PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

SPRING 2015 | VOL 25 | NO. 2

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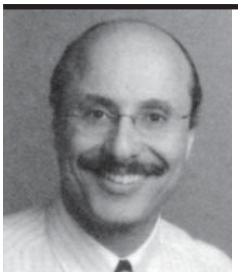


President's Message
The State of the Counties

by Tarek Naguib, M.D., MBA, FACP

We all strive towards a healthier citizen who enjoys life and family and who participates in making the community more prosperous. While this goal lies at the heart of PRCMS interests, it requires excellence in healthcare delivery that, in turn, requires a comprehensive approach that involves educating patients and professionals, ensuring viable means of care delivery, supporting public health measures, and upholding ethics.

Towards this goal, the society uses its publication, *Panhandle Health,* to enhance the education of both the public and the professional. Our journal, which highlights the history of medicine in the Panhandle and at large, publishes medical, social, health news, and patient education topics that expand the horizon of both the public and healthcare professionals. *Panhandle Health* has become a great asset to our community and is arguably the most comprehensive county medical society journal in the state of Texas.

The Board of Directors of PRCMS includes practicing, retired, and resident physicians, as it is our belief that our board's efforts cannot succeed in isolation from our meaningful past and promising future. PRCMS sponsors meetings that bring together area physicians, provide continuing medical education (CME) in ethics, and bring updates on regulatory changes that may affect healthcare delivery. The society also endeavors to support physicians through its committees on mediation and physician health.

As a part of the Texas Medical Association (TMA), PRCMS also provides opportunity for our physicians to have leadership training and meaningful roles while participating in shaping healthcare delivery. Our delegates to TMA participate in the American Medical Association's (AMA) national role in shaping healthcare delivery, a process that is admittedly complex but is democratically represented. Of note, TMA is the largest state medical society represented in AMA House of Delegates.

As the public health of our community has always been at the heart of our interests, the nearly 400 member strong society is fully supportive of the continuous efforts of the Amarillo Bi-City-County Health Department to fight communicable disease in both Amarillo and Canyon. The initial data available from the department for 2014 reflect consistent decline of sexually transmitted diseases reported in the counties for HIV, AIDS, syphilis, chlamydia and gonorrhea and a decline for both campylobacter and salmonella enteric infections.

I would be remiss not to highlight the recent birth of Amarillo Legacy ACO (ALMA) (an Accountable Care Organization) that is a partnership between several area private independent medical practices, including those in Canyon, Texas, to provide efficient and cost effective fee-for-service care to Medicare patients. As the only ACO in the Texas Panhandle, ALMA boasts a single health information system and nearly $4.9 million Medicare cost saving for 2014 while meeting strict quality measures.

Meanwhile, on the state level, we continue to have the highest rate of the uninsured in the nation, with over six million Texans (including one million children) lacking health insurance and nearly $80 billion of federal funding, over 10 years, on the table to be used for Medicaid expansion. Contrary to earlier reports, Governor Abbott, in his speech to the 84th Legislature, appears be against a deal with the Feds to improve Medicaid by utilizing these available funds. His reasoning was that "Medicaid is broken and is on a path to bankruptcy".

In this issue, the goal of the society remains to improve both access and delivery of medical care while keeping the viability of physicians' practices both intact and solvent. Proposals like Medicaid-to-Medicare pay parity (increase Medicaid pay to equal Medicare pay for select services) and reinstating the state's payment to physicians of the copay for the dual eligible poor (patients who are eligible for both Medicare and Medicaid but cannot afford the 20% copay) are examples of improvements that are needed. Our delegates to TMA share in formulating the association's position on these issues and more.

On the national level, we monitor with interest the expected ruling of the US Supreme Court (SCOTUS) on the appropriateness of the subsidies already provided to millions of enrollees (nearly one million Texans) who took part in the federal health insurance products under the Affordable Care Act (ACA). If ruled against, this case (King vs Burwell) may bring about major changes to the ACA and our nation's health insurance system, as it may send health insurance premiums to a new high while the Congress decides on whether the government should collect refunds from these enrollees.

Our counties' diverse population has kept us close to international events. Although the US is pulling troops from West Africa after near control of the Ebola epidemic that worried our Amarillo community, there is a senate bill that proposes more powers for the government during infectious disease emergencies. Of note, the epidemic has served as a wakeup call to overhaul our epidemiologic response, including isolation techniques.

In closing, I would like to reaffirm that the physicians of the 112th Board of Directors of PRCMS remain committed to the outlined goals and will strive, individually and through the medical society's representation, to improve the health and prosperity of the citizens of our counties.

Alliance News

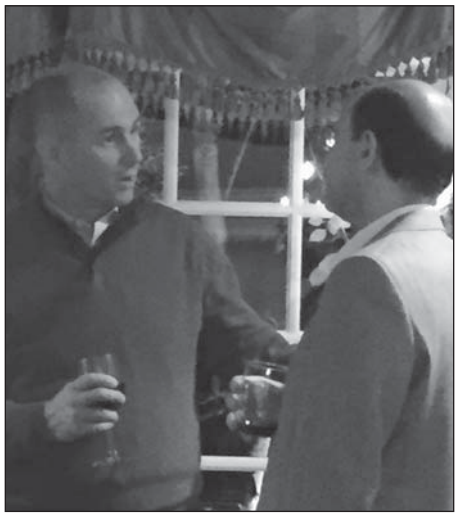
by KiKi Brabham, President

The Potter-Randall County Medical Alliance is gearing up for the new year. We are in full-planning mode at the moment. Stay tuned as we are finalizing information for the Women's Spring Social. This is always a favorite event of ours. We look forward to celebrating our local physicians again, as well, on the upcoming Doctor's Day, March 30. Thank you, local physicians, for all the many ways you serve our community and the people in it.

As the Potter-Randall County Medical Society is amidst their dues collecting, so are we. We look forward to another great year of fun, togetherness, growth, and fellowship. Please don't assume your spouse renewed your membership, as we found out last year that the line for spouse membership was near obscured on the dues page. Our directory from 2014-2015 is in process. It was delayed a bit, but will be coming soon.

We had a great turnout for the Holiday party at Michael and Heather Manderson's residence. This was a such a lovely event with great hosts. We had many "new" physicians and their spouses attend, and it was great to welcome them into to the community. Several pictures from the night are shown here. Thanks again to the Mandersons for hosting this fun night.

Please continue your support for the Medical Alliance. We are always open to new ideas, venues and new faces. Thanks to all of you who helped make 2014 a great year for the PRCMA.



Executive Director's Message

by Cindy Barnard, Executive Director

This issue of *Panhandle Health* deals with "Turning 65". As we all know, age 65 is not quite as special as it used to be as mandatory retirement has virtually vanished. Even Social Security has gradually changed its Full Retirement Age to 67, and most 65 year olds now live full and active lifestyles. But age 65 matters in many significant ways, since most people become Medicare eligible. There are several important steps to be taken when the symbolic milestone of 65 is reached (and even better, before). First, find out whether you need to sign up for Medicare and review your Medicare Part D options for prescription drug coverage. Then, make sure you have a doctor/doctors who accepts Medicare/Medicaid, and if not, find one who does. Meet with a financial planner to ensure you are using your nest egg wisely to meet future income needs. Make sure you have a will, and if so, that if it is up to date and that your family knows your wishes, including end of life issues (DNR, Medical Power of Attorney, hospice care, etc.) These are just a few of the subjects discussed in this issue that we hope you will find pertinent and interesting. If you, too, are a boomer, be responsible! As Carolyn Rosenblatt said in *Forbes* in a 2013 issue, "I think about how we, as a generation, are changing the concept of aging. I love it…We understand that we must savor the moment. We can have a wonderful time appreciating what we are and all we have. Let the beauty of this time of life shine on."

The 112th Annual Meeting of Potter Randall County Medical Society was held January 8th at Amarillo National Bank's Skyroom. The gold-headed cane was passed from Dr. Jay Reid, 2014 President, to Dr. Tarek Naguib, 2015 President. Officers for 2015 were installed by Dr. Austin King, President of Texas Medical Association. New officers include President, Dr. Tarek Naguib, President-Elect, Dr. Ed Dodson, and Secretary-Treasurer, Dr. Rouzbeh Kordestani. I want to thank Amarillo National Bank for their continuing and unfailing generosity and hospitality. The dinner was exceptionally delicious and well-attended!

Presidential appointments to Boards and Committees of PRCMS are now ongoing. If you have an interest in serving on a committee, please call the Society office at 355-6854. The core of the Society is its volunteers the physicians who volunteer for committees and board positions, working on behalf of their colleagues. We truly need you!

If you would like to update your picture for our 2015-2016 Physician Roster, or if you do not have a picture in last year's Roster, please call 373-1523 to make an appointment for your portrait at Gray's Studio. There is a $15 sitting fee that PRCMS will pay, and this also includes a free session for a family portrait, if desired. Gray's is located at 3317 6th Street and is open from 9-5, Monday-Friday, and 9-12 on Saturday. We would like to have 100% of our doctors' photos in our upcoming Roster.

Get ready for "First Tuesday" at the Capitol. Pack your white coat, and travel to Austin on March 3, April 7, or May 5 to participate in TMA's First Tuesdays. Please don't miss the chance to meet with legislators and their staffs to make sure the voice of medicine is heard. Remember, YOU, our physicians, are the best lobbyists for our patients. You will visit with your Senator, Representatives, and

their aides about key issues facing your profession, attend committee hearings and House and Senate sessions, and learn about the obstacles medicine faces: taxes, Medicaid, CHIPS, physician ownership, and scope of practice. Physicians are asked to wear white coats while at the Capitol. Legislative talking points and other materials will be provided. A course on lobbying will be conducted early on each First Tuesday. A $25 charge for each First Tuesday covers your breakfast, lunch, and all materials. For more information, visit www.texpac.org.

On March 30, we will celebrate Doctors Day, which was first observed in Winder, Georgia in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors Day. In 1958, a resolution commemorating Doctors Day was adopted by the U.S. House of Representatives, and legislation was introduced both in the House and Senate to establish a national Doctors Day in 1990. President George Bush signed S.J. RES #336 (which became Public Law 101-473) in 1991, forever designating March 30 as National Doctors Day. President Bush wrote in the Proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States indeed, throughout the world. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities."

And finally, this Edition's cover is by local artist, Marsh Clements, entitled *Dark Red Iris*. She graduated from West Texas State University and began her career as a public school teacher. At the same time, she began painting with Lou Hansen of Amarillo, who taught her the fundamentals of oil painting. As Executive Director of Amarillo Art Institute for two years, she had the opportunity to join the artists' community at Sunset Center. She says, "This community has the potential to put Amarillo and the Texas Panhandle on the map as a hub for the visual artists in this region… I paint because I love to paint, and I love to learn. Painting is giving me a new opportunity to develop a business and a career as an artist."

Our Next Issue Of

Panhandle Health

Features:

Medicine and Information Technology

Editor's Message
As I Lay Aging...

by Rouzbeh Kordestani, M.D., M.P.H.

For the Medicare Patients,

I have to often remind myself often that I am not young anymore. It seems that the years passed by quickly. What I realize now is that my mother and father are also no longer young. In fact, when I speak about Medicare patients, I am very much reminded that I am speaking about my father and my mother.

In this same mindset, the intent of this issue of *Panhandle Health* is to bring forth points that apply directly to the newly minted Medicare patient. It's true that when you turn 65, you have Medicare. But what does that exactly mean? In the confusing world of insurance, having Medicare seems simple. Unfortunately, it is not. The changes that have occurred over the last 2 years have dramatically affected medicine and will continue to do so for the foreseeable future. In this issue, our task and effort is not to change anything. It is merely an attempt by the editors to guide a new Medicare patient to start thinking of steps that he or she needs to take as he ventures into medicine, the new health care system, and turns 65 and older.

As patients become Medicare eligible, they need to know that they can first undergo a new Wellness Examination. Who gives me that? (We will explain in serial fashion in the articles listed and compiled.) They have to carefully look at their physicians. Does their regular doctor(s) take Medicare patients? If not, can they recommend a new doctor that is affable and caring and who does take Medicare? Are my finances in order? Do I have enough money to make it through these next few years and retirement? If not, do I need to get a financial planner? Do I need a will? (Yes you do – always!) Who can help me with that? What if I get sick – do the kids know what to do? Can I take care of myself? If I get sick, can the kids take care of me? If not, what can I do? Do I need to go to an assisted living situation? What is an assisted living situation? Are nursing homes really that bad? What if I get really sick, what then? Who has my power of attorney? Do the kids know what I/we want? If I die, do the kids have the money to take care of our affairs? Do they know where everything is? What if I am really sick, am I going to suffer?

Newly Medicare eligible patients have to remember that they have to discuss all of these issues, including those of life and death, with their children. They need to let their family know what their wishes are. These questions may be difficult to discuss. But they have to be discussed; or, God forbid, they will be discussed in the Emergency Room when no one wants to discuss them. It will always be better for patients and families to discuss these issues on their own and to come up with better conclusions than those forced in a pressured or critical type of situation.

In my few years in medicine, I have seen a dramatic series of changes. Many of these are not good changes. One of these changes is that the Marcus Welbys of medicine are, for the most part, gone. Now, physicians are too busy to take enough time for their patients to really see what makes them click. In that way, too little time is spent with each patient. (Please do not misunderstand – this is not a critique of any physician in particular but a generalization of the system in which we all now live.) Medicare patients feel that their needs are not really met. Their medical needs are met on

paper. Their labs are done. Their tests are done. But their health is slowly fading. They feel that they are another number or another patient simply being run through the system. Too often, their days become a long series of doctor visits and tests and labs. They go from office to office, from test to test. They literally feel as if they are fading away. Their lives get suspended, as if getting old meant that they were going to fall apart and modern medicine is going to stop that.

No one can stop aging. No one can stop anyone from going through the natural process of life that eventually ends in death. Medicine is supposed to treat disease. **Old age is not a disease**. For this reason, when patients become Medicare patients, they have to actively pursue knowledge. They have to actively pursue their ability to control their own health care. They and their families must see medicine and its different specialties as a way to make life and living more comfortable. Medicine is not supposed to simply make life longer, it is supposed to improve the quality of life. If it can do that, medicine has achieved what it was supposed to do.

Atul Gawande MD recently wrote a book and I respectfully borrow this section from his book, Being Mortal (2014). "People with serious illness have priorities besides simply prolonging their lives. As people become aware of the finitude of their life, they do not ask for much. They do not seek more riches. They do not seek more power….They have priorities beyond merely being safe and living longer…They ask only to be permitted, insofar as possible, to keep sharing the story of their life in the world-to make choices and sustain connections to others according to their own priorities. Surveys find that their top concerns include avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete. Our system of technological medical care has utterly failed to meet these needs, and the cost of this failure is measured in far more than dollars. The question therefore is not how we can afford this system's expense. It is how we can build a health care system that will actually help people achieve what's most important to them at the end of their lives."

The Medicare Handbook, as we have taken to calling this edition, is our attempt to pay our respect to all Medicare patients. It is our way of trying to remind these patients of many of the important issues that get left behind or are never discussed. Every Medicare patient must remember that — your health is important; your tests are important; but our true job as physicians and health care providers is to be your companion and your friends on your life journey, from birth to death.

Subject:
Letter to the Editor of
"Panhandle Health" Magazine

I was fortunate to have been given a copy of your 2014 Winter Issue of the *Panhandle Health* Magazine.

I want to commend you for a wonderful issue. When I started reading all the stories about Medical Missions I could not lay the magazine down before I read each and every one.

Being friends with Drs. Bechtol, Hampsten, and Keister made their stories really special.

A big thanks to all the Doctors who have given their time and talents to the various projects out of country, and to Dr. Keister for the Heal the City Clinic in Amarillo.

It makes me really appreciate having such a fine Medical Community in the Amarillo area.

Jay Sims
River Falls Addition
Amarillo

If you have a letter for the Editor,
please email to: prcms@suddenlinkmail.com
or mail it to:
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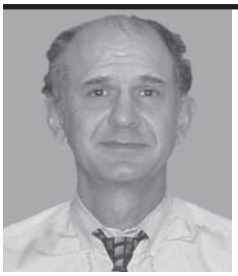

Medicare Pitfalls

by Steve Urban, M.D.

In 1965, Lyndon Baines Johnson signed into law the Social Security Act, title XVIII of which established the first effective US government sponsored health care program–Medicare. It has been modified several times since then in 1972 to cover physical, speech and chiropractic therapy, in 1982 to cover hospice benefits, in 2003 to cover some prescription drug costs; it continues to worry health care economists because of ever-rising costs. But, overall, Medicare has proved an enduring and essential program. Unfortunately, it is almost as complex to understand as it is cumbersome to administer. If you (like me) are approaching 65 years of age, you have a lot of learning to do! In this edition of *Panhandle Health*, I hope to help you recognize some of the pitfalls of getting started in Medicare.

Medicare Part A pitfalls.

Medicare Part A pays for acute hospital care, post-hospital skilled nursing care, acute rehabilitation, home health care and hospice benefits for patients above 65. It also provides coverage to patients who have been disabled for more than 2 years, and to patients with end-stage kidney disease or amyotrophic lateral sclerosis, even if they are under age 65. It's what you've been waiting for all these years, right? You've been envious of those severely disabled patients for their "entitlements" and now, just for surviving 65 years, you have your VERY OWN entitlement! But slow down, pardner; there are pitfalls even in Medicare Part A.

First of all, you have to pay in to Medicare for 10 years (officially, 40 quarters) to get this "free" benefit. You can also get it by being married to someone who qualifies, but only as long as you are 65 yourself (nice try, Anna Nicole Smith). If you don't qualify, you have to buy into Part A just like a regular insurance program. Secondly, Medicare doesn't cover certain potentially costly services dental care, routine vision and hearing care, and most importantly long term (nursing home) care.

In addition, you have to make co-pays when you are admitted to the hospital. This doesn't amount to a lot at first just a single payment of $1216 takes care of the first 60 days but if you're in acute care (either hospital, Long Term Acute Care, or Acute Rehabilitation) for more that 60 days, you have to start paying $315 a day. So let's say you are in a terrible car accident, get paralyzed, are slow to wean off the ventilator and stay in acute care for 90 days; your Part A bill could be $9,450 and this doesn't include all the doctor bills or your prosthesis.

After 90 days in acute care, let's say you finally get strong enough to go to a Skilled Nursing Facility. After 20 days, you are hit with another co-pays this time $152 dollars a day. Seventy days of this adds up to $10,640. And then, guess what! After 90 skilled nursing days, you run out of Part A completely.

Fortunately, you remember that you have 60 lifetime reserve days, but again there's a catch. The co-pay goes up to $630 a day (a possible total of $37,800) and you use up all your lifetime reserve days in the process. Now you are responsible for 100% of your charges at least for another 60 days, when your 90 day clock starts over (see, I told you it was complicated!) An unlikely scenario, admittedly, but we're up to almost $60,000 by now, and that's just for Part A. In real life we will occasionally see patients with severe traumatic injuries, recurrent infections (e.g. diabetic infections) or patients with end stage renal disease and numerous complicated admissions who exceed their Part A days.

Maybe things don't work out so well in rehab, and you get a terminal disease and qualify for hospice care (estimated life expectancy <6 months). Then Part A pays 100% of hospice benefits; you have no co-pays except for respite care (to give your family a break) and certain outpatient medications. From your standpoint, though, your level of coverage improves and you breathe a sigh of relief; then you remember that you ARE in hospice.

Medicare Part B pitfalls.

Medicare Part B pays helps out with doctor bills, day surgery procedures, certain outpatient medications (like cancer chemotherapy) and durable medical equipment (such as home oxygen, prostheses, wheelchairs, etc). But Part B isn't something you paid for with your FICA tax; it's more like a discounted medical insurance policy. You have to pay a monthly premium (starting at $105/month, but going up to as high as $335/month if you're rich), you have deductibles (now about $147/year), and it only pays 80% of approved charges. Plus, the charges have to be medically necessary, and you or your doctor may disagree with Medicare about what is medically necessary and what is not.

In addition, you have to be sure that your doctor/therapist/home health care agency is a "participating" provider. Most subspecialists are participating providers, but many primary care physicians are limiting their Medicare practice and some are opting out of participation entirely. If your physician is a participating pro-

vider, he or she has agreed to "take Medicare assignment" (i.e. to accept what Medicare pays and only bill you for the remaining 20%), but again not all providers participate in Medicare. It is estimated that Medicare Part B pays only 40-80% of the average patient's medical bills. This is why most seniors carry a "Medigap" policy policy to cover those fees and charges that Medicare doesn't pay.

Let's say you are a healthy old guy, and you think you'll just wait until you get some expensive disease, and THEN you'll apply to Part B and start paying the premiums. Guess what; they've thought about that too! If you don't sign up with Part B when you are first eligible, you're premium will go up 10% for every year that you skipped. So, unless you are covered by a qualified employer or unless you sign up for Part C (see below), it is usually a big mistake to opt out of Part B when you are 65.

There are a few more armadillos to dodge in the Part B highway. Whereas Medicare Part A pays for hospital admissions, Part B covers charges for patients in observation status. Physicians are under increasing pressure to place patients in observation and to get them out of the hospital before two midnights have passed; patients need to understand that they will face the deductibles and co-pays associated with part B, not the one-time co-pay of Part A. Another aspect of part B that our social workers face on a weekly basis relates to veterans who receive care in private hospitals, either through personal choice or because the VA does not offer the services that they need. These veterans have often opted out of Medicare part B (and part D) because they expected professional and pharmacy services to be provided through the VA system. The veteran often experiences "sticker shock" when he gets thousand-dollar bills for physician, outpatient therapy, chemotherapy, or other charges that would normally come under Part B.

Medicare Part C pitfalls

Since Medicare Part B can leave you open to a lot of additional medical expenses, some seniors sign up for a Medicare Part C plan. These are the so-called Medicare Advantage Plans; they are like being in a Medicare-subsidized HMO. The benefits are defined by Medicare, but the plan is administered by a for-profit company (like Aetna, Firstcare, United Healthcare, etc). Your out-of-pocket expenses are limited, premiums are usually fairly small, and some plans even cover expenses (such as vision or dental care) that are not covered by traditional Medicare. So, what's not to like?

Well, remember that your Part C plan is being administered by a for-profit company that is trying to SQUEEZE EVERY DOLLAR OUT OF THE SYSTEM! (many national health systems have cut out the for-profit middleman completely, but we here in the United States haven't figured that

| *continued on page 14*

out yet.) So, you really have to read the fine print in these policies to see what is covered and what isn't. One of the major headaches that our social workers confront almost every day is dealing with Medicare Advantage plans that won't approve rehabilitation care after a stroke, or necessary antibiotics after a severe infection, or skilled nursing care to get a patient back on their feet after a critical illness.

Another pitfall facing patients interested in a Medicare Advantage plan is finding a primary care provider (PCP) willing to face the administrative headaches that these tightly-managed plans entail. Part C patients MUST designate a PCP. In preparation for this paper, I went to the Medicare website to find a participating PCP in our area, and almost half of the PCPs were retired or had moved away. A few were dead, probably an "advantage" to a plan that wants to limit expensive tests, but perhaps not conducive to your good health. So, finding a willing Part C provider in an underserved area like the Texas Panhandle can be a real challenge.

Medicare Part D pitfalls.

Medicare part D is available for anyone already signed up for Part A or B who desires prescription drug coverage. You don't have to sign up, but (as with Part B) if you wait until after your first enrollment period, the premiums shoot up. Also, like Part B, you have to pay a monthly premium (which also increases as your income level goes up), and like Part C, it is administered by a multitude of for-profit companies, so coverage can vary greatly. You may think you don't need coverage for expensive rheumatoid arthritis or cancer chemotherapeutic drugs NOW, but what will you do with a bargain-basement plan if you come down with one of these expensive ailments?

Another pitfall of Medicare Part D is the famous donut hole: a gap (currently between $2,940 and $4,750) where you are responsible for 100% of your prescription drug costs. Yes, the donut hole is still there, although slated to dwindle away by 2020. Fortunately, it is estimated that only 5-10% of seniors are affected by the donut hole and many of them are taking WAY TOO MANY medications.

Wow. That's a lot of pitfalls. To read this, you might think I'm a disenchanted, entitlement-hating Rand Paul libertarian, rather than the optimistic, Great Society-loving liberal that I really am. I think that Medicare is one of the great social programs in US history and that LBJ (despite his manifest sins of character and disposition) is somewhere up there in public policy heaven. But you just have to be aware of the pitfalls of this complicated program in order to negotiate your way around them. And finally, remember, if you can just get to hospice, you've got it made.

I would like to thank Sara Hightower and Nancy Boyce from Northwest Texas Hospital for their input into this article. The useful information is mostly theirs; I myself am responsible for the attempted witticisms and the disreputable politics.

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

Submission process Material should be e-mailed to the editor at prcms@suddenlinkmail.com or mail a hard copy to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106. A recent photograph of the author (optional) and a curriculum vitae or a biographical summary are also to be submitted.

Conflict of Interest Authors must disclose any conflict of interest that may exist in relation to their submissions.

Journal Articles Manuscripts should be double-spaced with ample margins. Text should be narrative with complete sentences and logical subheadings. The word count accepted is generally 1200 to 1500 words. Review articles and original contributions should be accompanied by an abstract of no more than 150 words.

References References to scientific publications should be listed in numerical order at the end of the article with reference numbers placed in parentheses at appropriate points in text. The minimum acceptable data include:

Journals: Authors, article title, journal, year volume, issue number, inclusive pages.

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The Medicare Annual Wellness Visit: A Focus on Preventative Health Services

by Les Covington, Pharm.D.

One of the many provisions of the Patient Protection and Affordable Care Act is a focus on preventive medicine and health risk assessment to control healthcare expenditures by early detection and prevention of disease. In response to the new act in 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the Annual Wellness Visit (AWV) to provide Medicare beneficiaries with annual health risk assessment and a personalized prevention plan. The service is offered to patients through two separate but similar encounters: yearly AWVs and a one-time only Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare" visit.

Welcome to Medicare Visit

The "Welcome to Medicare Visit" or IPPE is only available to new beneficiaries within the first 12 months of Medicare Part B coverage and must be conducted by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist). It is outlined by seven required components that are intended to identify risk factors and detect early disease. These components include reviewing medical and social history, assessing risk factors for depression or mood disorders, evaluating functional ability, conducting an exam, discussing end-of-life planning, and providing education, counseling, and/or referral for preventive services. Medicare provides some guidance regarding minimum documentation for each component (Table 1). Covered but not required components of the IPPE are a screening electrocardiogram and ultrasound screening for abdominal aortic aneurysms. These services are covered as one-time-only screenings and must be conducted in concordance with or as a referral from the IPPE visit.[1]

Annual Wellness Visit

In contrast to the IPPE, the AWV is provided to all beneficiaries who are no longer within the first year of Medicare Part B coverage and have not received an IPPE within the past 12 months. Unlike the IPPE, an AWV may be provided by other licensed medical professionals including but not limited to various levels of nursing, pharmacists, and health educators under the supervision of a physician. The visit is provided at no cost to beneficiaries (co-payment and deductible do not apply) and is aimed at identifying and updating preventive services as recommended by the United States Preventive Services Task Force (USPSTF).[2]

Similar to the IPPE, Medicare requires several components to be updated and documented during each AWV. The first component is the health risk assessment which requires the practitioner to address at minimum the patient's demographic data, self-assessment of health status, psychosocial risks, behavioral risks, activities of daily living, and instrumental activities of daily living. Medical, family, social and surgical history must be collected along with documentation of all medications and the beneficiary.[3-5]

Several assessments are included in the visit. With the exception of vital signs, CMS does not require specific assessment tools but rather leaves

| *continued on page 16*

Table 1

Minimum Documentation for Components of the Initial Preventive Physical Examination	
Medical and social history	Past medical and surgical history, current medications and supplements, family history, history of alcohol and drug abuse, diet, and exercise
Risk factors for depression	Any appropriate screening recognized by a professional medical organization
Functional ability	Any appropriate screenings that assess at minimum hearing impairment, activities of daily living, fall risk, and home safety
Examination	Blood pressure, height, weight, visual acuity, BMI, and other factors appropriate for medical and social history
End-of-life planning	Verbal or written information provided to beneficiary regarding advance directives
Education, counseling, referral based on health risk assessment	Evaluate risk factors and document education, counseling or referral
Education, counseling, referral for preventive services	Evaluate and document referral for preventive services. Provide beneficiary with follow-up plan.

it to the discretion of the provider to choose recognized, appropriate instruments. Beneficiaries should be assessed for depression or other mood disorders, cognitive impairment, hearing impairment, and fall risk. Some quick and easy-to-use assessment tools include the Geriatric Depression Scale, Mini-Cog, Hearing Handicap Inventory for the Elderly, and the Timed Up and Go Test.

The real "heart and soul" of the AWV is the establishment of risk factors for disease and a written screening schedule for the beneficiary. These screenings and preventive services are typically grade A and B recommendations from the USPSTF and are covered by Medicare at no cost to the beneficiary. For the most part, Medicare coverage guidelines follow the recommendations and screening frequency set by the USPSTF but, in a few instances (i.e. PSA for prostate cancer screening), covered services follow professional health society guidelines. Table 2 lists those preventive services covered by Medicare at no cost to the beneficiary.[6]

The final component of the AWV is documentation of a screening schedule for the next 5 to 10 years. The schedule must be provided to the beneficiary and should include current screening history, recommended preventive services with referral information, and timeframe for follow-up screenings.

Subsequent AWVs can occur at a minimum interval of 12 months. In these visits, the same components are required to be addressed with the exception of depression and mood disorders; it is not required to screen for depression outside of the first AWV.

Texas Tech Department of Family Medicine has been conducting Medicare AWVs through physician-pharmacist collaboration since mid 2011. Hundreds of patients have been screened and referred for preventive services helping to improve the quality of healthcare for older adults in the Texas Panhandle. Overall, patients have reported positive experiences and perceive the visit as beneficial to their care.

For more information regarding AWV billing requirements, diagnosis codes, and screening criteria, please visit the CMS website and references provided with this article.

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Table 2

Medicare Covered Preventive Services

Abdominal aortic aneurysm screening	HIV screening
Alcohol misuse screening and counseling	Influenza, pneumococcal, and Hepatitis B vaccines
Bone mass measurement	Intensive behavioral therapy for cardiovascular disease
Breast cancer screening	Intensive behavioral therapy for obesity
Cervical cancer screening	Lipid panel for cardiovascular screening
Colorectal cancer screening	Medical nutrition therapy
Depression screening	Prostate cancer screening
Diabetes screening	Sexually transmitted infections screening and counseling
Diabetes self-management training*	Tobacco cessation counseling
Glaucoma screening*	

*Deductible and copayment applies

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Six Questions to Ask Older Parents

by Richard McElreath, Spring Capital Management, LLC

Regardless of whether you and your parents have always talked freely about money or never discuss the subject, there are several considerations you may want to address with them as they approach their later years. The six questions below can help you to start thinking about and planning for that conversation.

1. What's the best way to introduce the topic of your parents' financial needs and goals? When you do decide it's time to "have the talk," tactfully make clear what you would like to discuss, but also let your parents know you respect their privacy.

2. Are you confident that they are staying on top of their finances? Are bills getting paid on time? Are investments being monitored? Maybe you have already spoken with your parents about these money matters, but not in a long while. If you think they might appreciate a follow-up, it may be a good idea to check in again.

3. Are they taking advantage of direct deposit, online bill paying, etc., to help simplify their financial life? If your parents aren't comfortable with technology and/or using a computer, offer to help or ask another trusted family member to chip in.

4. Do your parents have an estate plan, and is it up to date? I believe any good attorney would, at a minimum, recommend that your parents have a will. If they don't, then the court system could step in and distribute their assets as it sees fit. In addition to having an up-to-date will, there are other planning considerations, such as shielding assets from estate tax. The federal estate tax exemption amount is $5.34 million in 2014 -- or double that amount for married couples. There are several strategies to consider that are designed to reduce an estate tax burden:

One is to make annual tax-free gifts of up to $14,000 (in 2014) to anyone they wish.

Another is placing assets in an irrevocable living trust. Income taxes on revenue-generating assets placed in such a trust are paid by the trust itself, not by them. In addition, the assets in the trust are not considered part of your parents' estate and are therefore not subject to estate taxes when they both pass away. However, "irrevocable" means that generally they cannot change beneficiaries or trustees once they are chosen; your parents also relinquish control of their assets once they are placed in such a trust.

5. Do you and your parents understand the potential benefits of the power-of-attorney designation? A power-of-attorney is a legal document that names an individual who will be charged with making financial or legal decision on behalf of another person, often a parent. This document can become very important should one or both of your parents become ill or incapacitated in some way.

6. Should they consider a long-term care insurance policy? The average cost of a private room in a nursing home – now topping $87,000 annually nationwide – can put a tremendous financial burden on a family.[1] For this reason, long-term care insurance can be a prudent addition to the financial plan of older parents.

For more information about any of the issues discussed above, contact a financial advisor.

This communication is not intended to provide tax and/or legal advice and should not be treated as such. Each individual's situation is different. You should contact a tax and/or legal professional to discuss your personal situation.

Source/Disclaimer:
[1]Genworth Cost of Care Survey, March 25, 2014.

Looking at Park Central, a Retirement Community

by Chelsea Williams and Wendi Swope

When our grandfather passed away suddenly, it threw our family into unknown territory. Not only were we grieving for a husband, father, grandfather and great-grandfather wrapped up in one incredible man, but we were also learning about the extent of my grandmother's illness. She had Alzheimer's disease, and although she was still a vibrant, kind and caring woman, We were not sure many of us knew before he was gone, just how much she was gone as well.

In the days after our grandfather's passing, family and friends both locally and from out of town came to pay their respects and visit with our grandmother. She received each person with grace and dignity, but every 5-10 minutes, she would stop and ask, "What's going on?" and would re-live her loss. After the funeral our family needed to make some tough decisions. The priority was our precious grandmother. The family wanted her to stay in the home she and my grandfather had built together over 50 years ago. For several weeks, there was a live-in nurse and an army of family and friends trying to make life normal again for her. This arrangement met the initial desires of the family, but for long-term care we were again faced with a tough decision. We needed to find a place in Amarillo that could give our grandmother the same care and devotion that her own family would. The Park Central community was a godsend for us.

Among several options of communities, Ware Living Center was the right fit for our family. It is a long term nursing center dedicated to exceptional resident care, and its goal is to maintain a diverse, harmonious environment that meets everyone's individual needs. We were able to get the high level of care my grandmother needed, and the 24-hour nursing care was a comfort to us all. The Village is a certified Alzheimer's center located within the Ware Living Center. It was designed for residents with significant dementia and also provides 24-hour licensed nursing care. We knew that all the needs and wants of our grandmother would be taken care of with all the care and compassion that we could ever ask for.

Being centrally located in downtown Amarillo, Park Central's was extremely convenient for our family. Each day, on multiple occasions, several of us would stop by to visit. We were always encouraged to share meals, participate in the many daily activities and to get to know the rest of the community. And, that's exactly what we did.

We often joined our grandmother in the dining room for lunch or dinner. Their professionally trained chefs always had a great menu planned out. We would also walk around the campus checking out the beautiful courtyards and the many bird enclosures. We discovered that Park Central had just about any amenity a person could want. The beauty salon was always busy and so was the Day Spa. There was even a pharmacy on campus, right next to the Jackson Square Grill, where we often ate.

As we walked the halls, it became evident just how big the Park Central campus was. This amazing community not only offered certified Alzheimer's care at Ware Living Center, but offered a full continuum of care from Independent Living and Assisted Living to Long Term Care and even Rehabilitation.

The four Independent Living buildings have big, spacious apartments that are decorated with each person's furnishings from home. Park Place Towers, The Continental, The Talmage and Plemons Court overlook either downtown Amarillo, beautiful churches, green courtyards or a tree-lined city park.

The two Assisted Living Centers are just as beautiful with one featuring a serene outdoor area with a relaxing water feature. Both Moore Assisted Living and The Harrington allow residents to remain independent, but offer support services as needed.

The Long Term Care offered at Ware Living Center was second-to-none and included the Namaste Program. Namaste is a Hindu term meaning 'to honor the spirit within'. This program is designed to provide gentle, end-of-life care fore residents with advanced dementia. It blends nursing care with activities to promote peaceful, relaxing experiences.

It wasn't until later that we learned Park Central even had a Skilled Nursing & Rehabilitation Center called The Arbors. It's located in the Medical Center, which is probably why we didn't connect all the dots at first.

Park Central is a saving grace, not only for our family, but also for so many other families. There are so many options available when facing these life-changing decisions, but we chose Park Central to help take care of our family. In the end, they became a part of ours.

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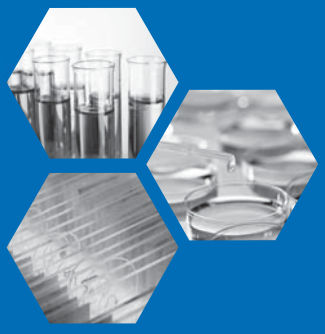

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So You're Medicare Eligible?:
What Does That Get You?

by Beverly McBeath, Director of Public Relations, Interim Healthcare

Turning 65 is a birthday milestone for many. So, if you are approaching the rite of passage that your 65th birthday brings, consider the following information on Medicare and enrollment as your health care options are rapidly changing.

For starters, Medicare exists to make it easier for aging adults to get the highest quality health care at the most affordable price. The ultimate goal of Medicare is to transform itself from a program which simply pays the bills to a program which actively supports a high quality health care system.

During the months leading up to your 65th birthday, it is essential to understand the enrollment periods and regulations that go along with signing up for Medicare. As someone approaching this birthday, the Initial Enrollment period is one to mark in your calendar. The Initial Enrollment Period is held during the 7-month period that begins 3 months before the month you turn 65, and ends 3 months after the month you turn 65. During this time, you can sign up for Part A and/or B. If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your start date will be delayed.

However, if you choose to not sign up for Part A and/or Part B when you were first eligible, you may sign up between January 1 and March 31 of each year. Taking this route will cause your coverage to begin July 1 of that year and you may have to pay a higher Part A and/or Part B premium for late enrollment.

If you chose to delay signing up or wish to change your plan, you can take care of that during Late Enrollment period between October 15 and December 7 each year. Waiting to enroll during this period means your coverage will begin on January 1 as long as the plan gets your request by December 7.

Approaching this age, it is important to bear in mind the different parts of Medicare to better understand and sign up for the plan best suited for your life right now. Basically, the different parts of Medicare help cover specific services. When first signing up for Medicare coverage, keep in mind these different parts to ensure you are getting the most from your plan. The Medicare parts are A (Hospital Insurance), B (Medical Insurance), C (Medicare Advantage Plans like HMO or PPO), D (Medicare Prescription Drug Coverage), and Medicare Supplements (Medigap).

Medicare Part A helps to cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care services, and inpatient care in a Religious Nonmedical Health Care Institution. This plan covers medically necessary and reasonable treatments. Also, you must show significant improvement or you may become ineligible for more coverage. For those of you who wish to continue to work, the Part A + Employer Plan is also available. Qualifying for this, you must be 65 or older, have a group health plan coverage based on your or your spouse's current employment, and the employer must have 20 or more employees.

For those of you who plan on making appointments to visit a doctor or other health care provider as an outpatient, Medicare Part B is an appropriate option. This plan helps to cover medical services needed to diagnose or treat a medical condition, ambulance services, mental health needs, durable medical equipment, and some preventive services such as mammograms or flu vaccines. However, if you do not sign up for Part B when you are first eligible, the Part B penalty kicks in, increasing your monthly premium by 10% for each 12 month period that you wait.

Looking for all of the above? Medicare Part C, also known as the Medicare Advantage Plan, is a unique and fitting option for those that wish to have Parts A and B and in most cases, Part D coverage. In addition, vision exams, eyeglasses, dental, and health and wellness programs are also covered through Part C. Part C is administered by private insurance companies under contract with Medicare. Through this plan, Medicare pays a fixed amount for your care each month to these com-

| *continued on page 22*

by Medicare. Since each company has different rules for how you get services, the plans can charge different out-of-pocket costs. In most cases, with Part C, you will receive the prescription drug coverage that Part D provides. If however, your plan does not cover prescription drug costs, you can join a Medicare Prescription Drug Plan.

Medicare Prescription Drug Coverage, or Part D, is an option run by Medicare-approved private insurance companies to help cover the costs of prescription drugs. Through this plan, your prescription drugs costs may decrease and you are protected against higher costs in the future. If you are planning on moving to a different state during your enrollment year, however, you may pay a different premium or possibly may not have access to the same selection of Medicare Part D plans due to the varying costs among states.

Separate from the standard Medicare coverage, Medigap covers out-of-pocket costs for deductibles and co-pays that are not covered by Parts A and B. This plan is sold by private insurance agents. In order for you to qualify for Medigap, you must have Parts A and B; you do not need Medigap if you signed up for Part C. If you are interested in this coverage plan, keep in mind that different insurance companies may charge different premiums for the same policy.

For more information on Medicare eligibility, visit Medicare.gov for the latest information concerning your health care options.

~

In keeping with this "Medicare Handbook," we felt comfortable inserting this poem from one of our readers. A homage to all of our mothers. Special thanks to Bonnie Rogers.

My Mama's Hands
by Bonnie Rogers

I sat and looked at my Mama's hands. If those hands could talk, what a colorful story they would tell. Mama would never be able to put into voice the story her hands would tell.

They would talk of:

* picking cotton on her Papa's farm until her hands bled and feeling the rough cotton sack slung around her back and shoulders;
* gripping the horse's mane if she got to sit in front as she rode to school with her brothers and sisters, and then holding onto the horse's tail if she had to sit in back;
* filling the coal oil lamp with oil and trimming the wick just right in order to be able to see to do her homework;
* fingering the rough, dried corn cobs in the outhouse and loving the feel of the smooth, slick pages of the Sears and Roebuck catalog that replaced the corncobs in the outhouse;
* cutting out cardboard to put in her shoes to protect her feet against the wet and cold and looking forward to the new shoes she would get when her Papa's cotton crop came in;
* languishing over the expected sumptuous taste when she felt the bumps on the plump orange that was her only gift waiting for her on Christmas morning;
* fastening her new high button shoes with the shoe hook that serviced a family of 10;
* gripping her overalls and praying she wouldn't drown when she went swimming in the stock tank;
* pulling on heavy woolen socks that her feet had outgrown but felt just the right size to protect her hands against the cold journey to school;
* feeling the grooves on the basketball as she and her team won the Texas girls basketball state championship in 1937;
* grasping the handle of her suitcase when she climbed up the steps of the bus bound for West Texas Teacher's College;
* holding my Daddy's hand during their courtship, and caressing that same hand when they become joined in marriage;
* waving bye to my Daddy when his ship pulls away from the dock bound for the South Pacific and clutching his civilian clothes when meeting his ship returning from the War;
* holding her babies when we successively arrived in 1948, '50, '52, and '55;
* sewing 4 matching Easter dresses and coats of different sizes while she would wear the same black eyelet suit for numerous Easters in a row;
* spanking the daylights out of us when we painted the commode with merthiolate or the times she caught us smoking in the fields surrounding our house;
* lifting a window air conditioner into place by herself in the spring, and then lowering it to the ground in the fall;
* slicing her finger open and requiring stitches pulling up Johnson grass in her garden that provided our family with the best tasting vegetables found at any farmer's market;
* touching her Papa's casket on a cold January morning as her final farewell to the man who gave little, but still loving and respecting him because he gave her life;
* rubbing Daddy's paralyzed hand and inwardly begging for life to be restored to this man who taught her heart to love;
* drying the tears on my face when she told me that Daddy had died;
* setting a quilt top together for her grandchildren and great-grandchildren;
* kneading the biscuit dough on the mouth-watering biscuits that only she can make;
* beating a chocolate pecan frosting for a cake that Paula Dean would envy;
* resting on top of the sheet of her hospital bed after she had had a stroke;
* holding the cane that gives her support and help, help that she won't ask for from anyone else; and,
*folding her hands in prayer to the one who is her only confidant.

Mama has never had a manicure and I've only seen her fingernails painted once in my whole life, but my Mama has the most beautiful hands in the whole world. Her hands are precious to me because in those hands, Mama holds my heart.

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Power of Attorney:
Legal Issues and Ramifications

by Ed Dowdy and Chris Harkins, Underwood Law Firm, P.C.

No one knows what the future will hold, but one thing is sure: if we leave unanswered questions - questions that many of us would prefer to avoid - about how to settle our affairs, life for our loved ones could be difficult. That's why answering questions now - and formalizing them in an estate plan - is an important step that shouldn't wait. Such questions include:

- Who will care for my children?
- How can I provide financially for my loved ones after I'm gone?
- Who has the legal authority to make medical and financial decisions for me if I become incapacitated?

Simply making others aware of your wishes is not enough. If you die without a will, also known as dying intestate, the Texas Estates Code – and not you – will determine how and to whom your assets will be distributed. Therefore, it is essential that you have the legal framework (such as a will) in place to ensure that your directions are communicated correctly and are followed.

Although a will is an important part of an estate plan, it only takes effect after you die. The following three documents, though often overlooked, are needed to carry out your wishes and manage your assets during life and in the event you are unable to do so:

- a Statutory Durable Power of Attorney,
- a Medical Power of Attorney, and
- a Directive to Physicians.

1. Statutory Durable Power of Attorney

A Statutory Durable Power of Attorney gives your designated agent the authority to make personal and financial decisions on your behalf. A Durable Power of Attorney can cover all aspects of your personal and financial affairs (other than medical decisions), or may be limited to specific situations and activities. This document can allow your designated agent to do such things as sign checks and tax returns, enter into contracts, buy or sell real estate, stocks, and bonds, deposit or withdraw funds, run a business, or make gifts to your beneficiaries.

A Statutory Durable Power of Attorney can be made effective at the time you sign it or become effective only when you are determined to be mentally or physically incapacitated. An "incapacitated person" is defined by the Texas Estates Code as an "adult who, because of a physical or mental condition, is substantially unable to … provide food, clothing, or shelter for himself or herself; care for the person's own physical health; or manage the person's own financial affairs."

If you become incapacitated and do not have a Statutory Durable Power of Attorney in place, a court-ordered guardianship may be necessary. Guardianship is time-consuming and expensive, and may be avoided by executing this document.

2. Medical Power of Attorney

A Medical Power of Attorney allows your designated health care agent to make decisions on your behalf regarding your health care in the event you cannot make those decisions. This document becomes effective only upon your incapacity as certified by your physician.

Without a Medical Power of Attorney, decisions about your medical care (should you become incapacitated) might not be made the way you intended. The result of not having a Medical Power of Attorney can wreak havoc on your loved ones, as they sort through medical options, especially those dealing with end-of-life decisions.

A well-drafted medical power of attorney should be "HIPAA compliant" in order to legally authorize your health care provider to share your protected medical information with your designated health care agent. If the Medical Power of Attorney does not specifically authorize transmission of your protected health information as required under HIPAA, your health care provider may err on the side of caution and refuse to share this information with your designated health care agent, who may need protected medical information to make an informed medical decision on your behalf.

3. Directive to Physicians

The Directive to Physicians, which is commonly referred to as a "Living Will", is a document that allows you to instruct your physicians not to use artificial methods to extend your life in the event you are diagnosed with a terminal or irreversible condition. An "irreversible condition" is defined by the Texas Health and Safety Code as "a condition, injury, or illness … that may be treated but is never cured or eliminated; that leaves a person unable to care for or make decisions for the person's own self; and that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal." A "terminal condition" is also defined under the Texas Health and Safety Code as "an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care."

The Directive to Physicians takes effect only after two physicians determine that the patient is terminally ill and the patient's attending physician determines that death is imminent or will result in a relatively short time without application of artificial life-sustaining procedures.

If you desire that your life not be artificially prolonged in the event of a terminal illness, you should consult with an attorney to have a Directive to Physicians prepared for you. It may also be desirable to inform your physician of your wishes and to provide him or her with a copy of this document. Failure to execute a Directive to Physicians may result in difficulties for your family in carrying out your wishes with respect to terminating artificial life-sustaining procedures.

If you have not already sought legal advice about your estate planning needs, we encourage you to contact a qualified estate planning attorney for assistance. [This article was prepared by the Underwood Law Firm, P.C.]

Everyone Needs a Will

by Ed Dowdy and Chris Harkins, Underwood Law Firm, P.C.

One of the comments estate planning attorneys hear most often from clients and potential clients is "I don't have enough assets to need a Will." While it is true that most of us don't need estate plans that are as complex as those needed by people like Bill Gates or Warren Buffett, it is equally true that everyone benefits from a basic level of estate planning. In short, EVERYONE NEEDS A WILL.

Most importantly, a properly drafted Will communicates to your loved ones your exact desires concerning your estate. Issues such as the person charged with finalizing your estate and who gets assets you worked all of your life to accumulate are important considerations, regardless of the size of your balance sheet.

What many don't realize is that a properly drafted Will potentially saves your loved ones thousands of dollars. This is because a Will can enable your estate to be settled virtually free from court involvement. In a nutshell, the less the court is involved in the probate process, the less expensive the process and the more assets available to your loved ones.

A Will also can allow an estate to be settled without the need for the executor to post a cash bond to protect your assets. Everyone knows we need to avoid being "penny wise and pound foolish." Avoiding the expense of a proper estate plan saves pennies during your life but almost certainly costs many unnecessary dollars after your death. None of us wishes to saddle our loved ones with that extra burden and expense.

This article was prepared by the Underwood Law Firm, P.C. If you have not already sought legal advice about your estate planning needs, we encourage you to contact a qualified estate planning attorney for assistance.

Sharon E. White
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Terminal Sedation and Physician-Assisted Suicide

by Kelly Thurston, MS4

One seemingly unanswerable debate in medicine is the issue of how to address end of life suffering. There are many approaches to this issue including pain relief, palliative sedation, and even physician-assisted suicide (PAS). There is a fine line between these already grey areas. Some feel physician assisted suicide is a right patients should have, while others feel it is unethical or perhaps even murder. Additionally, some might consider palliative sedation the beginning of a slippery slope to physician-assisted suicide. Therefore, one important distinction to make is that PAS purposefully hastens death, where palliative sedation does not. In any circumstance, the patients, families, law, ethics, and physician all play a part in this complex equation.

Palliative sedation is the administration of sedative medications to lessen severe or refractory symptoms as patients approach the end of life. The goal is to induce a lessened state of awareness and even unconsciousness at times. Palliative sedation is only used as a last resort when patients are considered to have intolerable pain or suffering and are terminally ill [1].

Sedation inherently is a continuum due to the fact that different doses of medications lead to varied levels of consciousness and also affect individual patients slightly differently. An attempt to relieve suffering and burdensome symptoms with lesser doses of medications and other methods altogether should be attempted as patients near the end of life before relying on palliative sedation. Palliative sedation is commonly utilized for the treatment of pain, dyspnea, agitated delirium, and convulsions [2].

While voluntary euthanasia refers to the deliberate termination of the life of a patient by active intervention at the request of the patient, palliative sedation is utilized for refractory suffering. The intent of the intervention is to provide symptom relief, not to end the life of the suffering patient. Unlike euthanasia, death of the patient is not the criterion used to gauge the success of the treatment.

Who might request palliative sedation? The patients who benefit from palliative sedation are people who are imminently nearing the end of life. First, a palliative care physician must evaluate the patient to determine whether palliative sedation is indicated. Reversible or treatable causes of the patient's symptoms may be present and should be addressed prior to initiating sedation. It is imperative that all other reasonable therapies or treatments have been attempted prior to palliative sedation. Also, if possible, a discussion between the patient and patient's family should occur to ensure that sedation is the best choice for the patient and that it will meet his or her goals.

In general, if palliative sedation is under consideration, review of the case by a multidisciplinary team should be conducted in order to assure that all other reasonable treatments have been provided and that palliative sedation meets the patient's goals [3,4].

Consent is extremely important. It should outline the purpose, process, benefits, and risks of palliative sedation and encourage conversation between physician and patient about the topic if it has not taken place already. Not only does this allow the patient to express their goals, concerns, and feelings about sedation, but can help everyone involved be on the same page. If consent is not obtained when the patient is lucid and capable of such conversations, it can be very difficult to make these decisions during a crisis situation.

For conscious and communicative patients, the discussion on palliative sedation should be a part of a more comprehensive conversation. This discussion includes the patient's general condition and the cause of distress, acknowledgment that prior treatments have not been successful and current prognosis, including predictions about survival. Of course, the discussion should also incorporate rationale, aims, and methods available for the use of palliative sedation. A plan for the depth of planned sedation, patient monitoring, and if appropriate, the possibility of planned weaning and even discontinuation of sedation should also be outlined. [5]

For a patient who is lacking decisional capacity, the advanced care plan of the patient must be followed. If an advanced directive does not exist, the discussion regarding palliative sedation (including consent) must be obtained from a legally recognized proxy. [6,7]. For an actively dying patient who is in severe distress and close to death, the opportunity to obtain consent by the patient or his/her health care proxy may not be present. In the absence of an advanced directive or health care proxy, the provision of comfort measures (including, if necessary, the use of sedation) should be considered standard of practice and the default strategy for clinician treatment decisions [5].

| *continued on page 28*

Stepwise administration is common, meaning small doses are used first and progression to larger doses occurs if symptoms are not adequately controlled with the previous dose. Administration routes include intravenous, intramuscular, subcutaneous, or rectal. It is also possible to use gastrostomy for administration. Emergency bolus therapy for breakthrough symptoms is also recommended.

Medications for palliative sedation usually start with a short acting sedative such as a benzodiazepine. The effects of benzodiazepines include sedation, hypnosis, anxiety reduction, muscle relaxation, anterograde amnesia, and anti-convulsion. Other drugs can be used for sedation, including dopamine antagonists like chlorpromazine, barbiturates like phenobarbital, and hypnotics/amnestics such as propofol.

Patients who are not imminently dying may be monitored in order to preserve physiological stability in the interim. This may include repeat assessment of the level of sedation and vital signs. A lower dose of sedative should be considered if life-threatening obtundation with respiratory depression occurs. This is part of the challenge when it comes to managing refractory symptoms adequately without hastening death. A benzodiazepine antagonist (flumazenil) should be available in case it is necessary.

Routine monitoring of vital signs is not necessary for patients who are nearing death. Comfort is the sole concern. Signs indicating pain, agitation, or respiratory distress such as tachypnea, should be observed and addressed. However, respiration is expected to decrease as patients near death and is not a reason to decrease sedation.

The limited data show that neither the administration of palliative sedation [8] nor the degree of sedation hastens death in otherwise terminally ill patients [9-11]. These findings are illustrated in the following studies:

The impact of sedation on survival for terminally ill patients was evaluated in a 2012 systematic review of observational studies involving over 1000 patients (34 percent of whom underwent sedation) [8]. There was no statistically significant difference in overall survival between hospice patients who underwent palliative sedation (median, 7 to 27 days) and those who did not (median, 4 to 40 days).

Of three studies evaluating the degree of sedation and its impact on survival after withdrawal of ventilatory support [9-11], there was no association between the dosages of medications used (morphine in most of these cases) and survival duration.

It is worth noting that palliative sedation does not require discontinuation of hydration and nutrition [15-19]. These may be continued while the patient's disease process progresses naturally. Since nutrition and hydration do not need to be discontinued, that is not a reason to think palliative sedation hastens death due to starvation or dehydration.

End of life care naturally brings ethical questions with answers that vary from patient to patient and family to family depending on their personal, cultural, and/or religious background. Not only must the ethics of sedation itself be considered, but what the decreased consciousness means in terms of nutrition, respiration, communication with family and other important considerations.

Once the lengthy discussion addressed previously has occurred with a patient, "the decision to act on these considerations relies on either obtaining informed consent by the patient (or his or her surrogate) or by previously determined advanced directive. In these deliberations, clinician considerations are guided by an understanding of the goals of care and should be within accepted medical guidelines of beneficence and nonmaleficence." As long as this is true, palliative sedation to relieve refractory symptoms at the end of life is supported by legal precedent [13-14].

Palliative sedation, when administered properly, does not hasten death, but if abused or given by an unskilled clinician it can hasten death. Whether deliberate or not, when given in large enough doses, sedatives such as benzodiazepines and barbiturates suppress the respiratory drive and lead to death [20-27].

Also, any physician involved in palliative sedation must be aware of a few other ethical considerations. Before sedation is given, the patient must be thoroughly assessed for reversible causes of symptoms [21- 28] and exploration of alternatives to palliative sedation should be offered and discussed [21- 29]. Another ethically grey situation related to palliative sedation is sedation given at the family's request, which may not be in line with what the patient or his/her advance directive indicates [30].

Sedation should not be withheld when it is appropriate to be given. It is important to remember palliative sedation as an option if you care for patients nearing the end of life. If you have questions as a physician, educate yourself so that you may offer the best care to your patients with as many options as possible. This will help avoid administration of futile care that occurs when the proposed therapy will not improve the patient's medical condition [31]. Physicians must be capable of determining when care is futile, and be resolute enough to explain to the patient's family and loved ones that the care given or left to give will no make a difference in the outcome. It is important to maximize communication between physician and family/patient in order to avoid arguments over what defines futility, as there is no unanimously agreed upon definition currently.

Euthanasia and Physician-assisted suicide are different situations and

both are controversial topics with different societies holding different views. Voluntary active euthanasia occurs when the physician intentionally ends the patient's life at the patient's request and with the patient's full informed consent. An incorrect use of the term euthanasia refers to "passive euthanasia" which includes terminating life-sustaining treatments, such as respirators and artificial nutrition. This is generally deemed ethical and legal [6]. Physician-assisted suicide involves the physician providing medication, a prescription, information, or other interventions to a patient with the understanding that the patient intends to use them to commit suicide.

Voluntary active euthanasia is legal only in the Netherlands, Belgium, and Luxembourg but is not legal in any state in the United States. On June 26, 1997, the United States Supreme Court ruled 9 to 0 that there is no constitutional right to euthanasia or PAS [12,13]. However, the Supreme Court did rule that there is no constitutional prohibition against states legalizing these interventions; this permitted states to enact statutes legalizing them.

Physician-Assisted suicide is legal in the Netherlands, Belgium, Luxembourg, and Switzerland. In the United States PAS was legalized in Oregon in 1997, Washington State in 2008, and in Vermont in 2013. It is currently being discussed in Montana and the act of "aid in dying" is an accepted medical practice in Hawaii while PAS is not legislated there [15].

Physicians should develop their own opinions and comfort level with this type of care before offering it to patients. Also, they should familiar with the laws governing euthanasia and PAS in the state where they practice. Patients should consider addressing this topic with their loved ones and finalize their advanced directives.

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Baby Boomers and End-Of-Life Care

by Ronnie Atkins, MSN, CNS, CHPN, RN
Administrator of Hospice Care of the Southwest

About 76 million people were born during the baby boom years, 1946 to 1964. The first wave of these baby boomers has already reached retirement age and has become eligible for Medicare. Caring for chronically ill elderly patients represents one of the biggest challenges in health care, a challenge that's likely to intensify as the baby boom generation grows older and, inevitably, sicker. Because of this issue physicians are focusing on chronic health concerns and considering new ways to think about end of life care.

According to the Dartmouth Atlas of Health Care, approximately 90 percent of deaths among Medicare participants are associated with nine chronic illnesses: congestive heart failure, chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia. Dartmouth researchers found that people with chronic illness in the last two years of life account for about 32 percent of total Medicare spending.

Chronic illness also takes a heavy toll on both the patient and their family caregivers. Patients experience difficult and uncomfortable symptoms which are hard for them to manage alone. They struggle to cope with their debilitating illness, their confusing and multiple medications, as well as their dependency on oxygen or other medical equipment. They also face the stress of frequent hospitalizations. Over half of patients with illnesses like COPD are readmitted to the hospital within twelve months. Family caregivers often feel overwhelmed and unprepared to care for their ill loved one.

The question for many has become: Does caring for a patient's well being include considering how they want to live at the end of life? Is it time to shift our focus from curing to comfort? When considering comfort care, research has shown that hospice can greatly improve the quality of life for patients coping with a chronic illness as well as reduce health care costs. Research published in the March 2013 issue of Health Affairs found that hospice enrollment saves Medicare dollars and improves the quality of care for Medicare beneficiaries with a number of different lengths of service.

However, despite the proven benefits of hospice care and the comfort it can bring, it is often underutilized for most chronic illnesses. Too few Americans entering life's final phase are availing themselves of high-quality hospice care, despite the fact that Medicare covers the expense. According to two articles in the New England Journal of Medicine, the situation is only going to become more problematic as the nation's baby boomers reach the end of their expected life spans in coming decades. "Only a third of Americans die under the care of hospice, and hospice care is free," noted the author of one article, Dr. Gail Gazelle, assistant clinical professor at Harvard Medical School. "Far too often, patients end up in an ICU, rushed to the emergency room, and they end up dying there, when really they would much rather have died in their own home," she added. And where is the comfort in that?

Gazelle stressed that hospice continues to meet or exceed the expectations of terminally ill patients and the people who love them. Perhaps because, at the end, comfort is what is most important to most of us. 98 percent of family members said they would strongly recommend hospice care to others in need. But the fact remains that a full third of hospice patients enter the service only in the last week of their life -- even though Medicare covers six months of this type of care. As baby boomers age and demand care on their terms, many believe this will begin to change.

"Baby boomers are going to turn all of this around," Gazelle said. "They are so empowered around their health care and the health care of their loved ones -- they're going to push hard to make sure that their needs are met."

"I think that we will see the reimbursement structure change dramatically over the next decade. Baby boomers have received the best medical care imaginable for their entire lives – why should their death be any different?" said Dr. Alexi Wright, an oncologist at the Dana-Farber Cancer Institute, in Boston.

Studies have consistently shown that hospice provides the comfort people seek by reducing symptom distress for chronic illness, improving caregiver outcomes, and reducing hospitalizations near the end of life, including emergency department visits, intensive care unit stays and hospital deaths. Hospices have specialized teams of caregivers uniquely trained in management of chronic serious

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illnesses including: congestive heart failure, chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia. Hospices not only assist in the day-to-day living of patients and families coping with serious illness, but also provide education and emotional support. As patients learn about their medications and disease, they tend to feel more confident, have less anxiety and experience a better quality of life.

Better quality of life has become the goal of many who choose hospice care. Beyond quality of life and symptom management, hospice helps individuals regain a sense of control as they decide how they want to live at the end of life. Control is an important factor to baby boomers known for their value of individual choice, strong opinions, and even stronger will.

According to Atul Gawande, a surgeon, public-health researcher, and New Yorker staff writer, "Hospice has tried to offer a new ideal for how we die."

Gawande writes in his book, Being Mortal: Medicine and What Matters in the End: "A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives."

"Death is the enemy. But the enemy has superior forces. Eventually, it wins. And in a war that you cannot win, you don't want a general who fights to the point of total annihilation. You don't want Custer. You want Robert E. Lee, someone who knows how to fight for territory that can be won and how to surrender it when it can't, someone who understands that the damage is greatest if all you do is battle to the bitter end."

It may be time to shift the focus from curative to comfort when patients are experiencing:

- Unintended weight loss
- Dependence in 3 or more Activities of Daily Living (ADLs)
- Progressive disease
- Increasing Emergency Room visits and/or hospitalizations for complications of disease
- Patient/family choosing to focus on comfort rather than cure of the disease
- Patient/caregiver experiencing increased stress or signs of anxiety
- Patient/family habitually calling their medical providers with questions about medications, symptoms they are experiencing, etc.

Hospice Care is considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

How does hospice care work? Hospice focuses on caring, not curing and in most cases care is provided in the patient's home. Hospice care also is provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients of any age, religion, race, or illness. Hospice care is covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations.

How does hospice care work? Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. The team usually consists of:

- The patient' s personal physician
- Hospice physician (or medical director)
- Nurses
- Home health aides
- Social workers
- Clergy or other counselors
- Trained volunteers and
- Speech, physical, and occupational therapists, if needed.

What services are provided? Among its major responsibilities, the interdisciplinary hospice team:

- Manages the patient's pain and symptoms
- Assists the patient with the emotional and psychosocial and spiritual aspects of dying
- Provides needed drugs, medical supplies, and equipment
- Coaches the family on how to care for the patient
- Delivers special services like speech and physical therapy when needed
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time and
- Provides bereavement care and counseling to surviving family and friends.

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Medicare, and its history:

A Study of a Worthwhile Idea

by Rouzbeh K. Kordestani, M.D., MPH

On July 30th, 1965, President Lyndon Johnson signed into law the Medicare Bill. With its signing, the United States for the first time chose to extend health care insurance to the elderly (above 65) and the unemployed poor. Prior to the enactment of this law, no such coverage existed. Unlike most industrialized nations, the United States did not guarantee access to health care for all of its population. In the United States, until the signing of the law, employers were the major providers of health insurance to their employees and their dependents. This, of course, left a significant portion of the population without coverage.

The initial push for the enactment of health benefits for the population at large was started by President Franklin Roosevelt in 1935. Unfortunately, the idea was thought to be too unpopular. For this reason, when President Roosevelt signed the Social Security Act into law in 1935, medical benefits were specifically left out of the bill. President Harry Truman, too, was concerned about the lack of appropriate health coverage. However, his concern was for a different reason. President Truman was alarmed by the number of draftees during World War II who failed their induction physicals. It became painfully clear to him that the general state of health of the country was poor. More importantly, it meant that the average citizen could not afford visiting the doctor to maintain his or her health. In response to this shortcoming, President Truman advocated comprehensive health coverage. In 1945, Truman pushed forward his first proposal providing for physician and insurance coverage for working aged Americans and their families. This first proposal was defeated soundly by different faction groups, the largest of which was the American Medical Association (AMA), which branded the president's plan as "socialized medicine," making full use of the stigma associated Russia and communism. Additional proposals followed. Even though President Truman was able to expand the topic of health care and bring the issue to the forefront of the national discussion, however, he was not able to pass any of his comprehensive agenda.

Like President Truman, President Eisenhower had a vested interest in a coherent and expanded medical care system. However, in the post World War II years, the focus was directed more towards outside threats than domestic concerns. During the Eisenhower presidency, the House Ways and Means Committee was created in Congress and was given amongst its many tasks the issue of health care. The members of the original committee, mostly Republicans and Southern Democrats, however, were not in favor of a comprehensive health care law. For this reason, there was little change in sentiment or action until President Johnson took office.

In 1964, in the aftermath of the Kennedy assassination, President Lyndon B. Johnson was elected into office on a sweeping landslide. With a great deal of political capital gained, President Johnson was able to once again place the issue of health care in the forefront of his agenda. It was a part of his "Great Society" initiative. More importantly, the Democratic Party now controlled both Congress and the Presidency. Along with this, more progressive members from both parties sat on the Ways and Means Committee. These factors combined to allow for favorable consideration of the new health coverage agenda.

One of the champions of cause of expanded health care was the Chairman of the Ways and Means Committee, Wilbur Mills (Democrat-Arkansas). He helped to decide between the three different pieces of legislation that were put forth in front of Congress for consideration. The three versions of the bill were sponsored by John Byrne (Republican), the AMA (better known as Eldercare), and the administration (better known as Medicare). After much deliberation, the AMA version was rejected. The two remaining versions were combined. This combined bill was then presented to Congress and went through more than five hundred amendments before being passed by both the House and the Senate.

The legislation created two amendments to the Social Security Act of 1935. Title XVIII, which is better known as Medicare Parts A and B, provided for hospital insurance for the aged, and for health provider coverage, respectively. Title XIX, which is now known as Medicaid, provided for the states to extend health care for individuals who were at or close to the public assistance level with federal matching funds.

In 1965, President Johnson signed the bill into law, making it Public Law 89-97. He chose to sign the law in Independence, Missouri, at the Truman Presidential Library as a tribute to President Truman's efforts. President Johnson thanked President Truman for "planting the seeds of compassion and duty which have today flowered into care for the sick and serenity for the fearful."

In 1966, President Johnson pre-

sented the now elderly and retired President Truman and his wife, with the first and second Medicare cards ever printed.

The specifics of the Medicare Bill

In 1965, when Medicare and Medicaid were passed as functional amendments to the Social Security Act of 1935, they were met with much suspicion. However, since its inception, Medicare and Medicaid have done much to ease the fear of the poor and the elderly in regards to their health care needs.

The amendments have specific provisions that have to be considered. Medicare Part A covers inpatient hospital stays for ninety days per illness, plus sixty lifetime reserve days. Part A also covers up to 100 days per illness for post-hospital skilled nursing facility care, hospice, and some home health care. Every person eligible for Social Security and over the age of sixty-five is eligible for Medicare Part A. Medicare enrollees are not charged premiums for Part A, but are subject to deductibles and co-insurance similar to commercial insurance programs.

Medicare Part B covers physician services and many outpatient hospital, diagnostic, therapy, and many other medical services. Medicare Part B is optional, although most Part A enrollees also sign up for Part B. Part B enrollees must pay a monthly insurance premium to CMS, and are also subject to deductibles and co-insurance.

Medicare Part C is the Medicare Health Maintenance Organization (HMO) program, called Medicare Plus Choice. Medicare Part C is an optional Medicare HMO, which enrollees may choose instead of Parts A and B. The HMO sets the additional premiums for Part C, and any deductibles, co-insurance and additional benefits, within the limits set by CMS. For example, about 10 to 15 percent of Medicare enrollees receive some limited prescription drug benefit by enrolling in a Medicare HMO under Part C.

As time has gone on, the Medicare and Medicaid amendments have been expanded to cover home health care needs, hospice, end-stage renal disease, and many other services. These additions are mostly due to political pressure. In addition, the disabled that were brought under the Medicare umbrella in 1972.

Even though various groups have challenged various aspects of the law, no litigant has ever challenged the Constitutional basis of the act as a whole.

The future of Medicare/Medicaid

As the population is aging and as the baby boomers are hitting 65, the cost of care is increasing dramatically. Medicare costs were $7.7 Billion in 1970. In 2000, they were over $200 Billion. Even though the costs are astronomical, the rate of increase is much more concerning. In 1970, health care costs represented 7% of the gross national product. In 2003, they represented 14%. Experts and economists agree that at this rate, health care costs and the percentage growth will overshadow the expenditures on defense and will cripple the economy and its potential for future growth.

The concern about cost and expenditures is well founded. The bit-by-bit addition to the coverage of Medicare/Medicaid is termed by some as incrementalism. This incrementalism is the point of contention for many as, bit-by-bit, more and more is being placed under the national coverage. This is at the heart of the increase in Medicare/Medicaid cost increases.

In the near future, as the specifics of the Affordable (Health) Care Act (ACA) become defined, the future and importance of Medicare and Medicaid will too be re-defined. As the population ages, there is a need for a better solution. But as in 1965, there must be movement for change, and patients and physicians have to be accepting of change for it to occur. How this will impact us is unsure. One thing that is certain is that it will have a tremendous impact.

The Advisory Group at Merrill Lynch forwarded this information to us, and we thought it would prove useful.

Understanding your Medicare options

Planning for healthcare costs is an essential component of a comprehensive retirement plan. It helps to ensure you have healthcare coverage throughout your lifetime, while guarding against negative impacts to your portfolio should you encounter significant or unexpected healthcare expenses. For most people, Medicare will be the anchor of their healthcare coverage plan once they reach age 65. However, Medicare will not cover all of your expenses. It's important to understand all of your options and their costs as you plan for your transition into retirement.

What is Medicare?

Medicare is a federal health insurance program. At age 65[1] you become eligible for Medicare, which consists of four types of coverage:

Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage Plans
Part D	Prescription Drug Coverage

Each part represents a different set of benefits and cost structures. Generally, there are two common ways to receive Medicare—Original Medicare, which is Parts A and B, or Medicare Advantage, which is Part C.

Some individuals may have the option to maintain coverage through their employer or union, but many will utilize Medicare to provide their healthcare benefits or as their primary coverage.

What isn't covered by Medicare?

Keep in mind that Medicare will not cover all of your healthcare expenses. For covered services in Parts A and B (Original Medicare) you typically will need to pay a deductible, coinsurance or copayment. Certain services such as long-term care, acupuncture, cosmetic surgery, routine dental care and routine vision care are not covered at all. Some of these services may be available to you through Part C Medicare Advantage, though an additional premium may be charged.

What is Medigap?

Medigap is supplemental to original Medicare Parts A and B and is designed to fill gaps in coverage such as copayments, coinsurance and deductibles. Some policies may also offer additional services not offered by Medicare. Medigap is optional.

- Policies are offered by private insurers, but follow strict federal and state laws. Policies are standardized, so insurers typically offer the same benefits for each type of coverage.[2]
- Generally, you must be enrolled in both Parts A and B to buy a Medigap policy. The policy covers one person.
- Medigap policies should be purchased during the first six months of being enrolled in Part B. During this six-month window you are guaranteed the right to buy a Medigap policy. This period cannot be delayed or replaced. After this period coverage may be available, but is not guaranteed.
- Costs vary based on the coverage and insurer.
- These policies cannot be used in conjunction with Medicare Advantage.

Medicare options overview

Program	Features and Benefits	Costs	Late Enrollment Penalties
Part A Hospital Insurance	• It helps pay for inpatient hospital and skilled nursing care, home healthcare and hospice care. • You are automatically enrolled if you are already receiving Social Security benefits. • No physical exam is required. • You may go to any hospital that takes Medicare. No referral is needed.	• Usually there is no premium if you or your spouse paid Medicare taxes while working.[3] • Deductible, coinsurance and copayments apply. • Some people who do not qualify for premium-free coverage can pay a premium to obtain it.	If you don't qualify for premium-free coverage and elect to purchase it but don't buy it when first eligible, your monthly premium may go up by 10%. This penalty will be assessed for twice as many years as you were eligible but didn't join. There is no penalty if you had employer health plan coverage during this period of time.
Part B Medical Insurance	• It helps pay for doctors' services, outpatient care, and other medical services and supplies not covered by the hospital insurance. • It covers an initial physical exam within the first 12 months of enrollment. • You may go to any doctor who takes Medicare. No referral is needed.	• A standard monthly premium will apply. Premiums are higher for higher-income beneficiaries.[4] • Typically Part B premiums are taken out of Social Security benefits. • Deductible, coinsurance and copayments apply.	If you do not enroll when first eligible, your monthly premium may go up by 10% for every 12 months you were eligible but did not enroll. This penalty may remain for as long as you are enrolled in Part B. There is no penalty if you had employer health plan coverage during this period of time.
Part C Medicare Advantage Plans	• They are an alternative to Original Medicare offered by private insurers. • Plans cover Parts A and B and often Part D. • They may offer benefits or services not covered by Medicare. • Different structures may be available, such as Health Maintenance Organizations and Preferred Provider Organizations. Some plans may require referrals or may restrict you to doctors in a network.	• They provide care under contract to Medicare, so you continue to pay the Part B premium and you may pay an additional premium. • Costs are determined by the insurer and will vary.	You may enroll only during specific periods of time. See penalties for late enrollment in Part A and Part B.
Part D Prescription Drug Insurance	• Protection is provided for people with high drug costs. • Both brand-name and generic prescription drugs are covered. • It is offered through private insurance companies approved by and under contract with Medicare.	• Premiums, deductibles and copayments vary depending on the insurer. • In general, you pay a monthly premium, along with cost-sharing amounts for each prescription. • Most plans have a coverage gap. After you and your plan have spent a certain amount, you pay all costs up to a yearly limit. • Plans do not cover every drug, so it is important to check the plan formulary that lists the covered prescriptions.	If you do not enroll when first eligible and do not have other coverage, your monthly premium will go up by 1% of the national base beneficiary premium for each month you were eligible but did not enroll. This penalty remains for as long as you are enrolled and may increase each year. There is no penalty if you had creditable coverage during this period, meaning coverage that is expected to pay on average as much as Part D. You should receive a written notice from the plan that provided your creditable coverage.

Planning considerations

What should you consider?

Deciding what type of coverage meets your needs requires balancing the benefits provided with the potential costs. Consider the following questions:

- What is most important to you—services covered, flexibility, cost structure, etc.?
- Do you have, or are you eligible for, other types of healthcare or prescription coverage?
- What types of services do you need and are these services covered?
- Do your doctors and hospitals accept the coverage?
- Do you have to choose your doctors and hospitals from a network? Do you need a referral?
- How much are your premiums, deductibles and copayments? Is there a limit for how much you could pay in a year for out-of-pocket expenses?
- What are your prescription drug needs? Are your drugs covered? What will they cost?

If you travel, you'll want to look into plans that will cover care across state lines and overseas.

Original Medicare will cover your hospital and medical costs anywhere in the United States. However, there is no requirement that non-urgent care will be covered, so it is important to read your policy carefully. Medicare Advantage covers emergency and urgent care in the United States.

For travel outside of the United States, in most circumstances Original Medicare will not cover your expenses. Some Medicare Advantage and Medigap policies may cover foreign travel emergencies.

If you plan to relocate when you retire, you should investigate your options based on the location you will be in when you retire.

Some Medicare Advantage plans may be limited to a certain geographic area. If you disenroll from your Medicare private health plan (Medicare Advantage plan) federal law does not usually give you the right to buy a Medigap plan. The laws in your state might give you more rights.[5] You should check with the State Health Insurance Assistance Program in the state in which you plan to retire to find out if and when you can enroll in a Medigap plan in that state.

If you have a younger spouse, your spouse will need separate coverage until he or she reaches 65 and becomes eligible for Medicare.

Medicare is not offered as a family or dependent benefit. Generally, Medicare is only available to individuals age 65 or older, so even though you might be 65 your spouse cannot receive Medicare benefits until age 65. Your spouse could evaluate COBRA, individual health insurance, or employer-sponsored health insurance as potential coverage options to fill the gap.

If you have COBRA or retiree health insurance coverage from a former employer, you will still want to sign up for Medicare when you are eligible.

COBRA and retiree health plans are not considered coverage based on current employment. You are not eligible for a Special Enrollment Period when that coverage ends. To avoid paying a higher premium, make sure you sign up for Medicare when you are first eligible.[6] It is also important to review the terms of your retiree health plan coverage carefully to understand how it will work in conjunction with Medicare. Generally, Medicare pays first for your healthcare bills and your retiree health plan coverage pays second.[7]

Medicare enrollment

When can you sign up for Medicare?

If you are already receiving Social Security, you will automatically be signed up for both Part A and Part B with the option to withdraw from Part B (if, for example, you have and wish to continue coverage through your employer). You will receive a Medicare card in the mail two to three months before your 65th birthday. Coverage begins the first day of the month you turn 65.

If you are not currently receiving Social Security, you will need to apply for Medicare during the enrollment periods. Your initial enrollment period is the seven-month period beginning three months before the month in which you turn 65. To help avoid a gap in coverage, it is recommended that you enroll during the three months prior to your 65th birthday.

For Part D coverage, you need to opt in by filling out a form and enrolling in an approved plan. You must have Part A or Part B or Medicare Advantage to enroll in Part D.

What if you have access to COBRA (Continuation of Group Health Insurance Coverage)?

If you have the option for COBRA coverage, you should be aware that this does not affect the special enrollment period, so do not wait to enroll. If you are over 65 and wait until the end of your COBRA coverage period to enroll in Part B, you may have to wait to enroll at the next general enrollment period. This may result in a period of time during which you are no longer covered by COBRA and are not yet covered by Medicare. In addition, you may face a penalty in the form of a higher premium.

What if you're still working at age 65?

If you're working at age 65, you are still eligible for Medicare; however you may find your employer-provided health plan meets more of your needs. Talk to your employer's benefits representative to determine how your plan interacts with Medicare and to determine what type of coverage makes sense for you.

- It may make sense for you to enroll in Part A and delay enrollment in Part B until you are no longer covered by your employer. While you are working, Medicare is generally secondary so your employer's plan will pay first.[8] Part A may cover some of the costs not covered by the employer's plan. Part B may offer limited value as premiums may be higher due to employment income and Part B enrollment may trigger the six-month Medigap enrollment period, which cannot be delayed or replaced.
- There is a special enrollment period for those still working at age 65 who are covered by an employer's plan. You can enroll penalty-free in Medicare any time while covered by your employer or during the eight-month period that begins after the month in which employment or coverage ends.

What happens if you miss an enrollment date?

If you miss the initial enrollment or special enrollment periods, you can still sign up for Medicare during the annual general enrollment period; however, there may be a penalty or an increased premium.

Enrollment Period	When It Occurs	Who Is Impacted	Helpful Hints
Initial Enrollment Period	It begins 3 months before your 65th birthday month and runs until 3 months after that month.	Those enrolling in any part of Medicare.	Those receiving Social Security benefits are automatically enrolled in Parts A and B. Those not yet receiving benefits must apply. Sign up early to avoid a delay in coverage. To get Part A and/or Part B the month you turn 65, you must sign up during the first 3 months before the month you turn 65.
Special Enrollment Period	It begins any time after age 65 while covered by an employer, and it ends 8 months after the month in which work stops or coverage lapses.	Those who continue to work after age 65 and decide to delay enrollment.	Receiving COBRA benefits does not affect the special enrollment period. Sign up for coverage the month before employment ends to avoid a gap in coverage. Coverage starts the month after enrollment.
General Enrollment Period	January 1 – March 31	Those who did not enroll in Parts A or B in their initial enrollment or special enrollment periods.	Coverage does not go into effect until July 1.
Annual Coordinated Election Period	October 15 – December 7	Those who want to switch from Original Medicare to Part C or vice versa, switch from one Part C plan to another, or join, switch or drop Part D plans.	Coverage goes into effect January 1.
Medicare Advantage Annual Disenrollment Period	January 1 – February 14	Those who want to switch from Part C to Original Medicare.	Those who switch may also enroll in Part D.
Medigap Enrollment Period	It begins the first day of the month you are age 65 or older and are enrolled in Part B, and it runs for 6 months.	Those who want a supplemental policy to fill their gaps in coverage	You need to be enrolled in Medicare Parts A and B and cannot be enrolled in Part C. Missing this enrollment deadline may limit your options and lead to penalties.

Information resources

- The Medicare website (medicare.gov) contains general information and publications. It allows you to search for and compare healthcare plans, Medigap policies, drug plans, hospitals, nursing homes, home health agencies and doctors in your area.
- The *Medicare & You* booklet can be found at medicare.gov and is mailed out each fall to households enrolled in Medicare.
- Speak with a Medicare agent at 1.800.MEDICARE (633.4227); TTY users should call 1.877.486.2048.
- Register at mymedicare.gov to access your personal Medicare information.
- Find information about insurance options, new healthcare legislation, public health programs and community services at healthcare.gov.
- Get information about Veterans health benefits at va.gov/healthbenefits.
- Enrollment information is also available through Social Security by calling 1.800.772.1213, using the website ssa.gov, or making an appointment at a local Social Security office.
- You can receive free personalized counseling through your State Health Insurance Assistance Program (SHIP) at shiptalk.org.
- National Council on Aging provides a Benefits Checkup on its website (ncoa.org) to determine eligibility for programs.
- Contact the Medicare Rights Center if you have concerns at medicarerights.org or call 1.800.333.4114.
- For links to local resources on Medigap coverage, visit the National Association of Insurance Commissioners website at naic.org.

Get started

If Medicare will be the anchor of your healthcare coverage plan once you reach age 65, it's important for you to understand your options, choose the coverage that's right for you, and know how to enroll. The checklist on the next page can help guide you through the enrollment process and ensure you don't miss any critical enrollment dates.

Your financial advisor can help you take a look at the broader picture of estimating your annual healthcare costs and incorporating them into your overall retirement plan.

Contact your Merrill Lynch financial advisor today or visit wealthmanagement.ml.com.

Enrollment checklist

Once you have decided which type of coverage best meets your needs, you may want to use the checklist below to help guide you through the enrollment process.

Before you enroll	☐ Maintain a good set of records. If you decide to maintain your employer or union-provided health plan and delay enrollment in Parts B or D, make sure you keep thorough records of your decisions and the conversations you had with Medicare so you don't face a higher premium when you later enroll. ☐ Keep your creditable coverage notice. You should receive a notice from your employer or union-provided plan that says you have creditable coverage.
7 to 9 months before your 65th birthday	☐ Check eligibility for Medicare benefits with Social Security at 1.800.772.1213. ☐ Review current and post-retirement benefits to determine what happens at age 65. ☐ Familiarize yourself with what Medicare covers.
4 to 6 months before your 65th birthday	☐ Review Medicare Advantage and Medigap options. ☐ Check with your doctors to be sure they accept Medicare.
1 to 3 months before and after your 65th birthday	☐ Enroll in Medicare Parts A and B. This can be done online or by phone. ☐ If you are receiving Social Security, you should be enrolled automatically. ☐ Consider enrollment in Medicare Advantage or Medigap. ☐ Consider enrollment in Part D prescription drug plan, if you are not covered elsewhere.
Within 1 year of your 65th birthday	☐ Make an appointment for your initial physical exam. ☐ Bring your records and medical history. ☐ Plan to discuss preventative measures.
After you enroll	☐ Review current coverage and any upcoming changes. ☐ Complete an annual Medicare coverage review. ☐ Look at other options to see if there is a better choice for your particular circumstances. ☐ Any changes must be made during the annual Medicare enrollment windows. ☐ Make sure your primary care physician reviews all of your medications.

[1] Medicare is also available for those under 65 who are receiving Social Security disability benefits or have End Stage Renal Disease. This material only addresses benefits for those who are 65 and older. For more information, see medicare.gov.

[2] Note that Massachusetts, Minnesota and Wisconsin standardize their policies differently.

[3] To avoid the premium, you or your spouse must have 40 or more quarters of Medicare-covered employment.

[4] If your income is above $85,000 individual or $170,000 married filing jointly, your premium will be higher than the standard monthly premium. The highest premiums apply if your income is above $214,000 individual or above $428,000 filing jointly. Your income is determined based on the most recent data available from the IRS (two years prior) and includes tax-exempt interest. If you experience a change in income you can file for an adjustment of the premium. (Source: SSA Publication No. 05-10536, ICN 470149, March 2014)

[5] Medicare Interactive, Section III.d. Changing Medicare Health Coverage.

[6] Medicare & You, Centers For Medicare & Medicaid Services, 2014.

[7] Medicare.gov, Retiree Insurance.

[8] If you work for a smaller employer (less than 20 employees), Medicare typically becomes primary and the employer-sponsored plan becomes secondary. For this reason it is critical to speak with your company's benefits representative.

This material should be regarded as general information on Medicare and is not intended to provide specific healthcare advice. If you have questions regarding your particular situation, please contact your legal or tax advisor.

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Be a part of the circle. In 2006, Potter Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment allows PRCMS to provide quality programs throughout the year, such as the Annual Meeting, Doctors Day, Resident Reception, Family Fall Festival, Retired Physicians Lunch and Women in Medicine. In return, these companies are invited to attend these events and discuss with the physicians the benefits that their companies offer a physicians practice.

We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of resources to assist the physician in the business of medicine so their practice of medicine can improve.

This program has proven to be a valuable resource of services such as liability insurance, accounting, banking and much more. This year, we hope to expand the Circle to include services the physician may use in his or her personal life. Through this program, we can invite businesses serving physicians to support the Society and increase their visibility among its members. Corporate support contributes to the Society's ability to advocate and care for physicians and patients in Potter and Randall Counties.

The Medical Society thanks all of its supporters as it offers new opportunities to its membership.If your business is interested in being a part of our Circle of Friends, please contact Cindy Barnard at 355-6854 or e-mail prcms@suddenlinkmail.com

MEASLES (RUBEOLA) (THE 9 DAY FEVER)

Why Measles?

Although endemic measles was declared eliminated from the US (i.e. indigenous disease transmission was interrupted), outbreaks continue to take place. The United States is experiencing a large multi-state measles outbreak that started in California in December 2014 and has spread to six additional states and Mexico.

The initial confirmed cases reported visiting Disneyland Resort Theme Parks in Orange County, CA, from December 17 through December 20, 2014. Through January 21, 2015, 51 confirmed cases of measles linked to this outbreak have been reported to CDC, 42 from California and 9 from six other states: UT, WA, OR, CO, NE, and AZ. No source case was identified.

Historically, measles, which remains untreatable, has killed millions of people across the globe.

What is Measles?

Measles is a viral illness that comes with fever, rash, and symptoms that include cough, runny nose, and pink eye. It usually presents in someone who has had contact with an infected person. Immunocompromised patients may deceivingly exhibit little or no rash. The average incubation period for measles (from exposure to fever) is about 10 days. The rash usually follows the onset of fever by 3 days and lasts about 6 days; hence the name 9 day fever.

The disease that may be self-limited can occasionally cause severe complications including brain involvement (encephalitis) and death.

Where did the name Measles come from?

The name of measles is probably derived from the Middle English "meseles" which describes the rash spots and, later on, after measles was well recognized, the word "measly" was derived, meaning small and inconsequential, perhaps as small as the rash spots. The virus that causes measles is called the rubeola virus.

How do I suspect Measles?

Suspect the measles when fever and rash emerge in a person who has recently come from an infected area or has been in contact with a person recently diagnosed with measles or rash.

How to diagnose Measles?

There is a blood test that is performed by the CDC laboratories to diagnose the disease. However, the appearance of rash after fever development is suggestive. The presence of Koplik spots, (small white spots in the inside of the cheeks) in this context is diagnostic.

How is Measles transmitted?

The transmission of the virus through infected respiratory secretions (saliva, sputum, and mucus) causes the disease. The mode of transmission is person to person through cough and sneezing particles, which then enter the body through the eyes, nose, and mouth. The virus can survive for 2 hours outside the human body suspended in the air; 90% of people close to the infected person become infected unless immune

How do doctors treat Measles?

There are no curative medications for the illness. Therefore, the treatment is largely supportive by giving nutrition, intravenous fluids, and antibiotics for any secondary bacterial infections that may develop.

How can I help prevent Measles?

Make sure that your children have received MMR (measles, mumps, rubella) vaccine among other scheduled vaccines. Persons who were born prior to 1957 are immune by virtue of having been exposed the disease in their childhood. However, younger individuals are at risk unless vaccinated. The vaccine is very effective in preventing the disease.

Practice hygiene prevention including careful hand washing and avoid contact with persons who have symptoms of disease.

Reported by Tarek Naguib, MD, MBA, FACP

Based in part on information from the CDC:

http://www.cdc.gov/measles/about/transmission.html

http://emergency.cdc.gov/han/han00376.asp

by Tarek Naguib, M.D., M.B.A., F.A.C.P.

Over 2 Drinks may Cause Stroke *Science Daily* (1/29) – Swedish researchers followed 11,644 twins for 43 years discovered that over 2 drinks daily of alcoholic beverages increases risk of stroke by a third in midlife (50-60 years old) compared with those who drank less than half a drink a day!

Brain Infections Need Better Recognition *JAMA Neurology* (2/8) - About 30% of patients with a suspected CNS infection never receive an etiological diagnosis. One-third of these patients die of the illness after prolonged hospital stays and extensive investigations. There is a need for prospective monitoring of the incidence and burden of CNS infections to include undiagnosed CNS infections.

$215 Million for Precision Medicine *Rare Disease Report* (1/30) – The White House budget will earmark funds for medical research including $130 Million for creating a data base of one-million volunteers by the NIH for better understanding of disease processes.

ED Doubles in Troops since 2004 *Army Times* (9/30/2014) – Erectile dysfunction has doubled in US military in the past decade from 5.8 per 1,000 person-years to 12.6 in 2013. This is nearly 3 times the incidence in the civilian population. Causes include post-traumatic stress disorder, depression, anxiety, injuries, and medications used to treat these conditions.

Pentagon Spent $504,816 on Viagra *Fox News* (2/7) – Department of Defense Spent over half a million dollars on the drug Viagra last year as a part of the drug benefits program.

VA Hospitals have Less MRSA *New York Times* (1/30) – The acquisition of methicillin-resistant staph aureus (a resistant staph infection commonly known as MRSA) in Veterans Hospitals is reported to have dropped by 68% between 2007 and 2012, more than the rest of the nation. Although exact cause is not known, the routine screening and isolation procedures in these hospitals may be the cause.

Veterans have more Arthritis *JAMA* (1/20) – Military veterans were found in a recent study to have more arthritis than their civilian counterparts. Interestingly, female veterans had much higher prevalence than male veterans (30% vs 25%, respectively).

CDC Advisory to Watch for MERS *US News & World Report* (1/30) – A new advisory for physicians to look for the Middle East Respiratory Syndrome (MERS) in patients with respiratory symptoms and history of travel or contact with travelers from the Arabian Peninsula.

Measles Outbreak in Disneyland – An outbreak of measles initially reported in visitors to Disneyland in California with excess of 50 cases diagnosed spanning 6 different states, in January 2015. While there are no drugs to treat measles, vaccination is very effective in the prevention for the disease

Persons Opting out from Vaccination *TMA Daily Headlines* (2/18) – Last year, 38,000 persons objected to vaccination in Texas for either personal or religious grounds.

Outbreak Bill! *The Texas Tribune* (2/11) – Senate Bill 538 proposes to grant health officials greater power to stop public transportation vehicles and detain individuals who may be infected, among other powers given to the governor to declare infectious disease emergency and stockpile gear and medications.

Sales of e-Cigarette to Minors *Dallas Morning News* (2/11) – Texas lawmakers appear to be ready to ban the sales of e-cigarettes to minors this session, in a bipartisan fashion. A debate may take place on whether a "sin tax" will also be added.

IUDs for Teenagers *TMA Daily Headlines* (2/11) – The American Academy of Pediatrics recommends intrauterine devices as most effective and least risky form of contraception in sexually active teens.

Latinos Have more Diabetes in US *JAMA* (1/20) – Latinos who are acculturated by US lifestyle develop a higher chance of acquiring diabetes mellitus, up to double that of the non-acculturated Latinos, in proportion to the acculturation level.

More ACA Enrollments *TMA Daily Headlines* (2/18) – The White House has announced that 11.4 million people had selected private health insurance plans or renewed their coverage under the Affordable Care Act in the enrollment period that ended Sunday 2/15/2015, exceeding the last year's enrollment.

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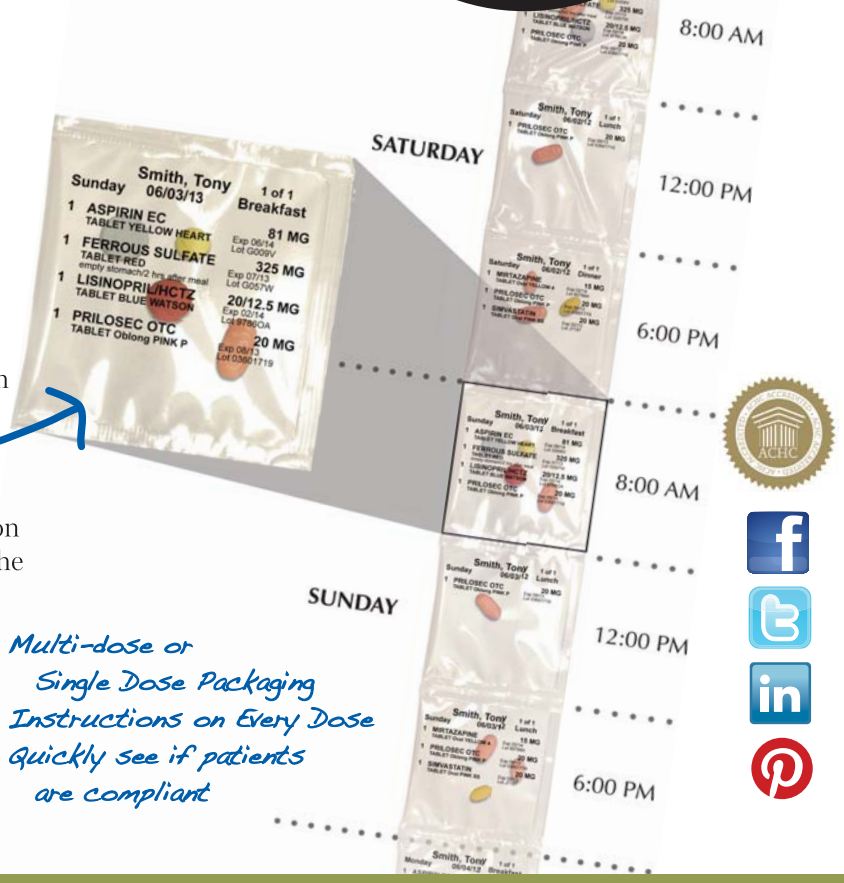

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*by Nibras Talibmamury MD, Mohammed A. Bahaa Aldeen MD, Omar Nadhem MD, Karima R. Ali MSIII, Abdelrazig Suliman MD, Rahul Chandra MD**

Introduction

We are presenting a case of an unusually large 17 centimeter bullous lesion, a form of drug induced bullous pemphigoid (BP), induced by a widely used drug: furosemide.

Bullous pemphigoid (BP) is an autoimmune blistering disease characterized by autoantibody deposition at the epithelial basement membrane zone. It most frequently affects elderly adults and classically presents with generalized pruritic, urticarial plaques and tense sub-epithelial blisters or bullae.

For the internist it is important to know about commonly used drugs which can cause this condition so that appropriate and timely therapy can be initiated.

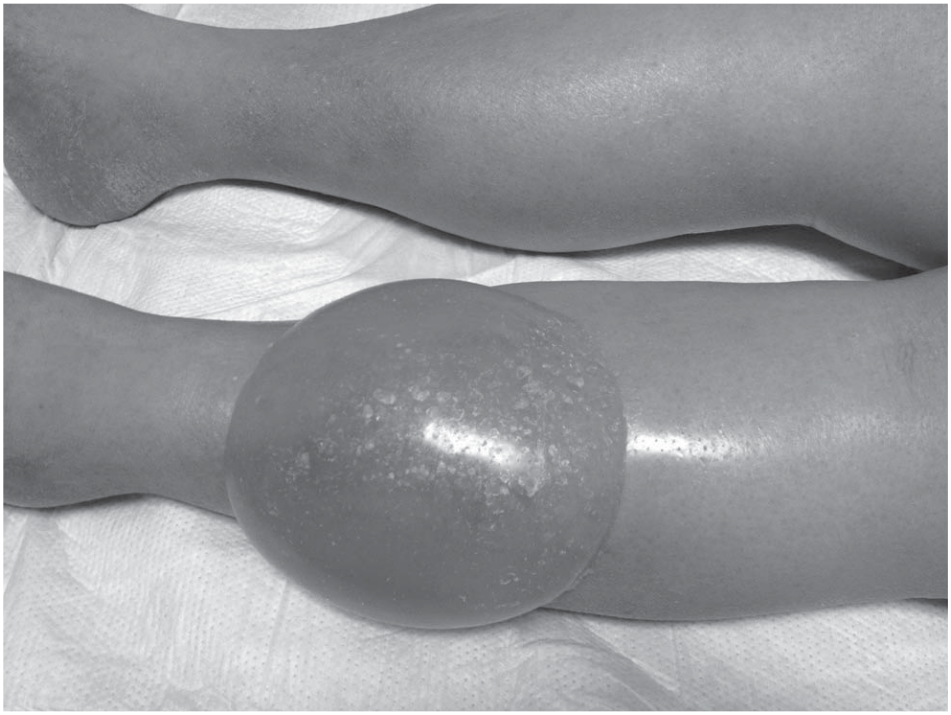

Figure 1 (bulla involving the mid left leg and it measured 17 x15 cm).

Case Report

A 63-year-old Caucasian female with past medical history of chronic obstructive pulmonary disease, hypertension, diabetes mellitus type 2, congestive heart failure, and hypothyroidism presented with a painless bulla on left lower extremity which started spontaneously without trauma. The lesion started as a quarter-sized blister which got bigger to reach 17 cm over 4 days duration. The blister was associated with mild redness around it. She had no fever or blisters anywhere else on her body, including her mucous membranes. No previously known allergies. The patient had been on furosemide less than a year and the dose was recently increased due the need to control heart failure. Other medications were aspirin, albuterol/ipratropium, carvedilol, levothyroxine, metformin, and omeprazole.

On examination the patient displayed normal vital signs with no fever. There was no lymphadenopathy. Chest auscultation revealed decreased air entry bilaterally with mild bibasilar crackles and end expiratory wheezes. Heart sounds were normal without murmurs, rubs or gallops. Abdominal and neurological exams were normal except for mildly decreased fine sensation.

The extremities revealed mild pitting edema bilaterally. However a huge bulla was noted emanating from anterolateral aspect of the left mid leg, measuring 17 x15 cm (Figure 1) and filled with clear fluid. There was mild erythema at the base of bulla but no signs of cellulitis in her legs. Peripheral pulses were palpable.

Laboratory data revealed WBC 11.5 K/µL, hemoglobin 15.6 g/dL, hematocrit 50%, and platelet count 234,000 and normal electrolytes. Serum creatinine was 0.7 mg/dL, blood sugar 138 mg/dL, calcium 8.3 mg/dL, albumin 2.8 g/L and BNP 1054 pg/mL. Chest radiograph revealed possible mild congestion and lower extremity doppler was negative for deep vein thrombosis.

Course of Hospitalization

The patient had two 5mm punch biopsies from the lesion and the peri-lesion areas. The histopathology confirmed the diagnosis of drug-induced bullous pemphigoid (BP) as evidenced by the presence of subepidermal bulla filled with eosinophils with necrotic keratinocytes in blister cavity.

| *continued on page 50*

A review of the medication list was performed to detect potential offending agents and review of literature was undertaken. Furosemide was found to be the most likely culprit and accordingly discontinued, and an oral prednisone regimen was initiated with good clinical response. A three-week follow up after discharge confirmed response with 90% resolution of the bulla without the development of any new blisters.

Discussion

Drug-induced BP is an acquired autoimmune disease characterized by sub-epidermal vesicles and bullae. BP commonly presents in older adults, usually about the age of 60 years, and clinically manifests with large tense bullous formation. It can be induced by variety of medications.

Sulfonamide and thiol containing compounds are particularly notorious for drug induced pemphigoid. Besides sulfonamide antibiotics, medications like furosemide and tolbutamide (that have a sulfa moiety) can cause this problem. Thiol containing compounds, including captopril, gold, penicillamine and antipsychotic flupentixol, were also reported to cause this condition.

The evaluation of patients with clinical findings suggestive of BP begins with obtaining skin or mucous membrane biopsy specimens from lesional tissue for hematoxylin and eosin and perilesional tissue for direct immunofluorescence (DIF). DIF is the gold standard for diagnosis and demonstrates characteristic basement membrane zone antibody localization in almost all patients with BP. Basement membrane localization is pathogenic and plays a major role in causing the separation of the entire epidermis from the dermis in BP. This localization also helps distinguish BP from other disorders like pemphigus, in which the localization is within the epithelium and not basement membrane.

Drug-induced BP can present as an acute or chronic form. The acute form commonly resolves after drug withdrawal, whereas the chronic form may sometimes assume all the characteristics of the typical autoimmune disease and may require protracted course of steroid therapy.

In conclusion, BP is a condition that is induced by furosemide, among other medications, and is usually manifested by blisters less than a few centimeters in size. We have not been able to identify a case that is similar to ours in the English language literature. Our case had a furosemide-induced 17-centimeter-wide BP lesion that responded well to oral steroids and withholding furosemide therapy. Clinicians should be aware of similar presentations in the elderly population.

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