advantage programs are seeing many changes taking place with respect to data collection, coding, and billing. Some of the most significant transformations in the history of the Medicare Advantage industry makes it more critical than ever for physicians to put enhanced focus on not only the accurate and timely capture of data, but also on tracking a patient’s care and condition over time.

I feel as though we should call this “year of transition” the “year of education” instead. I see providers needing to educate
among the study subjects who used the e-cigarettes.

The World Health Organization (WHO) also has its concerns about use of the e-cigarettes. WHO states on its website, "This illusive ‘safety’ of Electronic Nicotine Delivery Systems can be enticing to consumers; however, the chemicals used in electronic cigarettes have not been fully disclosed, and there are no adequate data on their emissions."

The electronic cigarette has four ingredients: nicotine, propylene glycol, vegetable glycerin and flavoring. Tobacco is not included. Beyond the four main ingredients, some researchers are concerned with the byproducts from the heat source and the solution contained within the device. Several studies have suggested the vapors of e-cigarettes can contain microscopic particulate matter, tin, chromium, nickel and other heavy metals, which can cause pulmonary pathology.

With an e-cigarette, the user inhales a vaporized liquid nicotine instead of the tobacco smoke that would be inhaled from a conventional cigarette. This is the alternative that is touted as “healthy” or less harmful. The process of smoking an e-cigarette is called “vaping.” Nicotine addiction, as most other addictions, is cue driven. The activity of using an e-cigarette is a powerful cue as it mimics the behavior, the actual activity of vaping.

The unregulated and unrestricted availability of highly concentrated electronic nicotine delivery systems has led to increased exposure and potentially significant nicotine toxicity. This is confirmed by the National Poison Data System, which reported triple the number of childhood exposures to nicotine in 2013 compared with 2012.

Nicotine is a plant derived parasympathomimetic alkaloid. Nicotine is essentially a highly agonist of the nicotinic acetylcholine receptors. Nicotine stimulates the reticular activating system in addition to stimulating a dopamine release. Emerging research also links nicotine to impairment of the immune system. With dosage increase of nicotine, cardiovascular effects can occur, including tachycardia and hypertension, gastrointestinal disturbance and at toxic levels neuromuscular blockade and central nervous system toxicity.

As physicians and healthcare professionals, especially addiction medicine specialists, what are our reactions and responses to our patients, community members, colleagues, and family when we are asked about electronic cigarettes? It seems reasonable that we continue to advise any current non-tobacco user to not start and not consider trying any of the currently available methods of using nicotine. We should consider this as we advise our patients regarding opiates, benzodiazepines, alcohol and other risk behaviors.

How do we respond to a current patient who’s considering cessation? Is this an opportunity to discuss life change with our patient? When a patient inquires about my opinion regarding e-cigarettes, it is an opportunity to begin discussing a goal of nicotine cessation and developing a treatment strategy.

A recent survey of North Carolina physicians published in PLOS ONE, measured physicians’ attitudes toward e-cigarettes use by adult smokers. “Even in the absence of evidence regarding the health impact of e-cigarettes and other vaping devices, a third of physicians we surveyed are recommending e-cigarettes to their patients to help quit smoking,” said Leah Ranney, PhD, one of the authors of the survey. “Yet, e-cigarettes are not approved by the FDA for smoking cessation.”

Clinically, with each patient encounter, I remember, first do no harm...

Recently, we added to our patient intake forms these questions:

1. Do you use electronic cigarettes? Yes/No
2. If yes, is it part of your plan to taper or quit smoking? Yes/No/Not sure

With any patient encounter I want to maintain the patient’s respect and trust in my providing guidance to healthy life choices. One of my goals is to help the patient attain his or her full potential.
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Kimberly M. Pruett, MD, Nashville
Jason M. Quevreaux, MD, Nashville
Krishna I. Reddy, MD, Nashville

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IN MEMORIAM

James A. Pitcock, MD, age 84. Died August 19, 2014. Graduate of Washington University School of Medicine. Member of The Memphis Medical Society.

William T. Aldrich, MD, age 92. Died September 9, 2014. Graduate of Loma Linda University School of Medicine. Member of Nashville Academy of Medicine.

Russell D. Ward, MD, age 94. Died September 9, 2014. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Michael H. Lynch, MD, age 71. Died September 16, 2014. Graduate of Louisiana State University School of Medicine. Member of The Memphis Medical Society.

Robert B. Whittle, MD, age 83. Died September 17, 2014. Graduate of the University of Tennessee Health Science Center. Member of Knoxville Academy of Medicine.

Margaret W. Rhinehart, MD, age 89. Died September 23, 2014. Graduate of Loma Linda University School of Medicine. Member of Warren County Medical Society.

Sue C. Cox, MD, age 89. Died October 3, 2014. Graduate of the University of Tennessee Health Science Center. Member of Chattanooga-Hamilton County Medical Society.
INSTRUCTIONS FOR AUTHORS

Manuscript Preparation – Electronic manuscripts should be submitted to the Editor, David G. Gerkin, MD, via email at Crystal.hogg@tnmed.org. A cover letter should identify one author as correspondent and should include his/her 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/Word document. Pages should be numbered. The transmit-
tal letter should identify the format used. If there are photos, e-mail them separately in TIF, JPG or PDF format along with the article; photos and
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