

South Carolina Chapter  
 Scientific Meeting  
 October 11-14, 2007

**\*\*\$125 Registration Fee for  
 Masters, Fellows and Members\*\***

For registration form go to:  
[www.acponline.org/cme/regmtg/regiona1.htm](http://www.acponline.org/cme/regmtg/regiona1.htm)

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**Governor's Corner**



**D**uring our busy days it is difficult to stay up with our specialty's literature, much less that of other disciplines, thus the Scientific Meeting Committee titled this year's meeting "Back to Basics." In addition to reminding us about what we have already learned about issues facing other specialties, we will have the chance to learn new evaluation and management strategies for the common and uncommon complaints we see everyday.

As poor reimbursement and high post-graduate debt remain responsible for medical students and residents deciding not to enter Internal Medicine, we will have 2 speakers inform us about what our college is doing to help. Our College Representative, Board of Regents member **Fred Turton, MD, MBA, FACP**, will update us on the College's Activities in his talk "*Internal Medicine: Pursuing a Brighter Future*," and will give us ideas on how to work smarter in his talk "*Trying Harder Is Not Enough*." The ACP's Senior

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**English or Spanish, That is the Question**



**Iván E. Monserrate, MD FACP**  
**Chairman, Patient Outreach Committee**

In our previous newsletters, many of you noticed in addition to English, the invitation to our annual meeting and its outcome were written in Spanish. This gesture was a bone fide attempt to recognize and welcome colleagues across the State of South Carolina who respond to the challenge of communicating to some of their patients in Spanish.

Upon receiving one criticism from a respected colleague demanding we write the newsletter only in

English, we polled the membership about the paragraph. While responses were evenly divided, one member made a very good point; with the ever changing state of Internal Medicine, the newsletter could better communicate important information to South Carolina Internists if all its space was fully used and if it were written in the language required to be licensed in the state - English. After much discussion the council decided to cease with the Spanish newsletter articles.

Vice-President for Governmental Affairs, Mr. **Robert Doherty**, will join us for the entire meeting, giving us a "Washington Update" and making himself available to discuss any concerns we'd like him to take back to Washington.

We will have an entertaining and informative talk about "Personality Disorders" during which **Robert Albanese**, MD, FACP, board certified in Internal Medicine and Psychiatry will use celebrity examples to help us remember each disorder, even if not all can be treated. **Thomas Keyserling**, MD, MPH, and **Patrick O'Neill**, PhD. will walk us through the good, the bad, and the ugly of diets and diet supplements with their talks "Healthful Dietary Patterns for Weight Loss: High Fat, High Carbs, or Combo" by the former and "Weight Loss Supplements" by the latter. Our resident expert, Dr. **Robert Ball**, will discuss "Hepatitis Update A-E," and Dr. **Ross Rames**, Associate Professor of Urology at MUSC, will speak on "Prostate Cancer - What Every Internist Needs to Know." Dr. **Jeff Bowers** will advise us on "Rational Approaches to the Evaluation of Coronary Artery Disease" and "Congestive Heart Failure - New and Old Approaches to Its Evaluation and Management" while Dr. **Emmanuel O. Quaye** will speak on the "Evaluation and Management of Pulmonary Emboli." Finally, former Gubernatorial Candidate **Oscar Lovelace**, MD, FAAFP will go over the health of South Carolina in his talk "South Carolina and Prevention - How Are We Doing and How Can We Do Better?"

This cornucopia of topics should have something to offer everyone, and, at just under \$10/hour of CME for at least 13 hours of CME it is a cost-effective way to work towards the 40 hours the licensing board requires every 2 years. You can book your room at the Charleston Marriott Hotel on the Ashley River at our discount rate of \$145/night (single/double) by calling 843-723-3000 and mentioning you will be attending the SC Chapter of the American College of Physicians' meeting or going online at <http://www.marriott.com> and using the booking code ACPACPA by September 11, 2007.

So mark your calendar for October 12-14, 2007, and join your colleagues in Charleston for this year's annual meeting. Not only will it be a great educational experience but you will see the best and the brightest of S.C.'s Internal Medicine trainees exhibit their scholarly abilities, while having time to reconnect with old friends, make new ones, and get your opinions to National ACP in Washington and Philadelphia. Here's to seeing as many of you there as possible!

Despite that decision, however, the fact remains that there are a large number of SC patients for whom English is not their primary language. To better assist all Internists who care for such patients, in future newsletters we will provide information about where to access patient educational materials for common Internal Medicine conditions in English and in Spanish, the 2 languages in which the ACP Foundation has written such materials. Should you find there are patients in your practice for which educational materials in another language would be helpful, please e-mail our Governor and she will work with the ACP to find appropriate materials in that language.

The Executive Council of the SC ACP sincerely thanks all who responded to the inquiry and contributed to the changes outlined above.



## Primary Care is the Overlooked Missing Link

**Chris McLain, MD**  
Chairman, Health and Public Policy Committee

As the upcoming 2008 presidential election approaches, political 'platforming' is in full swing. Choose any of the candidates and you will undoubtedly hear rhetoric about how to 'fix' the looming Medicare Crisis. Whether the rhetoric outlines universal health care for Americans or the idealistic advantages of a "Pay for Performance System," one thing is certain: health care reform is on the agenda.

Remarkably, though, all the candidates and pundits are missing the mark in their analysis of the etiology of America's medical system's current state of hemorrhaging. Contrary to their assessments, the remedy is not universal coverage; universally delivering equally inefficient care to all by overburdened physicians is unlikely to benefit anyone. This is evidenced by patients' poor access to care in countries that have increased the demand on physicians without considering the need to simultaneously increase the pool of high quality physicians through their versions of "universal health care coverage." Additionally, introducing quality care markers and pay for performance standards into an already overburdened market of primary care physicians is not the answer.

Two recent studies clearly demonstrate that quality of

care increases and all cause mortality decreases as the ratio of primary care physicians to the population at large and sub-specialists in particular increases. Chandra and Baicker show in their study a direct correlation between improvements in health care quality and the number of primary care physicians available to a patient population. This is in contrast to the inverse relationship noted between the quality of care delivered in areas with higher per capita health care expenditures and an increased number of sub-specialists. (1) In no way does this infer that sub-specialists provide substandard care; rather it is indicative of the importance of having well trained primary care physicians available to the sub-specialists to focus on prevention and assist them in choreographing patients' movements through the complexities of health care provision.

Starfield and Macinko et al further demonstrate evidence as to the importance of the roles primary care physicians. (2) In this study an increase in the ratio of primary care physicians of 1 per 10,000 patients correlates with a 6% decrease in all cause mortality. Further, that increase in primary care physicians resulted in improved efficiency and quality of care delivered at lower health care costs.

These references do not discount the remarkable medical advances enjoyed by this country in large part due to incredibly talented and dedicated medical sub-specialists. These venerable physicians are extremely valuable members of the health care system continuing to propel American ingenuity to the highest pinnacles of the global medical community. However, as every entry level physician knows, a pinnacle is only as strong as its foundation, and the foundation of this pinnacle is PRIMARY CARE.

One must resist the lure of the multitude of politically proposed changes to our health care system. Rather than reinventing the health care wheel, reinforcing existing productive spokes is likely more efficient and cost-effective.

Propagating excellence in primary care among medical students and residents should be the primary objective in improving the quality of health care in this country. Training quality primary care physicians and increasing resources available to those already proven more efficient and successful in delivering quality primary care will ultimately result in leaving greater resources available for sub-specialists in their continued pursuit of medical breakthroughs. In short, increasing the pool of quality primary care physicians will provide a win-win situation for patients, generalists, sub-specialists, and policy makers alike.

1Baicker K. and Chandra A "Medicare spending, the physician workforce, and beneficiaries' quality of care." Health Affairs. 2004. Suppl Web Exclusives:W184-97.

2 Starfield B, Shi L, Grover A, Macinko J. "The effects of specialist supply on populations' health: assessing the evidence." Health Affairs. 2005. Jan-Jun;Suppl Web Exclusives:W5-97.

## Quality Matters

**Mike Hawkins, MD, FACP**

**Chairman, Committee for Quality of Care/Patient Safety**

Recently, at an internal medicine conference, the statement was made that the Pay for Performance bus has left the station, and the doctors are not on it. This statement is not entirely true, as most physicians are all about quality, striving to do their very best for their patients. The push back comes from the fact that what we may think we are measuring in terms of quality may not be quality indicators at all, but rather, measurements of documentation skills. The MI patient does not go home on a beta blocker because of severe asthma, but the doctor fails to document why no beta blocker was prescribed on discharge. S/he gets dinged. Despite carefully doing the right thing, and taking time to educate the patient, because s/he failed to document properly, the perception is that of substandard quality. In this case it is obvious the measure had nothing to do with quality of care, but was all about quality of documentation. A quote here by **Vahe Khzanjian**, PhD seems appropriate: "There can be no greater justification for performance measurement than its power to impact that which it is measuring." In other words, we need actionable data. That being said, one can see that we all have to pay very close attention to our documentation skills so that we are actually measuring quality and performance, especially when a portion of our income may be tied to the measurements.

Recently, the Society of Hospital Medicine crafted a white paper on hospital medicine performance, metrics, reports and dashboards, which is relevant to anyone practicing in the hospital, both hospitalist and traditional models alike. The committee came up with ten top performance metrics important in demonstrating value and quality. These top ten performance metrics are as follows:

1. volume data
2. case mix
3. length of stay
4. patient satisfaction
5. hospital cost and ancillary utilization
6. productivity measures

7. provider satisfaction (PCP's satisfaction with the hospitalist)
8. mortality rates
9. readmission rates
10. JCAHO Core Measures (ACE inhibitors in CHF, etc...)

The paper emphasizes that the approach should be to first decide what to measure, set targets, generate and analyze reports, distill key indicators into some form of a dashboard, then develop an action plan around improvement.

With regards to making sure actual performance rather than documentation skills is being measured, systems need to be in place to allow that to happen. Teamwork is essential here. Care plans with checklists can serve as helpful reminders. Partnering with the Information Technology (IT) department to develop checklists on admission and at discharge to capture appropriate care with the click of the mouse can be very helpful. Partnering with the case management department can be very useful. Reminders ranging from stickers on the chart to pop up tabs on computer prompting the physician to give the reason why s/he is not sending the patient home on a beta blocker, for example, can help ensure that quality of care is being measured rather than how well one remembers to document (which can be scary given how busy most physicians are today).

I firmly believe that physicians are on the bus, in fact driving the bus, on quality. However, I also believe that to demonstrate that quality, and to work towards improvement, we all need to develop a team approach, partnering with our hospital administrators and appropriate departments in order to define what it is on which we need to improve, collect actionable data, and have systems in place, hardwired if you will, to ensure that what we are doing is appropriately documented fast and efficiently so as not to further erode into our time at the bedside.

## Welcome to Medicare Exam and South Carolina

**John Black, MD, FACP and William Robinson, MD, FACP ACP Representatives, Medicare Advisory Committee**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expanded Medicare's menu of preventive benefits by covering an



*John Black, MD, FACP*

initial preventive physical examination. All beneficiaries enrolled in Medicare Part B with effective dates that began on or after January 1, 2005 became covered for the "Welcome to Medicare Exam" benefit.

So, how did South Carolina do in its use of the exam? According to Palmetto GBA, in 2005 Medicare enrolled 40,000 new members in S.C., but only about 750 "Welcome to Medicare Exams" were done. In addition to the preventive services listed below, ultrasound screening for abdominal aortic aneurysms for men who have smoked > 100 cigarettes in their lifetime can only be ordered during the exam. To fully reap the benefit of this exam, physicians and patients need to be vigilant and physicians and their staffs need to know how to bill for the exam. To that end, the Practice Management Center (PMC) has dedicated part of their website to assisting internists perform and receive payment for the exam. Below is some of what is available on the site.

### How to Bill for the 'Welcome to Medicare' Visit

Since its introduction in 2005, the Welcome to Medicare visit has continued to confuse physicians with its requirements and limitations. Medicare will cover one initial preventive exam within the first six months of the effective date of a beneficiary's Part B coverage. The Welcome to Medicare visit is likely different from any other service that a physician would typically perform, so it is important to review the requirements for the service, which are:

- **Comprehensive medical and social history review.** This review should pay particular attention to modifiable disease risk factors. At a minimum, the medical history must include:
  - o Past medical and surgical history, including illnesses, hospital stays, operations, allergies, injuries and treatments.
  - o Current medications and supplements, including calcium and vitamins.
  - o Family history, with a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.
  - o Social history, defined by CMS to minimally include a history of alcohol, tobacco and illicit drug use; diet; and social and physical activities.
- **Limited Physical exam.** This must include measuring the patient's height, weight and blood pressure, as well as a visual acuity screen and other factors based on the patient's medical and social history.

- **Potential risk for depression review.** This review must include a patient's past experience with depression or other mood disorders, based on the use of an appropriate screening instrument, for patients without a current diagnosis.
- **Functional ability and level of safety assessment.** This should be based on the use of an appropriate screening instrument.
- **Electrocardiogram (ECG).** The exam covers performance and interpretation of an ECG.
- **Education, counseling and referral.** The exam also covers education, counseling and referral-including a written plan, such as a checklist-to help patients get appropriate screening and other preventive services covered separately under Medicare Part B. These include, but are not limited to:
  - o pneumococcal, influenza and hepatitis B vaccines and their administration;
  - o screening mammography;
  - o screening Pap smear and pelvic exams;
  - o prostate and colorectal cancer screening;
  - o diabetes outpatient self-management training services;
  - o glaucoma screening;
  - o bone mass measurements;
  - o medical nutrition therapy services;
  - o cardiovascular screening blood tests; and
  - o diabetes screening tests.

The exam is billed using CMS-specific G codes. A physician will always bill G0344 for the exam itself and an additional code for the component of the ECG completed by the physician. CMS recognizes that not all physicians can perform an ECG in their office. Physicians can make alternative arrangements to make sure an ECG is performed, then include ECG results in the patient's record to complete-and bill for-the initial preventive exam.

The following are the HCPCS codes to be used:

- G0344: Initial, face-to-face visit service limited to new beneficiary during the first six months of Medicare enrollment; payment is equal to 99203.
- G0366: Electrocardiogram, routine ECG with at least 12 leads with interpretation and report, performed as a component of the initial exam; payment is equal to 93000. (You must report G0344 and G0366 if you furnish the complete initial exam.)

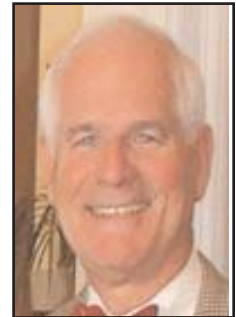
- G0367: Tracing only, without interpretation and report, performed as an initial exam component, payment is equal to 93005.
- G0368: Interpretation and report only, performed as an initial exam component, payment is equal to 93010.

For further details, go to

[http://www.acponline.org/college/misc/cms\\_ippe.htm](http://www.acponline.org/college/misc/cms_ippe.htm)

## Why Should I Be a Member of the ACP?

**-John DuBose MD, FACP  
Chairman, Membership Committee**



In today's economic environment, everyone is watching where s/he sends his/her dollars. Sometimes, that which one needs the most gets cut first due to looking at the amount without realizing the benefit. The ACP should not be one that is so cut. With all of the benefits the ACP has to offer, it is an expense for which one receives far more than one gives.

As the collective voice for internal medicine and its subspecialties, the ACP strives to enhance the professional development and quality of life for its members. The following outlines just some of what is available to ACP members.

### Patient Care and Professionalism

*The Physicians' Information and Education Resource (PIER®).* This top-ranked clinical tool contains over 445 disease modules, an extensive drug database, and is **FREE** to ACP members. *Patient Education Resources:* ACP offers a variety of **FREE** hand-outs for patients including HEALTH TiPS pads in English and Spanish provided by the ACP Foundation. *Clinical Practice Guidelines:* Remain on the forefront of Medicine with evidence-based ACP Guidelines covering almost every facet of medicine.

### Publications

*Annals of Internal Medicine and Annals.org:* ACP's flagship publication delivers major review articles, original research, topical clinical reviews, thought-provoking editorials and a spirited exchange of medical opinion twice a month. Its evocative commentary and unique perspective on medicine and humanities make it the most widely cited medical specialty journal in the world. The electronic version of Annals carries the full text of every article in every

issue and additional Web-only features. Members can also earn up to 20 **FREE** CME credits/ year by taking quizzes available on the Annals site, thus fulfilling SC Licensing board requirements of 40hrs/2 years. ACP Journal Club: Editors survey more than 100 leading medical journals to provide concise abstracts of the major findings and latest clinical research. A **FREE** member publication, it includes star ratings of each article's clinical impact, relevance to pertinent disciplines and newsworthiness.

**ACP Hospitalist** is distributed monthly to ACP member physicians who specialize in in-patient internal medicine care, providing articles of interest to hospitalists and traditionalists and information on related physician products and services, continuing medical education, and career opportunities.

## Medical Education

**Chapter Scientific Meetings**, organized by local chapters with help from College headquarters, provide a forum for updating clinical knowledge and skills and discussing issues related to internal medicine, in addition to offering Associates the opportunity to present clinical papers. At least 13 credits are available to SC Annual Scientific Meeting attendees in 2007.

**MKSAP® 14 New Edition!** Significant discounts are available to members to purchase this gold standard of self-assessment programs. Currently in print, CD-ROM, and online formats, it provides up-to-date theoretical and practical information in major areas of internal medicine and aids in preparation for initial and maintenance of certification.

**Prep for Boards 2**, an enhancement to MKSAP available in print and CD-ROM formats, is designed for those preparing for the ABIM certification and maintenance of certification exams.

**Maintenance of Certification Assistance.** ACP members have access to **FREE** resources to assist in answering SEP (Self-Evaluation Process) questions obtained from the ABIM. Topics include five General Internal Medicine modules, a Women's Health module, a Clinical Skills module, and two modules detailing recent advances in Internal Medicine. All include supporting content from MKSAP, PIER, ACP books and Annals of Internal Medicine, and have been indexed according to the module and question number.

Future newsletters will list additional membership benefits but to access the full list immediately go to: <http://www.acponline.org/college/membership/benefits.htm?hp>.



## Associates Update

**Mary Beth Poston MD, MSCR, FACP**  
**Chairwoman, Associates Program Committee**

Don't miss the Associates Abstract Competition at the upcoming SC ACP Scientific Session in October! Forty-seven clinical vignette and research abstracts were submitted for this year's competition, representing students and residents from MUSC, USC-SOM/Palmetto Richland, and the Greenville Hospital System. Please plan to arrive at the meeting in Charleston in time to hear the oral presentations and view the poster session. The Associates' and Students' Abstract Competition is scheduled for Friday, October 12, 2007 from 8am-12noon.

The South Carolina Associates Council continues to

carry the message of ACP to trainees across the state and beyond. All Associates Council members are now members of the Associate Leadership Network (ALN), created to foster on-going communication between Associates nationwide. ALN members will receive quarterly newsletters from the National Council of Associates regarding current hot topics. Issues previously highlighted in ALN newsletters include public policy changes and residency redesign.



## **New Opportunity to Present; Practice Assistance**

**Shakaib Rehman, MD, FACP**  
**Chairman, Council of Young Physicians**

The ACP will host the "Young Physicians Poster Showcase" at Internal Medicine 2008 (formerly called annual session). This opportunity, introduced and sponsored by the Council of Young Physicians (CYP), provides young internists (full members within 16 years of medical school graduation and not Associate or medical student members) a venue to present scholarly works at the national level. Only QI/Patient Safety Posters will be accepted for presentation in 2008, with submissions due

Wednesday, January 5, 2008.

To assist in your daily practice, the CYP provides ACP members with the 2007 edition of the Pocket Guide to Preventive Services for Adults. This free booklet, a great resource for our members, is available for downloading or ordering for free from the ACP website.

### **NEW DISTRIBUTION OF NEWSLETTERS**

**A new method of distributing the Governor's newsletters began on July 1, 2007. Chapter members with good e-mail addresses will receive an e-mail with a link directing them to the current newsletter on the chapter website. These members will receive the chapter news in a timely manner, while it is still fresh. Members with no/bad e-mail addresses will be sent a hard copy by postal mail.**