Update on Transgender Care

ALSO INSIDE:

• Board of Directors Meeting Summary
Definition of **FIRST MESSENGER**: an extracellular substance (as the hormone epinephrine or the neurotransmitter serotonin) that binds to a cell-surface receptor and initiates intracellular activity - *Merriam Webster (www.m-w.com)*

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**First Messenger**, published by the American Association of Clinical Endocrinologists (AACE), is dedicated to promoting the art and science of clinical endocrinology for the improvement of patient care and public health. Designed as an aid to AACE members, First Messenger includes current information and opinions on subjects related to endocrine practice. The information in this publication does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice may be appropriate.

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AACE is a professional medical organization with more than 6,000 members in the United States and more than 90 other countries. Founded in 1991, AACE is dedicated to the optimal care of patients with endocrine problems. AACE initiatives inform the public about endocrine disorders. AACE also conducts continuing education programs for clinical endocrinologists, physicians whose advanced, specialized training enables them to be experts in the care of endocrine diseases such as diabetes, thyroid disorders, growth hormone deficiency, osteoporosis, cholesterol disorders, hypertension and obesity.

ACE is a scientific and charitable medical organization dedicated to promoting the art and science of clinical endocrinology for the improvement of patient care and public health.
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There is no shortage of information in this issue. Dr. Lefert’s note to the membership gives us an overview of AACE activities, many of which are explored in detail in this issue. We have updates on the last board of directors meeting, including AACEPAC, committee initiatives, task force guidelines, a special memorial resolution for Mr. Don Jones, and other noteworthy efforts.

A special feature included in this issue is a summary of the recent papers published on transgender medicine. The revised clinical practice guidelines were published in *Journal of Clinical Endocrinology and Metabolism* (JCEM) and *Endocrine Practice* (EP). Whether or not you are actively treating this very special group of patients, it is worthwhile to review this article to help understand the complexity of this burgeoning aspect of medical practice.

The Key Contact Corner highlights the efforts of the Carolinas-AACE Chapter and their AACE advocacy. The Lone Star state of Texas proudly boasts of two Congressional recipients of the Eugene T. Davidson, MD, Public Service Award, Representatives Kevin Brady and Gene Green. And while we are in Texas, Dr. Susan Samson, from Baylor Medical Center in Houston and a current board member is in our Member Spotlight feature.

Read about the update for Medicare’s rules for year 2 on the Quality Payment Program, along with new and updated codes for continuous glucose monitoring (CGM) for 2018.

We introduce two of our newest staff members, Ms. Robin Shelly, CMO, and Ms. Sharyn Lee, CLO. They will bring a wealth of skills to help move AACE forward with public and media relations and AACE’s education initiatives, respectively.

Our Committee Feature explores the MAVEN Project, with an interview with Dr. Lisa Bard Levine, CEO of the MAVEN Project. The Second Messenger, written by Dr. Jad Sfeir, is replete with helpful information for our newest members of the endocrine profession and includes a special case for your consideration. I have encouraged inclusion of interesting cases in this column, from time to time, and welcome your input.

The 27th AACE Annual Scientific & Clinical Congress will be held in Boston, May 16-20. I am pleased to report we have an exciting agenda for all the membership, and look forward to seeing you there.

Future issues of *First Messenger* will continue to educate and empower our members with the information you need to know to help manage your professional commitments.

Warm regards,

Victor Lawrence Roberts, MD, MBA, FACP, FACE
Endocrinology in 2018: What Can AACE Do to Improve Our Daily Practice Life?

As most of you know, my day job is a clinical endocrinologist in a two-person group practice in Dallas. I’ve been in practice for 27 years, so I’ve taken care of a significant number of patients with diabetes, thyroid disorders, osteoporosis and calcium disorders, adrenal abnormalities and pituitary dysfunction, but I’m always learning about my patients and their diseases, so I am continuously confronted with exploring the literature for information. Educating myself is a constant for me, but the methodology for doing so has changed significantly over the last 27 years and AACE is about to expand our capability to obtain information even further.

At the meeting in October, the Board of Directors approved a major digital strategy project to increase our capabilities to educate AACE members. Our immediate goals will be to interact more efficiently with members through our website and to provide educational content that is available on-demand through our new digital infrastructure. The rollout of the digital strategy will be over the next three years with much of the educational information becoming available in late 2018 and early 2019. By committing the resources necessary to achieve this digital solution, AACE will be able to bring our high-quality clinical educational content to our membership through state-of-the-art technology.

The daily practice of endocrinology requires increasing responsibility for any number of activities other than seeing patients. Depending on your practice situation, you are confronted by prior authorizations, achieving your RVUs, teaching requirements, supervising staff and insurance company denials for necessary procedures, labs or imaging. This list is long but not exhaustive, and I know that practicing endocrinologists are confronted with many other issues. AACE is committed to work with insurance companies and Medicare to decrease these daily burdens, and AACE Treasurer, Dr. Howard Lando, has engaged both commercial insurance companies and Medicare in this regard. We are looking at pilot projects with insurance companies to test the concept that certain medications and tests ordered by endocrinology practices may not require prior authorizations in the future.

If you are in the Medicare program like myself and most other physicians, you most likely just finished your first-year reporting for the Quality Payment Program. If you are in a large group, academic center, or hospital practice, the details of the collecting and reporting of the data may be invisible to you, but still very important. Medicare has adopted a value-based contracting philosophy requiring quality measures to differentiate a level of incentive-based payment. This payment philosophy will be applied to all physicians in the Medicare program, so practices that are reporting on quality measures will receive incentive payments and those that are not will receive penalties in their Medicare reimbursement. AACE has actively participated in the process, under the leadership of our Secretary, Dr. Felice Caldarella, by presenting an innovative payment model for diabetes to Medicare, and by educating the membership through webinars and print materials. Our efforts in value-based contracting will continue by developing more quality measures in areas of endocrinology currently not represented, such as thyroid and osteoporosis.

Over the next several months, we will be preparing for the 27th AACE Annual Scientific & Clinical Congress, May 16-20, at the Hynes Convention Center in Boston. Our program has been developed carefully under the leadership of Dr. Vin Tangpricha and the Annual Program Committee to include just the right amount of translational and clinical endocrinology in a variety of different formats. Boston is a great venue for a meeting with a lot to offer in the areas of culture, history, cuisine and sports. I encourage you to bring your families as my wife, Carla, has developed outstanding daily programming with tours to the Kennedy Presidential Library, Boston Museum of Fine Arts, and the Grande Dame of baseball, Fenway Park. So as the songwriter Dave Loggins wrote in the first line of his classic song from 1974, “Please come to Boston for the Springtime.” I look forward to seeing you there.
SUMMARY OF ACTIONS

The following is a summary of major actions taken by the Board of Directors at its meeting on October 28:

EXECUTIVE COMMITTEE


Data Registry Business Plan and Assessment: The Board postponed pursuit of clinical data registry opportunities at this time, to be reassessed at the fall 2019 Board meeting.

AACEPAC

Appointment of AACEPAC Officers and Board of Directors: The Board approved appointment of the slate of candidates nominated to serve as Officers and Board of Directors of the American Association of Clinical Endocrinologists Political Action Committee (AACEPAC) beginning January 2018, as follows:

OFFICERS:
Dr. Raymond Fink, Chair
Dr. Gregory E. Peterson, Vice Chair
Dr. Elizabeth Holt, Secretary
Dr. John Stokes, Treasurer
Mr. Paul A. Markowski, Assistant Treasurer

BOARD OF DIRECTORS:
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Dr. Kim Pugh
Dr. Annaswamy Raji
Dr. Donald Richardson
Dr. Orlin Sergev
Dr. William Sullivan
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AWARDS COMMITTEE

AACE Frontiers in Science Award: The Board approved the selection of Sundeep Khosla, MD, as the recipient for the 2018 AACE Frontiers in Science Award to be presented during the 27th AACE Annual Scientific & Clinical Congress in Boston, MA.

This award is presented to an individual who has demonstrated exemplary contributions to their individual profession or area of expertise.

AACE H. Jack Baskin, MD, Endocrine Teaching Award: The Board approved the selection of Hossein Gharib, MD, MACP, MACE, as the recipient of the 2018 AACE H. Jack Baskin, MD, Endocrine Teaching Award to be presented during the 27th Annual Scientific & Clinical Congress in Boston, MA.

This award is presented to an AACE member in good standing who has made a profound impact in teaching and is actively involved in teaching in academic centers or otherwise. AACE membership required.

AACE Outstanding Corporate Partner Award: The Board approved the selection of Amgen as the recipient of the 2018 Outstanding Corporate Partner Award to be presented during the 27th AACE Annual Scientific & Clinical Congress in Boston, MA.

This award is presented to an industry partner who is a member of the Corporate AACE Partnership (CAP) and has demonstrated outstanding commitment and dedication to AACE through significant contributions that allow AACE to conduct various programs and initiatives to promote the future of endocrinology. CAP membership required. Selection based on level of giving to AACE and related entities.

LEGISLATIVE AND REGULATORY COMMITTEE

Medical Liability Reform: The Board adopted the proposed basic principles on medical liability reform, as amended:

AACE Basic Principles on Medical Liability Reform

1. It is the policy of AACE that effective medical liability reform, based, in part, on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. AACE-supported federal tort reform provisions include: (a) a $250,000 ceiling on noneconomic damages; (b) the offset of collateral sources of plaintiff compensation; (c) decreasing incremental or sliding scale attorney contingency fees; (d) periodic payment of future awards of damages; (e) making each party liable only for the amount of damages directly proportional to such party’s percentage of responsibility; and, (f) setting a statute of limitations of 3 years after the proof of injury date or 1 year after the claimant discovers the injury, whichever comes first, with certain exceptions:

(1) upon proof of fraud;
2. AACE also supports state and federal reform to establish: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms.

3. AACE supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective.

4. Federal preemptive legislation that endangers effective state-based reform will be actively opposed by AACE.

5. AACE supports federal and state legislation to provide that in any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

MACRA Corrections Bill: The Board adopted a position of support for legislation that modifies specific provisions of the Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act (MACRA), to provide flexibility during the program implementation as physicians become accustomed to the reporting requirements.

H.R. 3271 Protecting Access to Diabetes Testing Supplies: The Board adopted a position of support for H.R. 3271, Protecting Access to Diabetes Testing Supplies, as well as the soon to be introduced Senate companion bill.


NOMINATING COMMITTEE

2018 Selection of Independent Auditing Firm for Elections: In accordance with the AACE Bylaws, the Board approved the selection of Survey & Ballots, Inc., of Eden Prairie, Minnesota, to serve as the independent auditing firm for the 2018 elections to conduct, tabulate, and certify the results of the election. AACE will conduct a partial hybrid election process whereby domestic and international members with an email address eligible to vote will receive an electronic ballot only provided, however, they may receive a paper ballot upon request. Those members without an email address will receive a ballot.

AACE 2018 Elections Timeline: The Committee issued a call for nominations on October 2, 2017, to the entire membership and has received a large number of excellent nominations. The Committee will meet on November 27 to begin deliberations on a recommended slate of candidates for election to the Board.

As provided in the Bylaws, a preliminary slate of candidates was sent to the membership in January 2018 and the official ballot in March 2018.

TASK FORCE RE: THE PROPOSED THYROID NODULES GUIDELINES UPDATE

Update the 2016 AACE/META/ETA Medical Guidelines for Clinical Practice for the Diagnosis and Management of Thyroid Nodules for 2018: The Board approved the request to update the 2016 AACE/META/ETA Medical Guidelines for Clinical Practice for the Diagnosis and Management of Thyroid Nodules for 2018.

AMERICAN MEDICAL ASSOCIATION

AMA Interim Meeting: The AMA House of Delegates held its Interim Meeting on November 11-14, 2017, at the Hilton Hawaiian Village Waikiki Beach Resort. AACE was represented at the meeting by Dr. Kathleen Figaro, AMA Young Physicians Section (YPS) Delegate, who also served as the AACE Delegate at the Interim Meeting.

Memorial Resolution for Mr. Jones – AACE sponsored a memorial resolution recognizing the contributions and achievements of former AACE CEO, Donald Jones.

AACE Resolution on Insulin Costs

AACE introduced a resolution in the HOD, co-sponsored by the Endocrine Society, requesting that the AMA convene a summit to identify potential solutions to the dramatic increase in insulin costs and advocate for initiatives that will reduce patient cost-sharing for insulins, stabilize drug formularies throughout a plan year to reduce nonmedical switching of insulin products, facilitate greater transparency of insulin pricing and integrate drug formularies into electronic health records.

Due to impassioned and effective lobbying from Dr. Figaro to overcome concerns that the AMA should take a general approach to drug pricing and not single out a specific drug such as insulin, the House of Delegates overwhelmingly voted in favor of an amendment offered by AACE directing the AMA to study these issues and provide a report with findings and recommendations to the HOD at the 2018 Annual Meeting in June.
AACE and other cosponsoring organizations recently co-published revised guidelines with Endocrine Society entitled, “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” which is available in Journal of Clinical Endocrinology and Metabolism (JCEM) and the December 2017 issue of Endocrine Practice. (1)

Transgender medicine is an emerging field for both primary care and endocrinology. The revised guidelines come at a time when transgender individuals are receiving more media attention and seeking more healthcare services. It is imperative that endocrinologists and other healthcare providers know how to properly care for this population with a unique set of medical needs.

The first difference you will notice from the 2009 guidelines is the title. The term “transsexual persons” has been replaced with more encompassing terms of gender-dysphoria (GD) and gender-incongruent (GI); this is in line with current American Psychiatric Association terminology. The authors of the revised guidelines also foreshadow that ICD-11 may code with the term “gender incongruence” when it is released.

As a practitioner, even if you are not prescribing hormones you most likely have transgender patients whether you know it or not. The prevalence of transgender individuals varies by study, and a recent Massachusetts survey found a prevalence of around 0.5 percent or 1 in 200 people (2). In a full practice of seeing 20 patients per day, a practitioner is likely to have one transgender patient every two weeks. Avoiding outdated terms and addressing patients with their preferred pronouns can facilitate building trust within the doctor-patient relationship. The 2017 guidelines provides a glossary of terms and are summarized in Table 1. It is important that this knowledge extends beyond the physician to the clinical staff and billing and coding specialists as reimbursement for transgender care varies by region.

The guidelines remain consistent that the goals of hormone therapy are twofold: 1) decrease the endogenous hormone production...
that is incongruent with the person’s identified gender, and 2) target hormone levels within range of the identified gender such as you would target therapy for a hypogonadal adult.

The conclusion of the 2017 guidelines removes strong wording that a mental health provider “must” approve treatment, and instead recommends that any clinician comfortable evaluating psychopathology and understands the criteria for treatment may recommend hormone therapy. This model seems to widen the practice of hormone therapy for primary care providers as part of a multidisciplinary team.

In addition, the 2017 guidelines expand upon pediatric and adolescent care. Readers are likely providing care to adults but it is important to point out the age restriction modifications. The age restriction of 16 as the earliest age for starting cross-gender hormone therapy (CGHT) has been removed and replaced with a broader recommendation for CGHT when the teen has “sufficient mental capacity” and the decision should be made with an expert multidisciplinary team.

High quality evidence-based studies in transgender health are lagging compared to other endocrine subspecialties. The guidelines offer expert opinion where data is lacking, and the update lacks any recommendations with high quality evidence and grades these recommendations as a mixture of very-low, low or moderate quality evidence. Most of the very-low quality evidence related to gender-affirming surgery. The strongest evidence is available relates to the physician’s responsibility prior to initiating CGHT. There was moderate quality evidence for recommending physicians first confirm the correct diagnosis of GD/GI, assess eligibility for CGHT, address medical issues beforehand that could be altered by CGHT and discuss fertility preservation prior to CGHT as there is a paucity of data in this field.

Recommendations for screenings such as breast cancer and prostate cancer in either transgender people is extrapolated from cis-gendered persons. Evidence-based studies are lacking to inform providers of how screening for certain cancers should be modified as transgender patients have a reduced risk of certain cancers such as breast cancer in trans-men.

Some clinicians are uncomfortable or intimidated by this field. Part of this may stem from the fact that the average endocrinologist in the U. S. cares for a small number of transgender patients. (3) A multidisciplinary team of an endocrinologist or primary care physician plus mental health providers and surgeons is beneficial to patient care. Overall, mental well-being can improve with initiation of CGHT. The timing of physical changes varies for each parameter and for each patient but a general expectation is found in the guidelines. The guidelines provide eligibility, hormone dose ranges and recommendations for monitoring. These are summarized here but not intended to replace the intricacies of the guidelines.

Cross-Gender Hormone Therapy 101 Steps

1. Before starting treatment, confirm the diagnosis of gender dysphoria and eligibility for hormone use:
   a. DSM-V and ICD-10 provide criteria for diagnosis although during of symptoms vary
   b. Only World Professional Association for Transgender Health (WPATH) includes eligibility

2. Counsel regarding the impact of hormone therapy on fertility:
   a. Long-term estrogen therapy reduces spermatogenesis, which may partially recover when estrogen is stopped. Transgender men may become pregnant after testosterone therapy cessation

3. Optimize medical conditions that may be affected by hormone therapy:
   a. Table 10 of the 2017 guidelines outlines moderate to very high-risk conditions to consider
   b. In-depth discussion for those with relative contraindications such as tobacco use, diabetes, cardiovascular disease, liver disease

4. Start hormone therapy
   a. Table 11 of the 2017 guidelines provides information options and dose ranges

5. Monitor hormone levels and other parameters affected by CGHT. The goal is for hormone levels in the normal physiologic range of the desired gender:
   a. Table 14 and 15 of the 2017 guidelines
   b. Screening q3 months the 1st year, then 1-2x/year
      i. Transgender women
         1. Serum estradiol <200-300
         2. Serum testosterone <50 ng/dL
         3. Serum electrolytes, mainly potassium for those on spironolactone
   c. Transgender men:
      i. Serum testosterone 320-1000 ng/dL
      ii. CBC (Hct <50%)

6. Assess for eligibility of gender-affirming surgery for those interested
   a. Table 16 of the 2017 guidelines

FAQs

How do I decide which form of testosterone or estrogen to prescribe?

Clinicians should discuss with their patients the advantages and disadvantages of the various formulations including route of administration, frequency of administration and cost. For example, for patients without insurance coverage for transgender care, IM
As a founding chapter of the American Association of Clinical Endocrinologists, the Carolinas Chapter has always been committed to both the national and local needs of its members. Now is no different with development of a Chapter Legislative/Practice Management Committee.

**Why be involved?**

*All Politics Are Local:* The most effective advocacy is done locally. With assistance from national AACE, the local chapter committee can help direct and strengthen local grassroots advocacy activities to enhance our influence with policymakers.

*Power in Numbers:* A chapter committee provides a forum for mobilizing support to address state and local legislative and practice management issues affecting our practices and our patients.

*Sentinel Voice:* A chapter committee provides a mechanism to alert national AACE about state and local legislative and practice management issues on which national AACE should be engaged or may be able to help. It is important to ensure AACE is addressing the needs of its members.

At the Carolinas Chapter Annual Meeting last August, a question came up - “How can I make a difference?” The answer: Volunteer as a Chapter Legislative/Practice Management Committee member. And volunteer they did!

The Carolinas Chapter Legislative/Practice Management Committee has been established with the following volunteers:

- Dr. Donald Eagerton, Myrtle Beach, SC
- Dr. Elizabeth Holt, Raleigh, NC
- Dr. Augustine Obi, Mooresville, NC
- Dr. Alfred Okeke, Goldsboro, NC
- Dr. Raymond Stadiem, Charlotte, NC
- Dr. Michael Thomas, Raleigh, NC
- Dr. Sandra Weber, Greenville, SC

During the Chapter’s first committee conference call, we focused on actionable items. Our first goal is to make sure that each North and South Carolina’s U.S. Representative and U.S. Senator has at least one chapter member assigned as an AACE Key Contact. Alysia Perry, AACE Manager of Grassroots Activities, constructed a spreadsheet of our chapter members by congressional district based on their home address in the AACE database, which allowed us to see those representatives who do not currently have an AACE liaison but do have at least one AACE member residing in their district. It was agreed to contact several members to ask them to become Key Contacts. (This activity is just one reminder why it is so important to keep your contact information updated with AACE and why you can indicate both a work and home address in the system.) The AACE Key Contact Program needs the support of all the domestic chapter members in order to be effective.

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**Are You Participating in AACE Programs? Check Out Your AMP Accruals!**

Check your AMP online at [WWW.AACE.COM/MEMBERSHIP/AMP](http://WWW.AACE.COM/MEMBERSHIP/AMP) and participate in AACE programs to earn more.
The Committee reiterated the need to increase our Chapter’s participation in AACEPAC. The AACEPAC Board has a goal of securing AACEPAC participation by 20 percent of the AACE domestic membership. Of the almost 200 AACE members in the Carolinas-AACE Chapter, 23 members participated during the 2017 AACEPAC cycle. And yet, that’s already more than 11 percent of the chapter membership. It takes a few to quickly add up to many, and the most important factor is to be involved and not how much you contribute.

We reviewed the Merit-based Incentive Payment System (MIPS) and a possible endocrine registry, discussing 2017 and upcoming 2018 reporting requirements. Some key points were reviewed and we were reminded that all AACE members can contact the AACE Practice Management Department with questions on the Medicare Access and CHIP Reauthorization Act (MACRA) at MACRAinfo@aace.com and that a MACRA toolkit is available on the AACE.com website. We arranged for a letter to be sent to each Carolinas-AACE Chapter member with highlights of MIPS, MACRA and the available AACE resources.

Finally, we had the opportunity to discuss specific practice management issues of concern to individual Chapter members and received feedback from Michelle Cobb-King, AACE Director of Practice Management and Member Advocacy, who joined us on the call.

We are off to a great start with quarterly teleconferences planned and we strongly encourage our colleagues in the other AACE chapters to consider participating in their local legislative/practice management committee. Reach out to your designated chapter committee contact or your chapter president to inquire about joining today.

For more information about the AACE Key Contact Program, AACEPAC and other advocacy issues, please visit https://www.aace.com/advocacy/leg.

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Twice as Resourceful
AACE’s Resource Centers

AACE continues to create and provide tools and resources to help members facilitate care management in endocrine diseases states. The AACE Diabetes Resource Center and the AACE Obesity Resource Center are chock-full of the pertinent information including slides, publications, and other resources. Please click on the respective images below for more information.
Together We Can Make a Difference!

2017 AACEPAC HONOR ROLL

We would like to thank the 369 members listed below and recognize their commitment to AACE advocacy activities through their support for the AACE Political Action Committee (AACEPAC) in 2017. Every member contribution helps to expand AACE’s influence on Capitol Hill by enabling AACEPAC to support candidates who support us! For more information about AACEPAC, visit https://www.aace.com/advocacy/leg/AACEPAC or contact Alysia Perry at aperry@aace.com.
2017 AACEPAC HONOR ROLL

AACEPAC MEMBER
($50+)

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Dr. Kelly R. Aguilar
Dr. Bijan Ahari
Dr. Moussa Alhaj
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Dr. Rahta K. Zerikly
Dr. Alexander D. Zwart
Dr. Carlos Hamilton, Past President of AACE, presented the 2017 Eugene Davidson, MD, Public Service Award to Representative Kevin Brady who represents the 8th Congressional District in Texas. Representative Brady was chosen as one of two recipients of this award because of his strong support for AACE legislative priorities and distinguished service in the U.S. House of Representatives. Representative Brady was unable to receive the award at the 2017 AACE Annual Meeting in Austin; therefore, Dr. Hamilton, a fellow Texan, presented the award at an event in Houston, Texas last October. The other recipient of the 2017 Public Service Award is Representative Gene Green (D-29th-TX), who was presented the award during the 2017 AACE Spring Congressional Visitation trip in Washington, DC.

Representative Brady is Chairman of the House Ways and Means Committee, one of the most powerful committees in Congress with jurisdiction over health care, Medicare, Social Security, taxes, international trade and welfare. Representative Brady previously served as Chairman of the Ways & Means Health Subcommittee, where he focused on repealing and replacing the flawed Medicare Sustainable Growth Rate (SGR) physician payment formula.

Representative Brady was a strong advocate for passage of AACE’s diabetes legislation, the National Clinical Care Commission Act, and had urged the House Majority Leader to schedule a House floor vote on the legislation as soon as Congress returned following the 2016 elections. On November 14, 2016, the legislation passed the House of Representatives but was not taken up by the Senate before the 114th Congress adjourned.

House passage of the bill at the end of 2016 facilitated quick passage of the re-introduced bill by the House of Representatives early in the 115th Congress, leading to subsequent passage by the Senate and the National Clinical Care Commission Act being signed into law on November 2, 2017.

In his role as Chairman of the Ways & Means Committee in the current 115th Congress, Representative Brady has been instrumental in efforts to repeal and replace the Affordable Care Act and oversee the implementation of the new Medicare Access and CHIP Reauthorization Act (MACRA).

Representative Brady is serving his 11th term in the U.S. House of Representatives. Prior to his election to Congress, Representative Brady worked as a chamber of commerce executive for 18 years and served six years in the Texas House of Representatives where he was named one of the 10 Best Legislators for Families & Children.

Representative Brady has been a champion for physicians and has supported AACE legislative priorities, including his instrumental role in the advancement of the National Clinical Care Commission Act. AACE was pleased to award the Public Service Award to Representative Brady in recognition of his outstanding work on behalf of physicians and patients. AACE looks forward to continuing to work closely with Representative Brady on those issues most important to clinical endocrinologists and the patients we serve. -FM

AACE/ACE 2018 Comprehensive Type 2 Diabetes (T2D) Management Algorithm Now Available Online

The eagerly anticipated AACE/ACE 2018 Comprehensive Type 2 Diabetes (T2D) Management Algorithm, the latest in comprehensive, evidence-based recommendations for the treatment of T2D is now available for viewing online at www.aace.com/publications/algorithm.
Medicare's Physician Compare: How to Update Your Listing

Physician Compare helps patients find and compare physicians and other clinicians enrolled in Medicare so they can make informed decisions about their health care. To update your listing, including general information such as practice location and phone number, visit the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) on the PECOS section of the CMS website, https://pecos.cms.hhs.gov. It can take up to two to four months for changes in PECOS to be reflected on Physician Compare.

To learn more about which information can be updated via PECOS and which data can be updated by contacting the Physician Compare support team, visit the CMS website at https://www.cms.gov/Medicare/Medicare.html. Under the category “Quality Initiatives/Patient Assessment Instruments,” you will find the link to “Physician Compare Initiative.” If you have questions, contact PhysicianCompare@Westat.com. -FM

New Quality Payment Program 2017


Learn about:

- Base, performance, and bonus score reporting requirements
- Two measure sets available for the 2017 transition year that vary depending on the edition of Certified Electronic Health Record Technology
- Scoring and re-weighting methodology

TOTAL ACCESS gets you direct access to practice management experts, no matter where you are located.

PMI’s TOTAL ACCESS offers:

- Live Weekly Webinars where you can ask specific questions and get direct answers on a variety of current topics important to your practice
- 24-hour access to the TOTAL ACCESS Audio Library with more than 200 hours of pre-recorded training sessions. Choose from 100+ topics targeted topics
- A fast way to bring both experienced and new staff up-to-speed on current issues
- Include your physician to learn about important coding, billing, compliance and operational updates
- Inexpensive, convenient way to develop your own talent without leaving the office to attend training classes
- Use your office’s speakerphone so that multiple staff can participate

AACE members and their staff receive a 10% discount*

*To Receive Discount Register with Promotional Code: AACE10
Medicare Finalizes the Rules for Year 2 of the Quality Payment Program

Felice A. Caldarella, MD, FACP, CDE, FACE • AACE Secretary • Chair, Payment Model Subcommittee (formerly Task force on the Implications of the MACRA Law)

As most all of you know by now, the Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a quality payment incentive program for physicians, nurse practitioners, physician assistants, and clinical nurse specialists and certified registered nurse anesthetists, designed to reward value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). This is the second reporting year for this program and activities performed in 2018 will affect a physician’s Medicare payments in 2020 — 5 percent of a physician’s Medicare payments in 2020 will be at risk, an increase of 1 percent from the 2019 payment year (based on the 2017 performance year).

The Centers for Medicare and Medicaid Services (CMS) recently published the final rule for Year 2 of the Quality Payment Program, which includes increasing some of the requirements to avoid the 5 percent penalty, while still providing a transition to allow physicians to prepare for Year 3 when the MACRA law requires full implementation.

Specific Changes for Year 2 That Are Important to Note:

- Increase in Low-Volume Threshold for Program Exemption - Excludes individual MIPS-eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries.

- Increase in Performance Threshold - Raises the performance threshold to avoid the 5 percent penalty to 15 points in Year 2 (from 3 points in the transition year achieved by reporting one measure or one clinical improvement activity).

- New Bonus Points for Treating Complex Patients - Provides up to five bonus points on your final score for treatment of complex patients.

- New Bonus Points for Small Practices - Adds five bonus points to the final scores of small practices, defined as 15 or fewer participating clinicians, including physicians, nurse practitioners, physician assistants, clinical nurse specialists and certified registered nurse anesthetists.

- New Virtual Group Reporting - Gives solo practitioners and small practices the choice to form or join a Virtual Group to participate with other practices.

  - Virtual Groups can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS. The deadline to elect to participate as part of a virtual group in 2018 is December 31, 2017.

- Quality Measure Reporting - Continues to award small practices three points for measures in the Quality performance category that don’t meet data completeness requirements. All other practices will only receive 1 point. Also increases the data completeness standard from 50 percent in 2017 reporting to 60 percent for 2018 reporting.

- Factoring Your Costs in Your Performance Score - Weights the MIPS Cost performance category as 10 percent of your total MIPS final score. (In 2017 your costs were not included in your MIPS score.)

  - CMS is using the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate a clinicians Cost performance category score for the 2018 MIPS performance period.

- Public Reporting of Physician Performance - Continues a phased approach to reporting Quality Payment Program performance information on the Physician Compare website.

Year 2 of the Quality Payment Program also brings changes to the reporting/performance periods and the performance category weighting of the final score.

Continued on page 32
New and Updated Codes for Continuous Glucose Monitoring (CGM) in 2018

Endocrinologists who manage patients with diabetes are familiar with CPT codes 95250 and 95251, and January 1, 2018 brought about changes to the descriptions of these codes as well as the addition of a new code by the AMA.

The new CGM CPT introduced is code 95249. The official description for the code is:

**Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.**

According to the 2018 CPT book, CPT code 95249 requires the patient to bring the data receiver into the physician or other qualified healthcare professional’s office where the entire initial data collection process is performed. When following CPT guidelines, all elements described in the CPT code description must be performed to appropriately report the code to insurance carriers, therefore the correct date of service for CPT code 95249 is the date that the CGM recording is printed in the office. CPT guidelines indicate code 95249 can only be reported one time per month and should not be reported in conjunction with CPT code 99091 and/or 0446T. If a separate and significant evaluation and management (E/M) service is performed on the same date, a modifier 25 may be required to be added to the E/M code.

The 2018 updated description for CPT code 95250 is:

**Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.**

When physicians or other qualified healthcare professionals perform an analysis, interpretation and report on a minimum of 72 hours of CGM data, CPT code 95250 is reported to insurance carriers. The analysis, interpretation and report may be done with data from a physician or other qualified healthcare provider provided CGM device or a patient provided CGM device. The analysis, interpretation and report are separate and distinct from an evaluation and management service. The CPT description of 95250 does not include an assessment of the patient or indicate a plan of care for the patient. The CPT code for 95250 can only be reported one time per month and should not be reported in conjunction with CPT code 99091 and/or 0446T. If a separate and significant evaluation and management (E/M) service is performed on the same date, a modifier 25 may be required to be added to the E/M code.

The 2018 updated description for CPT code 95251 is:

**Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.**

When physicians or other qualified healthcare professionals perform an analysis, interpretation and report on a minimum of 72 hours of CGM data, CPT code 95251 is reported to insurance carriers. The analysis, interpretation and report may be done with data from a physician or other qualified healthcare provider provided CGM device or a patient provided CGM device. The analysis, interpretation and report are separate and distinct from an evaluation and management service. The CPT code for 95251 indicates an analysis, interpretation and report of a minimum of 72 hours of data collected from a CGM device. An appropriate CGM analysis, interpretation and report should include the following elements:

- Patient’s name
- Date of birth
- Medical Record #
- Indication for the device placement
- Name/Type of device placed
- Sensor placement date / / Sensor removal date / /
- Date of printout of data (which would be the date of service for 95250/95249 to be reported)
- Analysis of data
- Interpretation of data
- Signature of interpreting physician or other qualified healthcare professional

If you have additional coding or billing questions, please send an email to AACE at Endocoding@aace.com.

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Meet AACE's Newest Staff Members

Robin Shelly
Chief Marketing Officer

Robin Shelly is AACE’s Chief Marketing Officer. Robin comes to us with a wealth of association management, health care industry, and executive management experience. She most recently worked as an Innovation Consultant with GuideWell/Florida Blue/BCBS Florida where she led efforts with internal and external physicians to research and implement new innovative health solutions. Robin’s background in marketing and strategic messaging allows her to focus these efforts through multi-channel marketing campaigns. Prior to her experience there, Robin was the Marketing Director for JAX Regional Chamber of Commerce, Marketing Manager for FCC Equipment Financing, and VP of Product Development and Market Research with Merrill Lynch Credit Corporation. Robin has her BBA and MBA from George Washington University and has professional certifications in Project Management, Six Sigma (Green Belt) and Change Management. Robin oversees Public & Media Relations, Publications, Graphics and Membership.

Sharyn Lee
Chief Learning Officer

Sharyn Lee is AACE’s Chief Learning Officer. Sharyn has significant experience in the health care arena with a focus on patient care. Sharyn is one of the most preeminent voices in medical education and is the author of more than 30 publications in healthcare. Prior to Sharyn’s consulting work, she was the founder and president of the Medical Education Broadcast Network, an award winning accredited CME company. Sharyn has specific educational content development experience within the field of endocrinology, including winning the bid to write an 80-hour curriculum for Johnson & Johnson’s Diabetes Institute and being the Senior Clinic Manager for the multidisciplinary obesity program division of NE Deaconess Hospital. Sharyn’s experience also includes being a clinical nurse in the ICU and a faculty member in nursing education. Sharyn’s formal education includes a BS, Nursing and a MS, Management, and she was also awarded a Doctor of Humane Letters from Fitchburg State University. She oversees CME and Grants and Guidelines and will be responsible for developing and leading AACE’s education strategy for the future.
It has been well documented how music can improve the mood and even the outcomes of some patients from infants to seniors – something AACE Board Member Dr. Susan Samson knows all too well.

The musically-inclined, Houston, Texas-based endocrinologist, who serves as Associate Professor, Division of Endocrinology, Diabetes and Metabolism, Departments of Medicine and Neurosurgery, as well as Medical Director of the Pituitary Center at Baylor CHI St. Luke’s Medical Center and Fellowship Program Director, spent most of her childhood singing and playing the piano – so much so, that her family and friends just assumed she would choose a career in music.

“I think I had always thought of medicine as a career, but most of my extracurricular time as a child was spent playing the piano and singing,” said Dr. Samson who is originally from Calgary, Alberta Canada. “I even attended a performing arts high school, so when I announced that I was going into the sciences for university, I think my parents were a bit shocked.”

And while Dr. Samson did indeed go into the sciences, she didn’t totally abandon her music. In fact, she kept her hand in it and used her musical skills to her advantage.

“At university, I taught piano to help pay for my tuition and continued with a few select students through graduate school,” said Dr. Samson. “I think many physicians have dual interests in medicine and the arts – it helps to give your mind peace after a busy day.”

In medical school, Dr. Samson said she felt drawn to the complexities of endocrinology after managing a summer project.

“Dr. Susan Samson and her husband, Michael, on one of their holiday ski trips.
Interview with Dr. Lisa Bard Levine from the MAVEN Project

News from the AACE Underserved Populations Committee

Michael Dempsey, MD, FACE, is in private practice in Rockville, Maryland, and is a member of the AACE Underserved Populations Committee. He is also the current President of the Mid Atlantic Chapter of AACE and a member of the AACE Patient Education Committee. Recently, Dr. Dempsey spoke with Dr. Lisa Bard Levine, Chief Medical Officer of the MAVEN Project, a non-profit project that networks physician volunteers with organizations that care for the uninsured and underinsured using telehealth technology.

Q: Please tell me about the MAVEN Project.

MAVEN stands for Medical Alumni Volunteer Expert Network. Our founder, Dr. Laurie Green, noted that a lack of access to clinical expertise was prevalent in clinics and organizations that provided care to underserved populations. She thought that telehealth technology would allow us to bridge the gap between those sites that could benefit from outside consultants and physicians interested in volunteering their time and knowledge. We’ve evolved into a national organization of volunteer physicians focused on educating providers who care for the underserved. There are currently 120 volunteer physicians in our database and this number continues to grow. Our goal is to engage those volunteers to help us optimize health outcomes in the underserved.

Q: Is there a typical volunteer?

While there isn’t a typical volunteer, the common thread that connects all of our physician volunteers is the interest and willingness to volunteer a little bit of time to make a large impact with underserved communities in need. This is an excellent option for physicians who are recently retired, but want to continue their involvement in medical education. We are also pleased when physicians approach us who are in active clinical practice or industry. Their work helps maintain their identity as physicians, while at the same time giving back to their communities. Our only requirements are an active medical license with more than two years in medical practice, training at an accredited U.S. medical school and/or training program, and cultural sensitivity. By facilitating clinic access to physicians via telehealth, we match our physician volunteers with communities that desperately need their help. We hope that through leveraging telehealth, we’ll be able to optimize outcomes, improve access and reduce health care costs. If we can couple the cost savings with health benefits, we’ll make a difference in that community.

Q: What are your core services?

Our major focus is Physician-to-Clinic Provider education, mentoring and advice. Also, this is where we see our greatest opportunity for growth. Our primary focus is providing Advisory Consults where our physician volunteers help with de-identified case reviews. Physician-to-Clinic Provider education includes education to augment provider knowledge and streamline triage.

Q: Would a physician volunteer treat patients?

Our current focus is on Advisory Consults, which includes education and mentoring. Thus, our physician volunteers would not be directly treating patients and their name would not appear in any patient records. Our volunteers love this arrangement because they are able to work at the top of their license, in a provider-to-provider capacity.

Q: Is there much paperwork?

Thankfully, no. To make it easy to volunteer, other than requesting three references with an initial application, we’ve removed all administrative burden commonly associated with medical practice for the advisory consults. Malpractice is provided for MAVEN Project-related activities. There are no EMRs to complete. All the technology is HIPPA-compliant. It requires no paperwork on the volunteer’s part.

Q: What is the time requirement?

We ask for a time commitment of four (4) hours per month, distributed at the volunteer physician’s discretion, for a minimum of six (6) months. Our goal is to maximize their time so that they can have a big impact with a small commitment.

Q: Is experience in telemedicine required?

No, however, very little is required by way of technical expertise. MAVEN Project staff provide all training associated with using the platform and it’s typically completed within an hour via phone or video conferencing.

Q: How is your organization funded?

We’ve raised more than $3 million through industry grants, as well as individual, family and corporate philanthropic support. We ask the clinics and networks that we partner with to cover non-clinical administrative fees.
Cost of Diabetes and Its Effect on Underserved Populations from Both a Domestic and International Perspective

News from the AACE Underserved Populations Committee

Diabetes imposes a significant economic burden around the world, not to mention that the global expenditure on this chronic disease has risen nearly three times in the last 10 years to $727 billion (USD). There are more than 425 million people affected with diabetes globally and the projections are that by the year 2045, this number will increase to nearly 629 million people. Adding to this burden, are the 352 million people with prediabetes.

There is a rising incidence of diabetes in underserved populations, with approximately 80 percent of the affected in low and middle-income countries and about one-third over the age of 65. The impact of this economic burden is more profound in these communities due to factors such as the prevalence of diabetes and its complications in minorities, decreased access to quality health care, lower socioeconomic status, poor literacy rates, increased access to fast food/caloric dense food, and limited engagement in leisure-time physical activities. We’ll take a look at some of the effects that the cost of diabetes care has on the underserved populations from both a domestic and international perspective.

The Domestic Perspective

In the U.S, an estimated 30.3 million people have diabetes (9.4 percent of the U.S. population), of which 23.1 million are diagnosed and 7.2 million are undiagnosed. An astounding 84 million American adults aged 18 years or older have pre-diabetes.

The American Diabetes Association (ADA) reported that the estimated total economic costs of diagnosed diabetes in 2012 was $245 billion ($176 billion in direct medical costs and $69 billion in reduced productivity), which was 41 percent higher in comparison to the previous estimate of $174 billion five years prior.

The largest components of medical expenditures were attributed to hospital inpatient care, prescription medications to treat the complications of diabetes, anti-diabetes agents and diabetes supplies, physician office visits, and nursing/residential facility stays. Diabetes becomes costlier when associated with complications and 25 percent - 45 percent of diabetes attributed medical expenditures were spent treating complications of diabetes.

Lifestyle interventions along with anti-diabetic medications is the cornerstone for the management for type 2 diabetes (which accounts for more than 90 percent). For a patient who is uninsured, the cost of a multi-drug regimen for diabetes can vary from $200-$500 per month and for those who need blood sugar monitoring, tests strips can cost up to $1 a piece. The cost of insulin is rising steadily and poses a major financial hardship on patients who rely on it for life. In spite of having an armamentarium rich in management tools for the disease (newer oral medications, several versions of short-and long-acting insulins, GLP1 analogues, variety of insulin pumps), half of our patients with diabetes are not in control.

Prevention, education and raising awareness is key to preventing a complex, self-managed disease such as diabetes and thereby reducing the financial burden on societies and health care systems.

The Diabetes Prevention Program (DPP) aimed at reducing incident diabetes in at-risk individuals has proven to be successful in racial/ethnic minorities when taught by case managers on a one-to-one basis over a shorter period of time. There is much being done through public awareness campaigns in the U.S. regarding diabetes and its complications, but the time has come to make these campaigns more robust and reach out to communities that need them the most.

We need programs that are designed to be flexible, culturally sensitive, easily accessible and individualized via the use of nonmedical personnel from the community; thereby making it cost-effective, adaptive and sustainable. Effective quality improvement interventions among underserved and minority populations that showed improvements in A1C at the patient level include cultural and health literacy tailoring led by community educators; one-to-one interventions with individualized assessment; incorporation of treatment algorithms; focusing on behavior-related tasks; and providing feedback and high intensity interventions over a long duration. Other effective interventions at the level of the healthcare organization include systems for rapid turnaround A1C; circumscribed appointments; support staff (nurse case management, community worker, pharmacist); increased follow-up through telehealth visit and/or home visits; and most importantly, affordable anti-diabetes medications.

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Does Your Institution Subscribe to Endocrine Practice?

Institutional subscriptions to *Endocrine Practice* are available for purchase in both print and online form. If your medical library or institution doesn’t currently subscribe to the journal, download a Library Recommendation form at the following link: http://www.aace.com/pub/pdf/libraryRequestForm.pdf.

After you’ve completed the form, simply submit the form to AACE Publications Department via fax at 904-353-8185, and we’ll send it to your library on your behalf. If you have any questions about subscriptions, please contact the Publications department at 904-353-7878, ext. 129 or publications@aace.com.
International Diabetes Federation (IDF) 2017

Dr. Jonathan Leffert, AACE President, Mr. Paul Markowski, AACE CEO, and Ms. Julie Cockley, Director of Member and Community Engagement attended the International Diabetes Federation (IDF) 2017 along with the 3rd Annual Regional Chapter Meeting (MENA and Europe), December 4-8, in Abu Dhabi, UAE. AACE was afforded the opportunity to meet with H.E. Sheikh Abdulla Bin Mohamed Al Hamed, Chairman of the Health Department and a member of the Executive Council along with Dr. Khaled Aidha Al Jaberi, Director Health Regulation and AACE member. Dr. Leffert and Mr. Markowski also met with Professor Nam Cho, IDF President during their visit to Abu Dhabi. During the Regional Chapter Meeting, AACE members had a productive discussion on ways to increase and improve international member relations and activities. -FM
These are very exciting times to be part of AACE. A lot of changes are being implemented, of which the most important for us is increasing resources and engagement opportunities for fellows-in-training. I will dedicate this issue’s column to discuss these with you.

First, I would like to thank all of you who completed the AACE membership survey. The number of responses received from trainees was very encouraging and your input, as promised, will be the driving force for our future agenda.

Second, I am very pleased to let you know that we will have an all-new early career symposium at the upcoming AACE Annual Meeting. An amazing program is being prepared that includes a variety of topics requested by fellows. You will have an unprecedented opportunity to learn about the mechanics of endocrinology, from basic understanding of the economics of the practice to how to survive your first year after fellowship. The panel will include excellent speakers who have unparalleled expertise, experience and the motivation to address trainees and young physicians. Stay tuned for program details in AACE Online News, upcoming issues of First Messenger and on the meeting website at http://am.aace.com.

Third, be ready to meet and mingle in Boston. The Annual Meeting is a unique networking opportunity for early career professionals. Meet the AACE leadership, get introduced to chapter members, make future career plans, catch up with old colleagues or just mingle with other trainees. You surely will not fall short of the opportunity to network with all the receptions and events at Annual Meeting. Stay tuned and start packing!

Fourth, most trainees have asked for disease-specific education from AACE. Make sure to check out the modules on the AACE website https://www.aace.com/fellows/modules. It has a wonderful array of disease discussions presented by experts in their respective fields. In addition, the American College of Endocrinology just released the new version of ASAP (ACE Self Assessment Program) with a special discount for all fellows-in-training members. It covers all aspects of adult and pediatric endocrinology and the learning objectives span the entire endocrine training curriculum. Check it out as well!

Finally, I would like to introduce a new “Clinical Corner” in this column. Since we have retired the “Clinical Case Corner” from the fellows-in-training section of the AACE website, I’d like to present a brief clinical scenario in my upcoming columns.

On the next page you will find a short clinical vignette with two figures – what is the diagnosis? I will discuss this in the March/April issue of First Messenger.

Contact me!

- **e-mail:** jgsfeir@gmail.com
- **Facebook:** AACE Fellows

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**AACE MENTORSHIP Program**

To learn more, visit www.aace.com/membership/MPV2 or email membership@aace.com
A 64 year-old man was referred for evaluation of a neck mass noted on examination one year prior to presentation. At that time, an ultrasound identified a 5-cm cystic right thyroid mass that had benign cytology after fine needle aspiration. The mass doubled in size over the past year to the point that he was unable to button his shirt. He has also developed dyspnea, dysphagia to solids, as well as dysphonia and hoarseness of the voice that he describes as “voice cracking.” He was evaluated locally with an ultrasound that noted the now-10-cm cystic mass from which 137 mL of fluid were aspirated but re-accumulated within 3 days. He was also started on levothyroxine one month prior to presentation with the aim of “shrinking the nodule.” A right thyroid nodule, easily mobile with swallowing, was palpated in our exam. It measured 9.8 x 5.9 x 7.6 cm on ultrasound and had cystic appearance (Figure 1). Left tracheal deviation was noted on chest x-ray (Figure 2). Laboratory testing revealed a TSH of 0.2 mIU/L (0.3 – 4.2), total serum calcium of 11.0 mg/dL (8.9 – 10.1), parathyroid hormone (PTH) of 207 pg/mL (15 – 65), phosphorus of 3.0 (2.5 – 4.5), and serum creatinine of 0.8mg/dL (0.8-1.3).

What is the diagnosis? Find out in the next issue of First Messenger.
May in Boston means spring blooms in the Boston Common, the perfect weather to catch a Red Sox game, and of course the site of the 27th Annual Scientific & Clinical Congress. On May 16 – 20, 2018, AACE will chart the future of endocrinology at its Annual Meeting at the Hynes Convention Center and the Sheraton Boston Hotel in the beautiful Boston, Massachusetts. The city – rich with American history, New England cuisine, unique shopping, the New England Aquarium and a wide array of sports teams including the Red Sox, Celtics, Bruins and Patriots – offers something for everyone. After a full day of educational sessions, we encourage you to take advantage of all that beautiful Boston has to offer.
The early registration deadline is March 9, 2018.

The Sheraton Boston is the host hotel for this year’s Congress with additional rooms available at the Hilton Boston, Mariott Copley, and Westin Copley. All reservations can be made online at am.aace.com/housing.

LATE-BREAKING ABSTRACTS

AACE invites you to participate in the late-breaking call for abstracts. The submission period is open from Tuesday, February 13 – Friday, March 23, 2018.

Late-breaking abstract submissions should contain ground-breaking data and cutting-edge research, including results from clinical trials or significant breakthroughs of science and practice of clinical endocrinology.

Accepted late-breaking abstracts will be published in an online supplement to Endocrine Practice. Additionally, accepted late-breaking abstracts will participate in the general poster session at our Annual Meeting in Boston, MA.

Late-breaking abstracts must be submitted online at am.aace.com/abstracts.

We look forward to your submission and meeting you in May!
Program Highlights

PRE-CONGRESS

The Pre-Congress on Wednesday, May 16 will provide sessions that help endocrinologists expand and enhance their practice. These half-day practical sessions include both clinical approaches and socioeconomic aspects of endocrine disorders. Topics include:

- The Contemporary Approach to the Management of Diabetes as a Cardiovascular Disease
- Practical Thyroid Cancer Update: Molecular Genetics, Clinical Science and the Cutting Edge
- Advanced Bone Disease: Bone Density and Beyond
- The Practice of Obesity Medicine
- Diabetes Technology Workshop
- Clinical Thyroidology – Beyond the Basics
- Reproductive Endocrinology in Daily Practice
- Nutritional-Herbal New Perspectives
- AACE Lifelong Learning Board Review Course

GENERAL SESSIONS

Each day of the Clinical Congress begins with a series of general sessions by leading experts in endocrinology. These lectures reflect advancements in endocrinology, highlighting new approaches to endocrine diseases and translation of scientific knowledge into clinical practice.

- Insulin Signaling
- Cushing’s Syndrome
- Thyroid Receptors
- Beta Cell Regeneration
- Current and Evolving Approaches for Osteoporosis Treatment
- Undiagnosed Disease Program
- Thyroid Cancer
- 2018 Bariatric Surgery and Its Implications
- Pituitary Tumors
**IN-DEPTH SYMPOSIA**
The in-depth symposia will be held Friday, May 18 and are comprised of a panel of subject matter experts presenting on their individual specialties, followed by group discussion and Q & A.

- CV Disease for the Endocrinologist
- The Evolution of the Management of Intensive Diabetes Management
- Pituitary Disorders through the Life Cycle
- Obesity Treatment 2018: Behavioral and Nutrition Tools, Pharmacology, Endoscopic and Bariatric Procedures
- Thyroid Cancer 2018: A Collaborative Program between AACE, ACE, and the American Head and Neck Society Endocrine Surgical Section: Key Topics in Thyroid Cancer & Thyroid Cancer Cases
- In-Depth Symposium for Endocrine Physician Assistants and Nurse Practitioners
- Metabolic Bone Disease – The Common and Not So Common
- Nutrition 2018 – Is It All Apples and Oranges?
- Love and Water: A Posterior Pituitary Update
- Controversies to Realities in the Metabolic Syndrome (AACE/SMNE joint symposium)
- The Basics to Survive Your Endocrine Career: For Fellows-In-Training and Young Physicians
- Practice Management and Member Advocacy

**MEET-THE-EXPERTS**
Meet-the-Expert sessions offer attendees a chance to delve into case studies, new pharmacological treatments and guidelines from noted clinicians, researchers and “legends” in the endocrinology field. These one-hour sessions are offered on Thursday and Saturday of the Annual Meeting and include the following topics:

- Transgender
- Molecular Analysis of Thyroid Nodule FNA Sampling: Workup of a Thyroid Nodule
- Unusual Lipid Disorder Cases
- Challenging Pituitary Cases
- Bone Markers
- Inpatient Diabetes Management
- Case-Based Approach to Autonomic Testing
- Thyroid and Pregnancy
- Unusual Neuroendocrine Tumors
- Parathyroid Cases
- Hyperthyroidism
- Osteoporosis Management and Newer Medications
- Type 1 Diabetes in the Pediatric and Adolescent Patient
- Case-Based Applications of the Lipid Guidelines
- Hyperaldosteronism
- Case-Based Approach to the Pharmacologic Treatment of Obesity
- Social Media and the Physician
- Ketosis-Prone Diabetes
- Kidney Stones
- Transitions for the CAH Patient
- Transcultural Endocrinology
- Meet-the-Legend: Vitamin D
- Meet-the-Legend: Parathyroid
- Meet-the-Legend: Hyperaldosteronism

Accurate at time of print. Session topics and titles subject to change.
In the Exhibit Hall...

» Enjoy food and beverage activities during each break
» Visit over 500 scientific posters
» Mingle with exhibitors to learn about new products
» Lunch vouchers available to attendees on Thursday and Friday

EXHIBIT HALL SCHEDULE

THURSDAY, MAY 17
Hours: 9:45 am – 2:15 pm
10:00 am – 11:00 am: Poster-Viewing Coffee Break
10:00 am – 11:00 am: Young Investigator Poster Presentations
10:15 am – 11:00 am: Product Theaters (2)
12:00 pm – 2:15 pm: Exhibit Hall Break
12:00 pm – 12:45 pm: Oral Presentations
12:45 pm – 1:30 pm: Product Theater
1:00 pm – 1:45 pm: Product Theater
1:15 pm – 2:00 pm: Product Theater

FRIDAY, MAY 18
Hours: 10:30 am – 2:15 pm
12:00 pm – 2:15 pm: Exhibit Hall Break
12:00 pm – 12:45 pm: Oral Presentations
12:45 pm – 1:30 pm: Product Theater
1:00 pm – 1:45pm: Product Theater
1:15 pm – 2:00 pm: Product Theater
4:30 pm – 6:30 pm: Poster-Viewing Wine & Cheese Reception
5:00 pm – 6:15 pm: General & Late-Breaking Poster Presentations
5:30 pm – 6:15 pm: Product Theaters (2)

SATURDAY, MAY 19
Hours: 9:45 am – 1:00 pm
6:45 am – 7:30 am: Product Theaters (2)
10:00 am – 11:00 am: Poster Viewing Coffee Break
10:00 am – 11:00 am: General & Late Breaking Poster Presentations
10:15 am – 11:00 am: Product Theaters (2)
CORPORATE AACE PARTNERSHIP (CAP) EXHIBITORS

Abbott Diabetes Care
AbbVie
Amgen
AstraZeneca
Corcept Therapeutics
Dexcom Inc.
Eisai, Inc.
Health Monitor Network
Insulet Corporation
Janssen Pharmaceuticals, Inc.
Lilly USA
Medtronic
Merck & Co., Inc.
Novo Nordisk
Sanofi
Sanofi Genzyme
Shire
Veracyte, Inc.
PMI now has online training for coding, billing, management, administrative and compliance staff. The American Association of Clinical Endocrinologists members get 10% off PMI Online Training when entering promo code AACE10 at registration.

Top Picks include some of PMI’s most popular webinars for quick, convenient learning and CEUs.

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Board of Directors Meeting

Continued from page 5

Summary of Other Major House Actions

Other Drug Pricing Policy – The HOD also passed new AMA policy including:

- Support for legislation that requires pricing transparency via notice of drug price increases greater than 10% in a year.

- Advocate for the Federal Trade Commission (FTC) and Food and Drug Administration (FDA) to monitor relationships between pharmaceutical manufacturers and pharmacy benefit managers (PBMs), especially regarding drug formularies and non-medical switching.

- Oppose provisions in contracts between pharmacists and PBMs that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price.

- A directive to develop model state legislation addressing the development and management of pharmacy benefits.

Physician Reimbursement and Practice Management – The HOD also passed several resolutions regarding physician reimbursement that were consistent with AACE policy:

- The AMA will proactively engage with payers to advocate for continuing and increased use of consultation codes.

- A study and report will be completed on the availability of EHR interoperability that will allow real time checks of drug coverage and pricing at the point of care.

- The AMA will advocate for rules that protect physicians from penalties when their certified EHR has not been updated by the vendor, or there is not sufficient choice in EHR products available to a physician.

- The AMA will adopt policy to oppose legislation or regulation that allows physician assistant independent practices.

Hormonal Contraception as a Preventative Service – AACE cosponsored a resolution with the Endocrine Society and the American Society for Reproductive Medicine asking the AMA to advocate to rescind the 2017 Rule “Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act,” to ensure that all women have access to no-cost hormonal contraception. The AMA reaffirmed existing policy in lieu of passing this resolution and will continue to advocate against this rule. -FM

2018 AACE EDUCATIONAL PROGRAMS

AACE/ACE Principles of Endocrine Neck Sonography Course™

For those who wish to learn to diagnostic thyroid ultrasound and ultrasound guided fine needle aspirations.

The Monday and Tuesday prior to the AACE Annual Meeting Sheraton Boston Hotel.

May 14-15, 2018 Boston, MA

AACE/ACE Advanced Neck Ultrasound Training Course™

For those who are experienced in performing both diagnostic thyroid ultrasound and ultrasound guided fine needle aspirations.

September 8-9, 2018 Orlando, FL

For more information and to register online, please visit https://www.aace.com/meetings/symposia
testosterone esters are the least expensive option as cost is ~$20/month. Transdermal testosterone avoids the peaks and troughs of IM testosterone, can be tested any day, at least 2 hours after the last application. For transgender women, transdermal and parental estrogen may have less risk of VTE in those at higher risk.

Do I need to screen for thrombophilia before starting CGHT?

Only if the patient has a personal or family history of VTE.

Should I prescribe an anti-androgen for transgender women?

Not for those patients who have undergone orchiectomy. They will not have endogenous testosterone production so there is no need for suppression.

For patients with endogenous testosterone production, the use of estrogen alone is often not enough to suppress testosterone to a normal female range. Spironolactone or GnRH agonist is often used to further suppress testosterone.

What if my transgender male patient still has menses despite adequate testosterone replacement for at least 3 months?

Options include progestational agents endometrial ablation, or oophorectomy and/or hysterectomy. Hysterectomy also negates the need for routine cervical cancer screening. -FM

References


Table 1: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cisgender</td>
<td>Not transgender</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>The distressed feeling one experiences when their gender intended is not consistent with their assigned gender</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>A person’s inner sense of their gender. For a transgender person their gender identity does not match the gender at birth.</td>
</tr>
<tr>
<td>Gender Incongruence/Gender Variance</td>
<td>A term that encompasses disparity between a person’s assigned gender and the gender they identify with. This may include those who have a non-binary sense of gender</td>
</tr>
<tr>
<td>Gender reassignment/Gender-affirming treatment</td>
<td>Includes treatment of hormones and/or surgery to modify one’s body in line with their gender identity.</td>
</tr>
<tr>
<td>Natal sex</td>
<td>Sex assigned at birth, generally based on genital structure</td>
</tr>
<tr>
<td>Transgender man/Female-to-Male</td>
<td>An individual who identifies their gender as male but was deemed a female at birth</td>
</tr>
<tr>
<td>Transgender woman/Male-to-Female</td>
<td>An individual who identifies their gender as female but was deemed a male at birth</td>
</tr>
<tr>
<td>Transsexual</td>
<td>An outdated term referring to those who permanently transitioned their gender or had the desire to do so</td>
</tr>
</tbody>
</table>

Medicare Finalizes the Rules for Year 2 of the Quality Payment Program

Reporting/Performance Periods - There will be a 90-day performance period for Advancing Care Information and Improvement Activities and a 12-month performance period for Cost and Quality. In calendar year 2017, the minimum reporting/performance period for the Quality category was 90 days to earn a small bonus payment, with the option of reporting for 12 months to earn a larger bonus payment. In 2017 MIPS participants that wanted to do the bare minimum to avoid a penalty only needed to report on one quality measure for one patient at any point in the calendar year.

Performance Category Weighting in Final Score Calculation - The 2018 MIPS performance year final score will be weighted as: Quality 50 percent, Cost 10 percent, Improvement Activities 15 percent, and Advancing Care Information 25 percent. In 2017, the category weights were Quality 60 percent, Cost 0 percent, Improvement Activities 15 percent, and Advancing Care Information 25 percent.

Lastly, if you have not submitted data to CMS you can still avoid a penalty for the 2017 reporting year. The deadline to submit data for 2017 claims is March 31, 2018.

To learn more about the Quality Payment Program and the 2018 performance year impacting Medicare payments to clinicians in 2020, please visit the AACE MACRA webpage at www.aace.com or the Quality Payment Program website at www.qpp.cms.gov. -FM
The 2018 CPT Professional Edition Coding Manual (Page 5 under the E/M Service Guidelines) provides general coding guidelines for advanced practice nurses, PAs and defines “other qualified healthcare professionals.” This may be applicable to providing services regarding CGM.

“When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician. A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service. Other policies may also affect who may report specific services.”

Disclaimer

Please note that any AACE proprietary information or intellectual property may not be shared with any third party or utilized in any manner without the expressed written consent of AACE.

New and Updated Codes for Continuous Glucose Monitoring (CGM) in 2018

All medical coding must be supported with documentation and medical necessity.

“While this article represents our best efforts to provide accurate information and useful advice, we cannot guarantee that third-party payers will recognize and accept the coding and documentation recommendations. As CPT®, ICD-10-CM and HCPCS codes change annually, you should reference the current CPT®, ICD-10-CM and HCPCS manuals and/or follow the “Documentation Guidelines for Evaluation and Management Services” for the most detailed and up-to-date information.

This information is taken from publicly available sources. The American Association of Clinical Endocrinologists cannot guarantee reimbursement for services as an outcome of the information and/or data used and disclaims any responsibility for denial of reimbursement. This information is intended for informational purposes only.

Current Procedural Terminology (CPT®) is copyright and trademark of the 2017 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT®. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Interview with Dr. Lisa Bard Levine from the MAVEN Project

Q: What challenges have you faced?

One of our greatest challenges has been to balance the supply of physician volunteers with the demand of clinic organizations. It’s a constant balance to ensure we are able to provide a high level of comprehensive service to our clinic partnerships and also keep our physician volunteers fully engaged. This process requires careful monitoring and management.

Q: Where do you see MAVEN in five years?

As the “go-to” site for physician volunteers. We like to compare the MAVEN Project to Match.com meets the Peace Corps. Physician stewardship is critical to our success. We make every effort to recognize and reward physicians for their time through recognition dinners, physician advisory committees, newsletters, and letters of gratitude. We want this to be an easy, fun place to volunteer all while helping vulnerable populations and having a positive impact on health care.

Q: It’s a noble goal. Can we help?

The short answer is, yes. We’d love to establish an ongoing relationship with AACE, as well as provide an opportunity for mission-oriented physicians to volunteer their expertise.

AACE members interested in participating should submit an application via our website at https://www.mavenproject.org/get-involved/volunteer-physician/volunteer-as-a-physician/ or call us at 617-641-9743. I would also encourage members to contact me at llevine@mavenproject.org if they know of other organizations that could benefit from our services.

Lisa Bard Levine, MD, MBA, has devoted her over 15-year health care strategy and consulting career to the advancement of provider alignment and engagement within US payer and provider organizations. Dr. Levine served as The MAVEN Project’s Chief Medical Officer prior to taking on the role of Chief Executive Officer. Dr. Levine received her BA from the University of Pennsylvania and received her MD and MBA from Tufts University.
Dr. Susan L. Samson

Continued from page 17

In addition, Dr. Samson serves as the Vice Chair of this year’s AACE Annual Meeting to be held in Boston, where she is utilizing her expertise as an educator to help develop the program.

One of the biggest changes in AACE that Dr. Samson says she’s witnessed over the years – besides the growth in membership both domestically and internationally – is the commitment to involve more female members in leadership roles.

“It’s refreshing to see this happening at AACE and trying to understand the barriers that create the lack of involvement,” said Dr. Samson. “Dr. [Etie] Moghissi has been leading a task force on the development of a women’s leadership project aimed at understanding what our membership needs are for development of national female leaders in medicine. It’s a work in progress, but I believe it will bear fruit.”

“Also, last year marked the passing of our beloved CEO Don Jones, whose commitment to AACE and the College [American College of Endocrinology] was instrumental in achieving our organization’s current national and international status.”

She says being involved in and a member of AACE has afforded her many opportunities throughout her career. “I have forged relationships with colleagues in our specialty that I rely on for advice professionally and clinically,” said Dr. Samson. “The tireless work being done by the AACE leadership, the legislative staff and committee members is impressive. AACE is constantly advocating for our members and patients such as the National Clinical Care Commission Act which was signed into law last November.”

Her best advice to those contemplating a career in endocrinology – don’t do it for the money. “All kidding aside, hormones reach every tissue of the body and therefore, our work can impact our patients from head to toe – that is the reward.”

Last August, Dr. Samson and her husband experienced firsthand the effects of Hurricane Harvey when it hit the metropolitan Houston area. “I will say I never felt so afraid for so long,” said Dr. Samson. “Although it was only 36-hours of being trapped and not knowing when or how it would end, it felt like an eternity. I made the connection about what a patient feels when we give bad news and then expect them to walk out the door and be OK – they are living with the sustained fear of what will or will not happen. I take that to work with me now.” -FM

AACE Chapters 2018 Meetings on the Horizon

<table>
<thead>
<tr>
<th>February 16-18, 2018</th>
<th>September 14-16, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern States-AACE 2018 Annual Meeting</td>
<td>California-AACE 18th Annual Meeting &amp; Symposium</td>
</tr>
<tr>
<td>Renaissance New Orleans Arts Warehouse District Hotel</td>
<td>Ritz Carlton Marina del Rey</td>
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<tr>
<td>New Orleans, LA</td>
<td>Marina del Rey, CA</td>
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<tr>
<th>July 27-28, 2018</th>
<th>September 21-23, 2018</th>
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<tr>
<td>Ohio River Regional-AACE 20th Annual Meeting</td>
<td>Michigan-AACE 2018 Annual Meeting</td>
</tr>
<tr>
<td>Hyatt Regency Indianapolis</td>
<td>Crystal Mountain Resort</td>
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<tr>
<td>Indianapolis, IN</td>
<td>Thompsonville, MI</td>
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<th>August 3-4, 2018</th>
<th>September 22, 2018</th>
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<tr>
<td>Texas-AACE/TESS Annual Meeting &amp; Surgical Symposium</td>
<td>Minnesota/Midwest-AACE 2018 Annual Meeting</td>
</tr>
<tr>
<td>JW Marriott Houston</td>
<td>Hilton Minneapolis/Bloomington Hotel</td>
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<tr>
<td>Houston, TX</td>
<td>Bloomington, MN</td>
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<th>August 10-12, 2018</th>
<th>October 5-7, 2018</th>
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<tbody>
<tr>
<td>Heartland-AACE 8th Annual Meeting</td>
<td>Nevada-AACE 2018 EFNE Annual Meeting</td>
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<tr>
<td>Mayo Hotel</td>
<td>Atlantis Casino Resort Spa</td>
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<tr>
<td>Tulsa, OK</td>
<td>Reno, NV</td>
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<th>September 7-8, 2018</th>
<th>October 6, 2018</th>
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<tr>
<td>Arizona-AACE 2018 Annual Meeting</td>
<td>New Jersey-AACE 11th Annual Meeting</td>
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<td>Hilton Sedona Resort at Bell Rock</td>
<td>Westin Princeton at Forrestal Village</td>
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<tr>
<td>Sedona, AZ</td>
<td>Princeton, NJ</td>
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<tr>
<th>September 7-9, 2018</th>
<th>November 9-10, 2018</th>
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<tbody>
<tr>
<td>Carolinas-AACE 2018 Annual Meeting</td>
<td>Mid Atlantic-AACE 16th Annual Meeting</td>
</tr>
<tr>
<td>Kiawah Island Golf Resort</td>
<td>College Park Marriott Hotel</td>
</tr>
<tr>
<td>Kiawah Island, SC</td>
<td>Hyattsville, MD</td>
</tr>
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</table>

Contact information: https://www.aace.com/chapters

If you have questions regarding the Chapter Meetings and/or other Chapter-related issues, please contact:

<table>
<thead>
<tr>
<th>Julie Cockley</th>
<th>Kathy Harper</th>
<th>Ariane Stribling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director, Member and Community Engagement</td>
<td>Assistant Director of AACE Chapters</td>
<td>AACE Chapters Coordinator</td>
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<td>Phone: 904-353-7878, ext. 121</td>
<td>Phone: 904-353-7878, ext. 146</td>
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<td>Email: <a href="mailto:kharper@aace.com">kharper@aace.com</a></td>
<td>Email: <a href="mailto:astribling@aace.com">astribling@aace.com</a></td>
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</tbody>
</table>
International Perspective:

India is one of the epicentres of the diabetes epidemic and is ranked second globally with 73 million people having diabetes. An estimated 24 million are impaired glucose tolerance (IGT) which increases the disease burden further. Half of India’s affected population is unaware that they have diabetes. Epidemiological studies have shown that those newly diagnosed with diabetes outscore the known patients with diabetes. India lost nearly 1 million people due to diabetes and its complications in 2017.

India is a country of diversity with a per capita income of $1,600 (USD), except in rural areas where it runs around $600 (USD). Despite this difference, three-fourths of the population live in rural villages.

For those in a lower income group, living in rural and urban areas, direct expenses consume 27–34 percent of their household income. While middle and high income groups in the same areas consume 5–12.6 percent and 4.8–16.9 percent of their incomes, respectively, on diabetes care.

The medical costs incurred by a person with diabetes are two to five-fold higher than those incurred by a person without diabetes. In India, 85-95 percent of all health care costs are incurred by the patient as only 15 percent of the population has medical insurance. Thus, a majority of the population is dependent on their earnings, savings or borrowing for any medical treatment. For a country with 73 million people diagnosed with diabetes, the cost burden of diabetes management is exuberant and funding is needed in order to properly care for the population. (Estimates per International Diabetes Federation - http://www.diabetesatlas.org/)

In addition, the cost of investigations also poses a burden on people with diabetes. A fasting, postprandial blood sugar along with A1C test (which is a three-month average of blood sugar) costs nearly $12. If you add kidney testing, retinal examination, foot examination, ECG and lipid parameters testing, the cost increases to $50 to $75 USD. In a country where the economic disparity is at its extreme, testing itself takes a toll out of patient’s resources. On one hand, affordability is a big issue; but on the other hand, all the drugs available globally are available in India as well. The majority of patients still insist on cheaper available options like regular and NPH insulin and cheaper oral hypoglycaemic agents, despite knowing that the newer drugs would help them control their blood sugar better. An average prescription for diabetes costs approximately $50 to $65 USD per month. The additions of newer drugs could increase the economic burden on a patient to $150 to $200 USD per month. Despite this, less than one-third of patients maintain A1C levels below 7 percent.

Uncontrolled blood sugar levels lead to complications and if someone is admitted to the hospital due to these complications, they could ultimately spend 5 to 10 times of their monthly expenditure. Though India’s government has reduced the price of commonly used antidiabetic drugs and insulin, these controls do not apply to the newer drugs. Insurance must be made compulsory for all citizens in the country; either they pay the premium or the government must pay for them if they are poor.

As diabetes poses a heavy economic burden, education and prevention should be the key to avoid the morbidity and mortality associated with the disease. Global support is needed for developing countries like us to keep the cost of newer antidiabetic agents reasonable and affordable.

Diabetes is a global epidemic and concrete, synchronized international effort is needed to combat this epidemic. -FM

Give Your Patients a Price Break on Prescription Costs

In response to the growing number of patients who need financial assistance to purchase their prescription medications, AACE and ACE have developed and launched a prescription savings directory web portal.

The site, prescriptionhelp.aace.com, includes an alphabetical listing of all endocrine-related prescription drugs that are eligible for cost-assistance programs, and a searchable list of all programs/organizations that offer reduced or no-cost medications for common endocrine disorders.

Additionally, the site features a comprehensive listing of additional patient assistance programs that help low-income, uninsured and under-insured Americans gain access to the prescription medications they cannot afford. Also featured is a listing of other support groups such as patient advocacy organizations and a helpful health insurance glossary of common terms.

The portal is an outgrowth of an AACE Task Force assembled, in large part, to study the rising costs of insulin.
Dr. Ira Laufer of New York, NY, passed away in August 2017. Dr. Laufer joined AACE in 1991 and acquired his FACE in 1995. He was also a member of the AACE-New York chapter.
## CME Opportunities

We encourage you to participate in the following online educational activities accredited by AACE:

[https://education.aace.com/courses](https://education.aace.com/courses)

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>URL</th>
<th>Faculty</th>
<th>Estimated Time of Completion</th>
<th>Expiration</th>
<th>Approval Status</th>
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<tbody>
<tr>
<td><strong>American College of Endocrinology Self-Assessment Program (ASAP) 2018</strong></td>
<td><img src="https://education.aace.com/node/7205" alt="Image" /></td>
<td>Lawrence Blonde, MD, FACP, MACE; Martin Abrahamson, MD; Alan Garber, MD, PhD, FACE</td>
<td>100.00 hours</td>
<td>January 15, 2020</td>
<td>This activity has been approved for AMA PRA Category 1 Credit(s)™</td>
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<tr>
<td><strong>Treatment Advances for Challenging Patients with Type 2 Diabetes: The Role of Emerging Insulin Combinations</strong></td>
<td><img src="https://education.aace.com/node/7205" alt="Image" /></td>
<td>Lawrence Blonde, MD, FACP, MACE; Martin Abrahamson, MD; Alan Garber, MD, PhD, FACE</td>
<td>1.75 hours</td>
<td>January 16, 2019</td>
<td>This activity has been approved for AMA PRA Category 1 Credit(s)™</td>
</tr>
<tr>
<td><strong>Integrating New Type 2 Diabetes Algorithms into Clinical Practice: Applying AACE Guidelines to Complex Patients with Diabetes</strong></td>
<td><img src="https://education.aace.com/node/7155" alt="Image" /></td>
<td>Janet McGill, MD, MA, FACE</td>
<td>1.00 hour</td>
<td>May 3, 2018</td>
<td>This activity has been approved for AMA PRA Category 1 Credit(s)™</td>
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<tr>
<td><strong>Latest and Greatest in Practical Application of CV Outcomes for T2D Drugs</strong></td>
<td><img src="https://education.aace.com/node/7158" alt="Image" /></td>
<td>Daniel Einhorn, MD, FACP, FACE; Lawrence Blonde, MD, FACP, FACE; Mikhail Kosiborod, MD, FACC, FAHA; Zachary Bloomgarden, MD</td>
<td>1.25 hours</td>
<td>July 24, 2018</td>
<td>This activity has been approved for AMA PRA Category 1 Credit(s)™</td>
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<tr>
<td><strong>Burning Questions About New and Emerging Injectable Therapies for Type 2 Diabetes: A Hot Topics Presentation</strong></td>
<td><img src="https://education.aace.com/node/7158" alt="Image" /></td>
<td>Daniel Einhorn, MD, FACP, FACE; Ralph DeFronzo, MD; Michelle Magee, MD; Jorge Plutzky, MD</td>
<td>1.75 hours</td>
<td>August 3, 2018</td>
<td>This activity has been approved for AMA PRA Category 1 Credit(s)™</td>
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</tbody>
</table>

Visit [http://journals.aace.com/](http://journals.aace.com/) to read articles and submit manuscripts in AACE’s online-only case reports journal.
## UPCOMING MEETINGS

**February 14 - 17, 2018**  
ATTD 2018 - 11th International Conference on Advanced Technologies & Treatments for Diabetes  
Vienna, Austria  
http://attd.kenes.com

**February 15 - 17, 2018**  
9th Annual Obesity Treatment & Prevention Conference  
San Antonio, TX  
http://www.dannemillerobesity.com

**February 16 - 18, 2018**  
Southern States-AACE 2018 Annual Meeting  
New Orleans, LA  
https://www.aace.com/chapters/southern-states

**February 28 - March 3, 2018**  
ISCD Annual Meeting  
Boston, MA  
https://www.iscd.org/education/annual-meeting/

**March 8 - 9, 2018**  
17th Global Diabetes Conference & Nursing Care  
Paris, France  
https://globaldiabetes.conferenceseries.com

**March 15 - 18, 2018**  
Austrian Thyroid Dialogue 2018  
Seefeld, Tirol  
http://www.schildruesengesellschaft.at/Schildruesendialog2018

**March 17 - 20, 2018**  
The Endocrine Society Annual Meeting  
Chicago, IL  
http://www.endocrine.org

**May 19 - 22, 2018**  
20th European Congress of Endocrinology (ECE 2018)  
Barcelona, Spain  
https://www.ece-hormones.org/events-deadlines/

**May 21 - 22, 2018**  
ICNST 2018 International Conference on Nanoscience & Technology  
New York, NY  
http://nanotech.alliedacademies.com

**June 22 - 26, 2018**  
78th Scientific Sessions  
Orange County Convention Center (West Building)  
Orlando, FL  
https://professional.diabetes.org/meeting/scientific-sessions/77th-scientific-sessions

**September 21 - 23, 2018**  
Michigan-AACE Annual Meeting  
Thompsonville, MI  
https://www.aace.com/chapters/michigan

**September 29 - October 1, 2018**  
2018 Annual Meeting of the American Society for Bone and Mineral Research  
Palais des Congres de Montreal  
Montreal, Quebec, Canada  
http://www.asbmr.org/Meetings/FutureAnnualMeetings.aspx

**October 3 - 7, 2018**  
88th Annual Meeting of the American Thyroid Association  
Washington, DC Marriott Marquis  
https://www.thyroid.org

**October 13, 2018**  
Diabetes: What's New, What's Next?  
Irvine, CA  
http://cmetracker.net/HOAG/Catalog?SessionType=C&furl=events

**December 1 - 4, 2018**  
International Congress of Endocrinology  
Cape Town, South Africa  
http://www.isendo.org

**March 23 - 26, 2019**  
The Endocrine Society Annual Meeting  
New Orleans, LA  
https://www.endocrine.org

**April 24 - 28, 2019**  
AACE 28th Annual Scientific & Clinical Congress  
Los Angeles Convention Center & JW Marriott  
Los Angeles, CA  
http://am.aace.com

**October 30 - November 3, 2019**  
89th Annual Meeting of the American Thyroid Association  
Sheraton Grande Chicago  
Chicago, IL  
www.thyroid.org

**May 6, 2020**  
AACE 29th Annual Scientific & Clinical Congress  
Washington Convention Center & Marriott Marquis  
Washington, DC  
http://am.aace.com

**May 28 - 30, 2020**  
Spring Meeting of the American Thyroid Association  
Westin Times Square  
New York, NY  
www.thyroid.org