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2008 IAFP Family Medicine Update

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- To provide responsible advocacy for and education of patients and the public in all health-related matters;
- To preserve and promote quality cost-effective health care;
- To promote the science and art of family medicine and to ensure an optimal supply of well-trained family physicians;
- To promote and maintain high standards among physicians who practice family medicine;
- To preserve the right of family physicians to engage in medical and surgical procedures for which they are qualified by training and experience;
- To provide advocacy, representation and leadership for the specialty of family medicine;
- To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.

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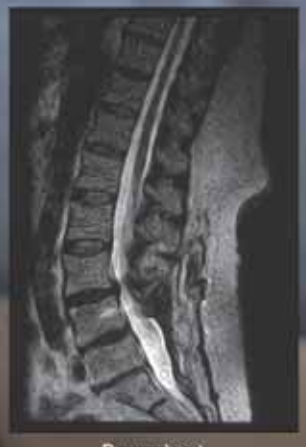

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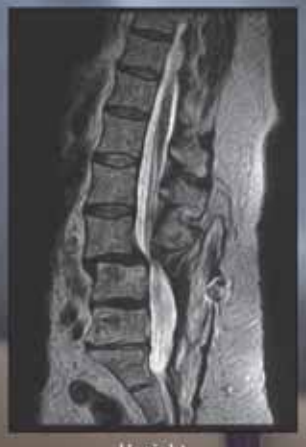

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Larry Allen, MD

There's No Place Like Home

In that classic line from *The Wizard of Oz*, Dorothy realizes that everything she really needs or wants has always been right there by her. "There's no place like home" is the lesson of a scary journey in a foreign land. Today, we are hearing a lot about the "medical home," and I hope it is the end of our journeys into the land of fragmented care.

Many groups, including the Primary Care Coalition, supported by the AAFP, are spending a lot of effort to define in detail what a medical home is and should include. At the state level, the IAFP is representing your interests with input to insurance companies, association coalitions and state government to promote family medicine as the key ingredient to provide medical homes for everyone. All of these efforts are commendable, as the end goal is not necessarily to change what we do as family physicians, but to influence health care policy and reimbursement systems to value the importance of the medical home.

Still, I am somewhat concerned with the choice of the phrase "medical home" as opposed to a "personal, primary or family physician." Hopefully, everyone understands that the essential building block of a medical home is the physician-patient relationship. We spend time as an Academy working on promotion, practice enhancement and education, but it is all to support what you and I do every day by being with our patients and guiding them through a vast array of problems and preventions. In his 2006 (Harper Collins) book, *The End of Medicine*, Andy Kessler interestingly speculates about a day when technology replaces physicians. But unless technology can prevent all disease, it can never replace the human relationship that our patients need and want. A few years ago, I wondered how patient use of the Internet would affect my practice. Although it has presented new challenges and expectations, it seems to me to have increased patients' desires to consult with someone they can trust. They still desire human contact to verify, correct or add to what they glean from cyberspace. Patients want to have a doctor when they face and fight illness.

A longtime patient of mine, who recently suffered the death of a close family member, sent me a note expressing how much she appreciated knowing I was her physician. This surprised me because I had not seen her in more than a year, and she never came in for a visit during this difficult time. I did nothing specific to help her, but what mattered to her was simply that she had a doctor she could trust if she ever needed one.

The individual physician-patient relationship (medical home) is as old as medicine and has survived many recent assaults: overspecialization that fragments care, managed care arrangements that put the choice of health plan above choice of individual physicians, and government regulation that sets policy based primarily on cost, to name a few. I don't think we can go wrong if we continue to focus primarily on the relationships we have with our patients. **Although there is no Wizard of Health Care Delivery who can give us all the brains, heart and courage that we need, I think the magic of the physician-patient relationship will keep us from ever straying too far away from home.**

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St. Francis Family Medicine Chief Honored for Cervical Cancer Prevention

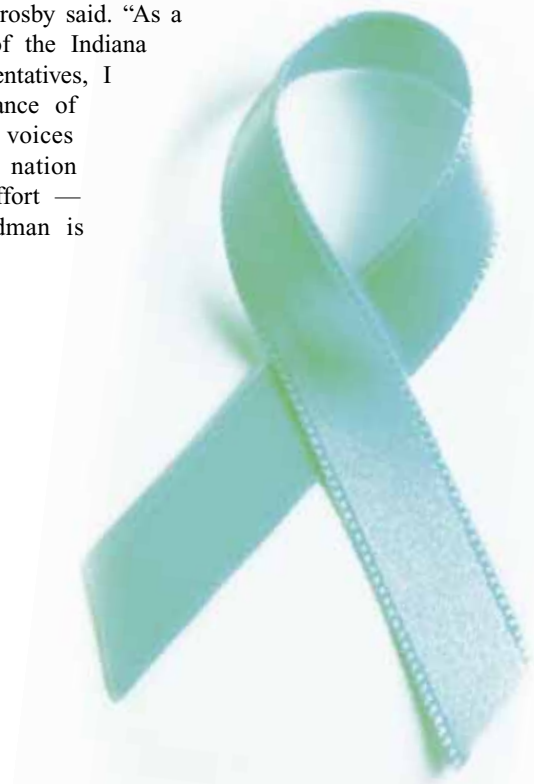
Richard D. Feldman, MD, director of the Family Medicine Residency Program at St. Francis Hospital & Health Centers, was honored nationally for championing the cause of cervical cancer awareness and prevention.

Feldman is the recipient of the Presidential Leadership Award from the Women In Government, a national bipartisan organization of women state legislators. He was recognized at the organization's Third Annual HPV and Cervical Cancer Summit in Washington, D.C., November 15-17.

"Dr. Feldman's work in Indiana to support access to the human papilloma virus vaccine for all Hoosier girls and women by providing critical medical background and testimony to the Indiana State Legislature has been invaluable," said Indiana State Sen. Connie Lawson, chair of the WIG's Board of Directors.

Feldman participated in committee hearings during the legislature's debate over requiring the newly available HPV vaccine for school entry. The bill ended as an educational measure, directing the Indiana State Department of Health to create informational materials which schools are required to provide to parents of girls entering the sixth grade. The materials focus on the link between cervical cancer and HPV and information about the availability of the HPV vaccine.

"Our organization is a leader in the nation's efforts to eradicate this deadly disease of cervical cancer," WIG President Susan Crosby said. "As a former member of the Indiana House of Representatives, I know the importance of having strong voices across the nation supporting this effort — and Richard Feldman is one such voice."



Dr. Bowen Receives the Highest Honor from the American Academy of Family Physicians

by Debbie Allen, MD

During the October 3 Congress of Delegates meeting of the American Academy of Family Physicians (AAFP), Otis Bowen, MD, received the John G. Walsh Award for Lifetime Contributions to Family Medicine. Established in 1973, the Walsh Award is one of the highest honors bestowed by the AAFP. The award recognizes long-term commitment and dedicated leadership toward furthering the development of family medicine. The Walsh Award is not an annual award and is only given at the discretion of the AAFP Board of Directors.

Bowen is affectionately known around Indiana as "Doc." He attended Indiana University for undergraduate and medical school. After completing medical school, Bowen did an internship at South Bend Memorial Hospital. He joined the Army in 1943 and served in the U.S. Army Medical Corps during World War II. After returning from the war, he set up his medical practice in his hometown of Bremen, Indiana.

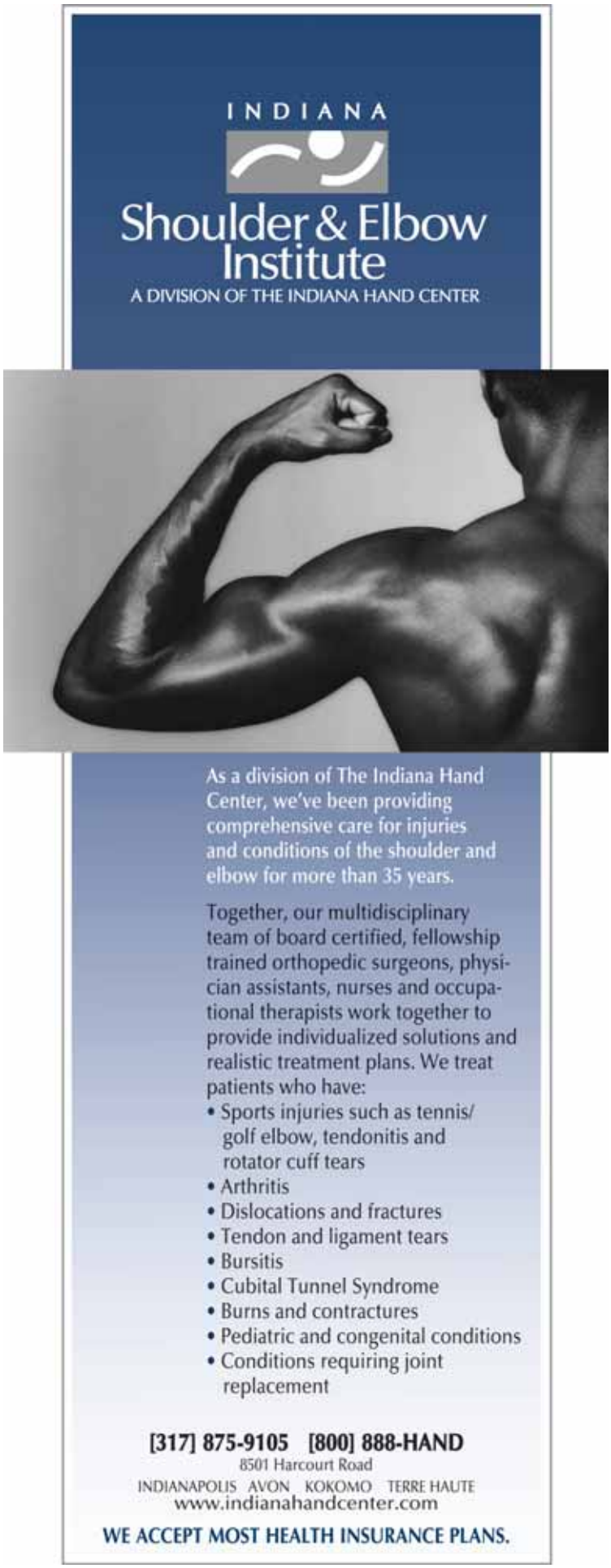
Doc got interested in local politics and became the coroner for Marshall County. He was elected to the Indiana House of Representatives in 1956. Back then, the House only met for 60 days a year, so he was able to spend most of his time in his practice. In 1965, Bowen became minority leader and then speaker in 1967. He was elected governor of Indiana in 1972. That same year, voters ratified a constitutional amendment allowing the governor to serve successive terms, and he won re-election in 1976.

After serving his final term as governor, Doc came to the Indiana University School of Medicine and became what we now call the "Pre-Doc" director of the Department of Family Medicine. One fateful day at IU, he received a call from then-President Ronald Reagan asking him to consider becoming the secretary of Health and Human Services. He became the first physician to serve in that position. In 1989, he retired and returned to Bremen.

Dr. Bowen remains an ongoing advocate for family medicine. He lent his name to the Otis Bowen Research Center in the Department of Family Medicine. The center is the research arm of the Department of Family Medicine and is dedicated to his commitment to improving the health of the citizens of Indiana. Doc continues to come to events that honor medical students who have been chosen as Bowen Scholars. In 2000, he wrote *Doc: A Life in Public Service* (IU Press 2000).

Many of the family physicians attending the AAFP Scientific Assembly attended a special reception for him sponsored by the IAFP and the Department of Family Medicine. Dr. Bowen gave a short speech and talked to everyone in attendance.

Congratulations from all the family doctors in the state, Doc, on this well-deserved award.



IAFP's Commission on Healthcare Services Advises of PPO Requests for Patient Charts

The IAFP's Commission on Healthcare Services met to discuss the issue of Medicare PPO requests for patient charts. Dr. Larry Allen, IAFP president, brought it to the Commission's attention that certain insurers are requesting multiple patient medical records from physicians. In order to meet these requests, office staff must duplicate and mail these records — adding to the office's time and expense spent on these administrative matters. Our Commission members wanted to know whether physicians must comply with these requests and/or be reimbursed for the mailing and duplication costs. The Commission suggested that IAFP members review the following *ISMA Reports* article dated October 29:

"The ISMA has received several calls from physician offices that received requests from Humana for multiple patient medical records dating from January 1, 2006, to present, related to Humana's Medicare Advantage program.

"The primary questions practices asked were whether they must comply and if they can be reimbursed for copying costs. The ISMA staff has been receiving conflicting — and sometimes inaccurate — information on this issue, but now has answers.

"Physicians not contracted with a Medicare Advantage plan sponsor are 'deemed' to be participating in the network on a case-by-case basis for Medicare Advantage fee-for-service patients. Physicians seeing patients insured in a private fee-for-service product who are not contracted with Humana or other plan sponsors are not required to comply with these requests for chart audits. If physicians choose to send records, they may charge the amounts permitted by Indiana law for photocopying parts of the medical record. Additionally, HIPAA privacy requirements limiting disclosure to these requesting plans apply. Make sure to disclose only the minimum necessary to comply with the request; do not send copies of the whole chart.

"Any physicians contracted with Humana or other Medicare Advantage plans should review their contracts as they likely must comply as part of their contractual terms."

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IAFP Residents' Day/Research Forum Call for Abstracts

2008 IAFP Residents' Day/Research Forum
Thursday, March 6, 2008
Marriott North, Indianapolis

The IAFP is currently accepting abstracts for the perennially popular Residents' Day and Research Forum, which will be held at the Marriott North in Indianapolis. Please join us for this exciting event!

General Information and Guidelines
All members of the IAFP are eligible to submit an abstract for consideration, including active, resident and student members. (Students will select the staff category if they assisted a staff member in their research project or will select the resident category if they assisted a resident member in their research project.) Presenters should also be clearly noted on the application form.

Selected abstracts will be invited to participate in the competition and present either by an oral presentation with PowerPoint slides or by submission of a poster. Judges will eliminate themselves from reviewing any abstract, paper or presentation if they have had active involvement in a project's development, implementation or presentation.

Competition – Non-Published/Presented Abstracts
The abstract should describe an original work in one of the three categories:
(1) Original Research
(2) Case Presentation
(3) Article Review

Abstracts must be factual and report on completed research. Materials previously published or presented at another national meeting are not acceptable for this research competition.

For complete submission guidelines and forms, please visit www.in-afp.org.

To submit an abstract, please send two copies (one blinded and one unblinded) ELECTRONICALLY to cbarry@in-afp.org no later than Friday, February 8, 2008.

Questions? Call the IAFP at 317.237.4237 or e-mail us at iafp@in-afp.org.

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Important Safety Information: In clinical trials the most common side effect assessed as possibly or probably related to ACIPHEX with a frequency greater than placebo was headache (2.4% vs 1.6% for placebo).

Symptomatic response to therapy does not preclude the presence of gastric malignancy. ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles, or to any component of the formulation. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

Please see brief summary of full prescribing information on adjacent page.

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BRIEF SUMMARY
Before prescribing ACIPHEX®, please see full prescribing information.

INDICATIONS AND USAGE
Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)
ACIPHEX® is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX® may be considered.

Maintenance of Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)
ACIPHEX® is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

Treatment of Symptomatic Gastroesophageal Reflux Disease (GERD)
ACIPHEX® is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD.

Healing of Duodenal Ulcers
ACIPHEX® is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

***Helicobacter pylori* Eradication to Reduce the Risk of Duodenal Ulcer Recurrence**
ACIPHEX® in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. (See **CLINICAL STUDIES** and **DOSAGE AND ADMINISTRATION** in full prescribing information.)

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. (See **CLINICAL PHARMACOLOGY, Microbiology** in full prescribing information and the clarithromycin package insert, **CLINICAL PHARMACOLOGY, Microbiology**.)

Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome
ACIPHEX® is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

CONTRAINDICATIONS
Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

WARNINGS
CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE. If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See **WARNINGS** in prescribing information for clarithromycin.)

Amoxicillin: Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See **WARNINGS** in prescribing information for amoxicillin.)

SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile colitis*.

PRECAUTIONS
General
Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

Information for Patients
Patients should be cautioned that ACIPHEX® delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX® can be taken with or without food.

Please see FDA-approved patient labeling in the full prescribing information.

Drug Interactions
Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients. There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death.

In vitro incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an IC_{50} of 62 micromolar, a concentration that is over 50 times higher than the C_{max} in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and C_{max} for digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

Combined Administration with Clarithromycin
Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxyclarithromycin. (See **CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials** in full prescribing information.)

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. (See **PRECAUTIONS** in prescribing information for clarithromycin.) (See **PRECAUTIONS** in prescribing information for amoxicillin.)

Carcinogenesis, Mutagenesis, Impairment of Fertility
In a 88/104-week carcinogenicity study in CD-1 mice, rabeprazole at oral doses up to 100 mg/kg/day did not produce any increased tumor occurrence. The highest tested dose produced a systemic exposure to rabeprazole (AUC) of 1.40 µg•hr/mL which is 1.6 times the human exposure (plasma $AUC_{0-\infty}$ = 0.88 µg•hr/mL) at the recommended dose for GERD (20 mg/day). In a 104-week carcinogenicity study in Sprague-Dawley rats, males were treated with oral doses of 5, 15, 30 and 60 mg/kg/day and females with 5, 15, 30, 60 and 120 mg/kg/day. Rabeprazole produced gastric enterochromaffin-like (ECL) cell hyperplasia in male and female rats and ECL cell carcinoid tumors in female rats at all doses including the lowest tested dose. The lowest dose (5 mg/kg/day) produced a systemic exposure to rabeprazole (AUC) of about 0.1 µg•hr/mL which is about 0.1 times the human exposure at the recommended dose for GERD. In male rats, no treatment related tumors were observed at doses up to 60 mg/kg/day producing a rabeprazole plasma exposure (AUC) of about 0.2 µg•hr/mL (0.2 times the human exposure at the recommended dose for GERD).

Rabeprazole was positive in the Ames test, the Chinese hamster ovary cell (CHO/HGPRT) forward gene mutation test and the mouse lymphoma cell (L5178Y/TK+/-) forward gene mutation test. Its demethylated-metabolite was also positive in the Ames test. Rabeprazole was negative in the *in vitro* Chinese hamster lung cell chromosome aberration test, the *in vivo* mouse micronucleus test, and the *in vivo* and *ex vivo* rat hepatocyte unscheduled DNA synthesis (UDS) tests.

Rabeprazole at intravenous doses up to 30 mg/kg/day (plasma AUC of 8.8 µg•hr/mL, about 10 times the human exposure at the recommended dose for GERD) was found to have no effect on fertility and reproductive performance of male and female rats.

Pregnancy
Teratogenic Effects. Pregnancy Category B: Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 µg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 µg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers
Following intravenous administration of ^{14}C-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on mg/m^2) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use
The safety and effectiveness of rabeprazole in pediatric patients have not been established.

Use in Women
Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse events and laboratory test abnormalities in women occurred at rates similar to those in men.

Geriatric Use
Of the total number of subjects in clinical studies of ACIPHEX®, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS
Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment. In general, rabeprazole treatment has been well-tolerated in both short-term and long-term trials. The adverse events rates were generally similar between the 10 and 20 mg doses.

Incidence in Controlled North American and European Clinical Trials
In an analysis of adverse events assessed as possibly or probably related to treatment appearing in greater than 1% of ACIPHEX® patients and appearing with greater frequency than placebo in controlled North American and European trials, the incidence of headache was 2.4% (n=1552) for ACIPHEX® versus 1.6% (n=258) for placebo.

In short and long-term studies, the following adverse events, regardless of causality, were reported in ACIPHEX®-treated patients. Rare events are those reported in ≤1/1000 patients.

Body as a Whole: asthenia, fever, allergic reaction, chills, malaise, chest pain substernal, neck rigidity, photosensitivity reaction. Rare: abdomen enlarged, face edema, hangover effect. *Cardiovascular System:* hypertension, myocardial infarct, electrocardiogram abnormal, migraine, syncope, angina pectoris, bundle branch block, palpitation, sinus bradycardia, tachycardia. Rare: bradycardia, pulmonary embolus, supraventricular tachycardia, thrombophlebitis, vasodilation, QTC prolongation and ventricular tachycardia. *Digestive System:* diarrhea, nausea, abdominal pain, vomiting, dyspepsia, flatulence, constipation, dry mouth, eructation, gastroenteritis, rectal hemorrhage, melena, anorexia, cholelithiasis, mouth ulceration, stomatitis, dysphagia, gingivitis, cholecystitis, increased appetite, abnormal stools, colitis, esophagitis, glossitis, pancreatitis, proctitis. Rare: bloody diarrhea, cholangitis, duodenitis, gastrointestinal hemorrhage, hepatic encephalopathy, hepatitis, hepatoma, liver fatty deposit, salivary gland enlargement, thirst. *Endocrine System:* hyperthyroidism, hypothyroidism. *Hemic & Lymphatic System:* anemia, ecchymosis, lymphadenopathy, hypochromic anemia. *Metabolic & Nutritional Disorders:* peripheral edema, edema, weight gain, gout, dehydration, weight loss. *Musculo-Skeletal System:* myalgia, arthritis, leg cramps, bone pain, arthrosis, bursitis. Rare: twitching. *Nervous System:* insomnia, anxiety, dizziness, depression, nervousness, somnolence, hypertonia, neuralgia, vertigo, convulsion, abnormal dreams, libido decreased, neuropathy, paresthesia, tremor. Rare: agitation, amnesia, confusion, extrapyramidal syndrome, hyperkinesia. *Respiratory System:* dyspnea, asthma, epistaxis, laryngitis, hiccup, hyperventilation. Rare: apnea, hypoventilation. *Skin and Appendages:* rash, pruritus, sweating, urticaria, alopecia. Rare: dry skin, herpes zoster, psoriasis, skin discoloration. *Special Senses:* cataract, amblyopia, glaucoma, dry eyes, abnormal vision, tinnitus, otitis media. Rare: corneal opacity, blurry vision, diplopia, deafness, eye pain, retinal degeneration, strabismus. *Urogenital System:* cystitis, urinary frequency, dysmenorrhea, dysuria, kidney calculus, metrorrhagia, polyuria. Rare: breast enlargement, hematuria, impotence, leukorrhea, menorrhagia, orchitis, urinary incontinence.

Laboratory Values: The following changes in laboratory parameters were reported as adverse events: abnormal platelets, albuminuria, creatine phosphokinase increased, erythrocytes abnormal, hypercholesteremia, hyperglycemia, hyperlipemia, hypokalemia, hyponatremia, leukocytosis, leukorrhea, liver function tests abnormal, prostatic specific antigen increase, SGPT increased, urine abnormality, WBC abnormal.

In controlled clinical studies, 3/1456 (0.2%) patients treated with rabeprazole and 2/237 (0.8%) patients treated with placebo developed treatment-emergent abnormalities (which were either new on study or present at study entry with an increase of 1.25 x baseline value) in SGOT (AST), SGPT (ALT), or both. None of the three rabeprazole patients experienced chills, fever, right upper quadrant pain, nausea or jaundice.

Combination Treatment with Amoxicillin and Clarithromycin: In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse events unique to this drug combination were observed. In the U.S. multicenter study, the most frequently reported drug related adverse events for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse events or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

Post-Marketing Adverse Events: Additional adverse events reported from worldwide marketing experience with rabeprazole sodium are: sudden death; coma and hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; and TSH elevations. In most instances, the relationship to rabeprazole sodium was unclear. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

OVERDOSAGE
Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug. There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

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2008 "Short" Legislative Session

The upcoming 2008 Legislative Session will be a "short session," as the Legislature must wrap up the lawmaking process by March 14. The short session is traditionally jam-packed and fast-paced as legislators seek to cover lots of ground in a relatively small amount of time. Legislators will also only be allowed to introduce a limited number of bills. You can expect property taxes to take center stage — and legislators to step carefully as they prepare for the showdown of the 2008 election. On the health care front, we expect Rep. Charlie Brown to introduce or amend legislation on Certificate of Need or Moratorium. Also a potential issue will involve MRSA disclosure, which might be burdensome to some physicians but particularly troubling to the hospitals.

Proposed Legislation Recommended by Interim Health Committees for the 2008 Legislative Session

This summer, the Indiana General Assembly's interim study committees met to discuss and make recommendations on several important issues. A summary of the summer study committees follows.

Note: The Preliminary Draft (PD) will change once the bill has been filed with the Clerk's Office. Once the bill has been filed, it will receive a bill number. Bills are allowed to be filed beginning on Organization Day, which is scheduled for November 20, 2007.

Commission on Medicaid Oversight

- Continue the Commission on Medicaid Oversight by removing the sunset date and adding language "to give the Commission oversight of managed care organizations" (PD 3333).
- Managed care organizations will be subject to the same payment standards as the Office of Medicaid or a contractor under Medicaid. MCOs will be required to pay or deny each clean claim within 21 days if the claim is filed electronically, and within 30 days if the claim is filed on paper (PD 3235).

Drafts That Did Not Receive an Endorsement from the Commission on Medicaid Oversight

Long-Term Bed Moratorium – This issue was discussed extensively during the interim but failed to receive an endorsement from the Commission on Medicaid Oversight when no member of the Commission would second the draft to be voted on. However, expect the administration to pursue this legislation in the 2008 Legislative Session (PD 3389).

Health Finance Commission

- Require coverage of cyberknife technology if it has been approved by Medicare (PD 3297).
- Provide "emergency" rulemaking authority to IDOH as it relates to the reporting of communicable diseases. This draft was in response to legislative concerns regarding the state's ability to collect accurate and reliable data on confirmed incidences of MRSA infections (PD 3336).
- Lead poisoning prevention efforts (PD 3384)
- Cancer research check-off on state tax forms (PD 3369)
- Cleanup bill from last year's legislation, HEA 1457, which required the registration of out-of-state mobile health care entities (PD 3388).
- Study by Health Finance Commission regarding what is the most appropriate state agency to oversee and administer the state's Domestic Violence Program (PD 3368).
- Prohibition of smoking in public places (exempts bars, casinos and private clubs), which provides for the protection of any local ordinance that would be stricter or more comprehensive than state law (PD 3364). This PD was modeled after the Marion County ordinance, which is not a comprehensive ordinance. The bill will be introduced in the House. A comprehensive statewide smokefree air law is also expected to be introduced in the House.
- Creation of a statewide public umbilical cord blood bank (PD 3387)
- Raise fees for out-of-state residents who receive treatment at opiate treatment centers. The in-state resident fee will be set at $20 and the out-of state resident fee will be established at a rate higher than $20 but cannot exceed $300 (PD # not available).
- Require coverage of $10,000 per year for children younger than 18 years of age who use prosthetic devices. For individuals who are 18 years or older, the measure would require coverage of $10,000 over a three-year period (PD 3298).

Drafts That Did Not Receive the Endorsement of the Health Finance Commission

- Smoking in an automobile while a child is present in the vehicle. Establishes monetary penalties for violation. Would not be considered a primary offense (PD 3348).
- Change the criminal penalty from a Class A misdemeanor to a Class D felony for altering a birth certificate. This change would put this document in line with the forgery of other documents that are used in identity theft (PD 3376).

Commission on Mental Health

- Require a certain percentage of funding from the Forensic Diversion Program to be used for mental health treatment. This money would flow through the Division of Mental Health & Addiction in order to leverage federal dollars (PD 3291).
- Require all employees and volunteers working with the Forensic Diversion Program to be trained and participate in the Crisis Intervention Program (PD 3307).

Draft That Did Not Receive the Endorsement of the Commission on Mental Health

- Require the Department of Corrections drug formulary to mirror the formulary used under Medicaid (PD 3281). All interested parties will continue to work on this draft.

It Was a Banner Year for Indiana at the 2007 AAFP Congress of Delegates in Chicago!

Jason Marker, MD, was elected as New Physician Director of the AAFP Board of Directors at the AAFP Congress of Delegates in Chicago.

Jason Marker, MD, was officially elected by the Congress and was later installed as the New Physician director of the AAFP Board of Directors during the closing session of the Congress on Wednesday. Dr. Marker was selected by his constituency to be the New Physician candidate while at the National Conference of Special Constituencies in Kansas City in May.

"I am honored to have been elected by my peers to serve a term as the New Physician member of the AAFP Board of Directors. As a solo, private-practice physician providing a full scope of family medicine services, I will bring a unique perspective to the Board," Dr. Marker said. "Additionally, my rural practice location will be crucial as the AAFP looks at redeveloping its resources for rural family physicians." He currently leads a solo practice in Wyatt, Indiana.

Dr. Marker has been a valuable member of the IAFP Board of Directors and has served family medicine in various capacities since his years as a student. He looks forward to building on his national leadership when his term with the AAFP Board ends, saying: "…I will be able to bring that experience and knowledge base back to Indiana, further enhancing the work of the IAFP." The IAFP applauds Dr. Marker and looks forward to his return to IAFP leadership.

The IAFP Foundation received the **AAFP Foundation Outstanding Programming Award for the Historic Family Doctor's Office** project at the Indiana Medical History Museum. This award is the only award given to a state chapter by the AAFP Foundation and one of only three awards given overall. It was presented to **Richard Feldman, MD**, president of the IAFP Foundation Board of Trustees and the Indiana Medical History Museum Board of Directors at the AAFP Foundation Annual Gala on Tuesday, October 2, in Chicago.

Deanna Willis, MD, MBA, was named chair of the Commission on Finance & Insurance for the upcoming year.

As reported after the National Conference of Family Medicine Residents, **Roy Miner, MD**, represented all residents as the Resident alternate delegate to the 2007 Congress. Dr. Miner will serve as a Resident delegate at the 2008 Congress in San Diego.

Dr. John Haste, the senior member of the Indiana delegation, completed his time as a delegate at the microphone when he introduced Tom Felger, MD, as Indiana's candidate for the AAFP Board of Directors in 2008. A BIG thank you goes out to Dr. Haste for the leadership and representation that he has provided to our Academy.

Tom Felger, MD, has officially kicked off his campaign for the AAFP Board of Directors. Dr. Felger now serves as the senior member of the Indiana delegation, along with Clif Knight, MD, Worthe Holt, MD, and Richard Feldman, MD. Stay tuned for updates about the campaign. Best of luck to Dr. Felger!

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Membership Update

Keep Us Informed
Please remember to keep all of your contact information up-to-date with the AAFP and the IAFP.

This includes: your address (home and office), phone number, fax number and e-mail address.

To update your information, call the IAFP Headquarters at 317.237.4237 or e-mail iafp@in-afp.org.

Membership Status Totals as of October 31, 2007

Active	**1,663**
Supporting (non-FP)	**6**
Supporting (FP)	**2**
Inactive	**13**
Life	**191**
Resident	**253**
Student	**117**
Total	**2,245**

Active

Katie Bosch Baeverstad, MD
Fort Wayne

Melinda Sykes-Bellamy, MD
Chicago

Dhamayantha Sivamoham, MD
Floyds Knobs

Resident

Alejandro Alberto Alvarez, MD
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Rebecca Baker-Palmer, MD
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Please Join Us for the 2008 IAFP Family

January 17-20, 2008 • Marriott North, Indianapolis • To Register Online, Visit www.in-afp.org Today!

Program Goals
Registrants for this program will receive current information on a variety of medical subjects pertinent to patient care in the daily practice of family medicine. Subject matter was chosen based on assessed educational needs of the IAFP membership. At the conclusion of the program, registrants should have a working and applicable understanding of the topics.

Who Should Attend
Family physicians and other primary care health care providers, including other MD/DO specialties, PAs, RNs, nurse practitioners, etc.

AAFP CME Credit
This activity has been reviewed and is acceptable for up to 23 Prescribed credit(s) by the American Academy of Family Physicians.

Individuals with Disabilities
If you have a disability that requires special service to enable you to attend this conference, please contact the IAFP office by January 11 to speak with our staff regarding your special needs. Advance notification of any special need or service helps us to serve you better.

Meeting Location
Marriott North, 3645 River Crossing Parkway, Indianapolis, Indiana. The Indianapolis Marriott North is located on the prestigious North Side, in the Keystone and River Crossing areas, just 25 minutes from the airport and 20 minutes from downtown. The hotel offers 300 spacious guest rooms, with a beautiful indoor pool, whirlpool and fitness center.

Overnight Accommodations
A block of rooms is being held at Marriott North. Reservations may be made by calling 317.705.0000. You must identify yourself as being with the Indiana Academy of Family Physicians and make your reservation prior to December 17, 2007 to receive the group rate.

Registration Fee Includes:
Registration materials, including a certificate of attendance and syllabus. Refreshment breaks each day, along with dinner on Thursday, continental breakfast and lunch on Friday and Saturday, and full breakfast on Sunday.

For further information call the IAFP at 317.237.4237 or visit www.in-afp.org.

CME Schedule

Thursday, January 17

1:30-6:30 p.m.	Registration open
3:30-4:30 p.m.	**Preventing Male Infertility** **Sam Thompson, MD**
4:30-5:15 p.m.	**Tennis Elbow: Fact Vs. Legend** **Greg Merrell, MD**
5:30-7 p.m.	**Chronic Pain in the Elderly Patient** **Bill McCarberg, MD**

Friday, January 18

7:30 a.m.	Registration open and breakfast buffet available
8-8:45 a.m.	**The Aging Spine** **Peter Gianaris, MD**
8:45-9:45 a.m.	**Management of Post-Date Labor** **Shannon Joyce, MD**
9:45-10:45 a.m.	Break to view exhibits
10:45-11:45 a.m.	**Allergic Reactions and Anaphylaxis Allergy** **Barbara Yawn, MD**
11:45 a.m.-12:30 p.m.	**Travel Medicine Update** **Thomas A. Jones, MD**
12:30-1:30 p.m.	Physician and Exhibitor Luncheon
1:30-2:15 p.m.	**Current Trends on Mitral Valve Disease** **David A. Heimansohn, MD**
2:15-3 p.m.	**Colitis Update** **Thomas A. Kintanar, MD**
3-3:30 p.m.	Break to view exhibits
3:30-4:15 p.m.	**Antibiotics Update** **Thomas A. Kintanar, MD**
4:15-5 p.m.	**Smoking Cessation Strategies: Options for the Family Physician** **Risheet Patel, MD**

Saturday, January 19

7:30 a.m.	Registration open and breakfast buffet available
8-9 a.m.	**Breast Cancer Prevention Issues for the Rural Family Physician** **Teresa Lovins, MD**
9-9:30 a.m.	**Minimally Invasive Spine Surgery – What Is It?** **Jean-Pierre Mobasser, MD**
9:30-10:15 a.m.	**How to QUICKLY Motivate Patients with Chronic Illness Toward Improved Health Behavior – Part One** **Kathy Zoppi, PhD, MPH**
10:15-10:30 a.m.	Break
10:30-11:30 a.m.	**How to QUICKLY Motivate Patients with Chronic Illness Toward Improved Health Behavior – Part Two** **Kathy Zoppi, PhD, MPH**

Medicine Update!

11:30 a.m.-12:15 p.m.	**Common Causes of Hand Pain: Diagnosis and Treatment** **Alex Meyers, MD**
12:15-1:30 p.m.	CME Lunch
1:30-2:15 p.m.	**Neurological and Cognitive Outcomes of Prematuritiy and Low Birthweight** **Andrea Schwarte, PhD**
2:15-3 p.m.	To Be Announced
3-3:30 p.m.	Break
3:30-4:15 p.m.	To Be Announced
4:15-5 p.m.	To Be Announced
4:15-5:15 p.m.	**Treating Cardiovascular Disease with Evidence-Based Nutritional and Lifestyle Changes** **Steven Masley, MD**

Sunday, January 20

7:30 a.m.	Registration open and breakfast buffet available
8-9 a.m.	**Erectile Dysfunction: Surgical and Non-Surgical Solutions** **Ronald Suh, MD**
9-10 a.m.	**Prematurity and Low Birth Weight** **Andrea Schwarte, PhD**
9-10 a.m.	**Ten Years Younger? – An Evidence-Based Lifestyle Program Geared to Assess and Enhance Physiological Markers of Wellness and Fitness** **Steven Masley, MD**
10-10:15 a.m.	Break
10:15-11:30 a.m.	**Coding and Billing Update** **Joy Newby, LPN, CPC**

Disclaimer

The material presented in all Academy scientific sessions is being made available by the IAFP for educational purposes only. The material is not intended to represent the only, nor necessarily the best, method or procedure appropriate for the medical situations discussed, but rather is intended to present an approach, view, statement or opinion of the faculty that may be helpful to others who face similar situations.

The IAFP disclaims any and all liability for injury or other damages resulting to an individual attending this meeting and for all claims that may arise out of the use of the techniques demonstrated herein by such individuals, whether a physician or any other person shall assert these claims. Every effort has been made to ensure the accuracy of the data presented at this meeting. Physicians may care to check specific details in standard sources prior to clinical application.

Coming Soon...
Medical Home Series

With the changing expectations for health care and the release of the AAFP's "Health Care for Everyone" plan, the term "medical home" has quickly become one that everyone in the world of family medicine needs to know. Family physicians must be able to provide a medical home for their patients. The IAFP hopes to facilitate this progression and will begin 2008 with a series of articles about the concept of the medical home and the principles of the patient-centered medical home, as defined by the AAFP and its partners (American College of Physicians, American Academy of Pediatrics and American Osteopathic Association.) Look for these articles in upcoming issues of *FrontLine Physician*.

Previewing the Principles of the Patient-Centered Medical Home

Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation: The personal physician is responsible for providing for all of the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care, when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and the practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on an appropriately defined framework.

IAFP Awards: Call for Nominations

The members, leaders and staff of the Indiana Academy of Family Physicians seek to improve the health of the people of Indiana by promoting and enhancing the practice of family medicine. In order to recognize the achievements and dedication of its members, the IAFP Board of Directors honors individuals with the following awards each year.

Lester D. Bibler Award
The Lester D. Bibler Award is given to an active member of the Academy who, through long-term dedication and leadership, has furthered the development of family medicine in the state of Indiana.

A. Alan Fischer Award
Established in 1984, the A. Alan Fischer Award is designed to recognize persons who, in the opinion of the Board of Directors of the IAFP, have made outstanding contributions to education for family medicine in undergraduate, graduate and continuing education spheres. The award was named in honor of Dr. Alan Fischer, a longtime member of the IAFP who actively served both the Indiana chapter and AAFP. Dr. Fischer established the Department of Family Medicine (Practice) at Indiana University School of Medicine and the IU Family Medicine (Practice) Residency Program.

Certificate of Commendation
The Jackie Schilling Certificate of Commendation was established to recognize non-physicians who have been deemed to contribute, in a distinguished manner, to the advancement of family medicine in the state of Indiana. The recipients of the award are considered to be persons of repute in many fields, including, but not limited to, medical education, government, the arts and journalism. In 1999, the award was named after past IAFP Executive Vice President Jackie Schilling.

Distinguished Public Service Award
The Distinguished Public Service Award is to be presented to members in good standing who have distinguished themselves by providing a community or public service. The service for which this award is bestowed should have been performed on a voluntary and uncompensated basis and should have benefited the community in an exceptional way. Service must be separate from the candidate's job responsibility.

Indiana Family Physician of the Year Award
The Indiana Family Physician of the Year must have maintained membership in good standing with both the IAFP and AAFP and must have been in practice for at least 10 years. Nominees must provide their patients with compassionate, comprehensive and caring family medicine on a continuing basis, and must be directly and effectively involved in community affairs and activities that enhance the quality of their communities. A nominee must be a family physician who is a credible role model professionally and personally to his/her community, to other health professionals and to residents and medical students. Nominees must also be able to effectively represent the specialty of family medicine and the IAFP and AAFP in a public forum.

Outstanding Resident Award
The Outstanding Resident Award seeks to reward a mature family medicine resident who demonstrates exceptional interest and involvement in family medicine and exemplifies a balance of the qualities of a family physician. The recipient of this award should exemplify the following qualities: community service and social awareness, evidence of scholarly inquiry, caring and compassionate patient care, involvement in Academy affairs locally or nationally, balance between personal and professional activities and mature interpersonal and collegial skills.

This call for nominations plays an important part in the process of recognizing outstanding service. Nominations must be in writing and submitted on an official nomination form with appropriate attachments. The IAFP Commission on Membership & Communications will review the entries and present its recommendation to the IAFP Board of Directors for approval. Nominations will be accepted from IAFP members until April 4, 2008.

If you would like a nomination form or need more information, please check www.in-afp.org or contact Missy Lewis via e-mail (mlewis@in-afp.org) or phone (317.237.4237). Thank you for your participation in recognizing outstanding family physicians and supporters of family medicine. You are a valuable advocate for your specialty!

IAFP GOES LEAN AND GREEN FOR YOU!

Your Academy is stepping up its efforts to become more environmentally aware and to become more efficient in the process.

We are **increasing communications via e-mail** wherever possible, sending information electronically instead of printing and mailing. At our Board and committee meetings, we are sending materials to our members the week before the meeting, so they can review them in advance and, if need be, download them to their laptop computers and bring them along to the meeting. At our CME meetings, we are offering attendees **the option to have their educational syllabus provided on CD or USB drive instead of paper.**

At the IAFP Headquarters, we are trying to **eliminate as many disposable products as we can, and shutting off computers, peripherals and lights when they aren't in use** — or, better still, unplugging them so they can't draw power in the standby mode. We are also **reusing packing boxes and envelopes** where possible and have switched to **100 percent recycled office paper**. We have purchased recycling containers and now **recycle paper, all plastics, aluminum, glass, printer cartridges and batteries**. We have also decided to start using **natural, biodegradable, non-toxic, environmentally friendly cleaning products**.

We hope that, in these small ways, the IAFP will not only help the environment, but will also save money that can then be used for other member services and leave us with more resources to continue our mission to provide advocacy, representation and leadership for the specialty of family medicine. We encourage our members to consider implementing some of these changes in their own offices, as many of them are not only free, but will actually save money in the long run.

IAFP Family Medicine Interest Reception Builds Excitement in Our Specialty

On Tuesday, November 6, 2007, more than 30 students from the IU School of Medicine attended the IAFP's annual Family Medicine Interest Reception at the Riverwalk Banquet Center in Broad Ripple. The evening gives medical students a chance to meet with representatives from Indiana's family medicine residency programs and find out more about the exciting world of family medicine.

Congratulations to the following students who won prize drawings that were held throughout the night.

Prize Winners

Starbucks $25 Gift Cards
1. Rebecca Blila, MS2
2. Anna Edwards, MS4

Rock Bottom $30 Gift Card
Rachel Simmons, MS4

P.F. Chang's $30 Gift Card and Pacer Tickets (Package)
Amanda (Amy) Hall, MS3

John Turner, MD, and Topper Doehring, MD, talk with IU School of Medicine students at the reception.

P.F. Chang's $30 Gift Card
Laura Nader, MS4

Rock Bottom $30 Gift Card and Pacer Tickets (Package)
Brian Coppinger, MS3

Children aren't concerned about osteoporosis.

But their physicians should be.

As a physician, you know that if kids eat three daily servings of dairy, it can help reduce their risk of osteoporosis years from now. But some parents don't know; so you can help by informing them that dairy foods supply key nutrients necessary for better bone health.

The U.S. Surgeon General's report on Bone Health and Osteoporosis recognizes the role that nutrients in dairy foods – including calcium, magnesium, phosphorus, potassium, protein, and vitamin D – play in helping to build and protect bones.

In fact, a report from the American Academy of Pediatrics states that eating calcium-rich foods such as milk, cheese and yogurt during childhood and adolescence will help build strong bones, which may reduce the risk of fractures and osteoporosis later in life.

Helping patients can be easy. Just remind them to get three servings of low-fat or fat-free milk, cheese or yogurt every day, as recommended by the U.S. Dietary Guidelines for Americans. Or, direct them to MyPyramid.gov to learn more.

And remind parents that it's never too late for them to take care of their own bone health too. By getting three daily servings of dairy and participating in weight-bearing exercise, adults can help protect their bones while setting a good example for their children. To learn more, visit nationaldairycouncil.org.

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"Food Groups to Encourage" for the Right Start in Life

It's well-known that too many American children are overweight. But just as troubling is the fact that many are also undernourished. Because kids do not eat enough of the right foods, they aren't getting enough of five key nutrients: calcium, magnesium, potassium, vitamin E and fiber, according to the 2005 Dietary Guidelines for Americans (DGA).[1]

The guidelines identified four "Food Groups to Encourage" from the USDA's MyPyramid: fruits, vegetables, whole-grain foods and low-fat and fat-free milk or milk products. Encouraging kids to eat adequate quantities of these nutrient-dense foods can help ensure that they are getting balanced nutrition from their diets.

"When a child learns good eating habits, it can pave the way for better lifelong health," Julie Hardin, RD, says. "Parents, schools and the community — and especially health care providers — all have roles to play in teaching kids to make the right dietary choices."

Dairy Foods: Rich in Nutrients, but Lacking in Some Diets

The dairy group, one of the highlighted food groups, is often underestimated as a source of key nutrients. Dairy foods like milk, cheese and yogurt are well-known as a source of calcium, but together, they also deliver potassium and magnesium — three of the five "nutrients of concern for children."

A number of studies have shown that getting calcium is a key to building peak bone mass and preventing osteoporosis and fractures later in life. The American Academy of Pediatrics calls dairy foods "preferred" sources of calcium compared to supplements and other foods.[2]

According to the National Dairy Council, half of children ages 2 through 8 and three-quarters of children ages 9 through 19 don't get the recommended daily amount of milk or milk products.[3] The 2003-2004 National Health and Nutrition Examination Survey found that African-American children have lower intakes of calcium, magnesium and potassium than children of other races and ethnicities.[4] This is consistent with a recent finding that adolescent African-Americans eat and drink less dairy than non-African-Americans.[5]

All children 2 to 8 years old should get at least two cups a day of low-fat or fat-free milk or milk products and three cups a day once they turn 9. The American Academy of Pediatrics recommends four dairy servings a day for adolescents.[6] The first step to putting these guidelines into practice is to be aware of them — but 60 percent of parents don't know how much calcium their kids are supposed to be getting.[7]

A Doctor's Influence – In and Out of the Office

For a physician, promoting healthy eating starts in the office. Asking patients about their eating habits, educating them about the importance of balanced nutrition, and recommending a healthy diet pattern that follows the 2005 DGA are all constructive steps a family health care provider can take. A doctor can also help by referring a patient to a registered dietitian when appropriate.

Outside the office, one way a physician can promote better nutrition is by partnering with non-profit organizations, industry-supported organizations or government agencies that promote nutrition education. A nationally prominent group working along these lines is Action for Healthy Kids (www.actionforhealthykids.org), a public-private partnership of national organizations and government agencies that encourages healthy eating and physical activity in children and youth in schools. Action for Healthy Kids teams at the state and local level welcome doctors as expert volunteers.

"Sometimes, advice can be more effective when it comes from more than one source," Diane Ruyack, MS, RD, CD, says. "What you tell people in your office may influence people more if they hear the message confirmed out in the community."

Doctors can also make a difference by engaging with local schools. One option is to encourage the local district to form a partnership with Action for Healthy Kids or a similar organization. A physician's voice may also carry influence when a community's schools feature unhealthy choices in a lunch program or are weighing a beverage contract with a vendor whose products are high in sugar and low in nutrients.

Poor nutrition in American children isn't only a behavior gap; it's a knowledge gap. Because of their expertise and the respect they command in their communities, health professionals have an important role to play in closing that gap and steering kids onto a healthier path through education, guidance and active involvement.

References

1. U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005, p. 7.

2. Frank R. Greer, M.D. and Nancy F. Krebs, M.D. "Optimizing Bone Health and Calcium Intakes of Infants, Children, and Adolescents." Pediatrics *(2006). 4 Sept. 2007 <http://pediatrics.aappublications.org/cgi/content/full/117/2/578>.*

3. National Dairy Council, unpublished data based on the National Health and Nutrition Survey, 1999-2002.

4. Fulgoni, Victor. "Dairy Consumption and Related Nutrient Intake in African-American Adults and Children in the United States: Continuing Survey of Food Intakes by Individuals 1994-1996, 1998, and the National Health and Nutrition Examination Survey 1999-2000." J Am Diet Assoc. *(2007). 4 Sept. 2007 <http://lib.bioinfo.pl/pmid:17258962>.*

5. Fulgoni, Victor. "Dairy Consumption and Related Nutrient Intake in African-American Adults and Children in the United States: Continuing Survey of Food Intakes by Individuals 1994-1996, 1998, and the National Health and Nutrition Examination Survey 1999-2000." J Am Diet Assoc. *(2007). 4 Sept. 2007 <http://lib.bioinfo.pl/pmid:17258962>.*

6. Frank R. Greer, M.D. and Nancy F. Krebs, M.D. "Optimizing Bone Health and Calcium Intakes of Infants, Children, and Adolescents." Pediatrics *(2006). 4 Sept. 2007. <http://pediatrics.aappublications.org/cgi/content/full/117/2/578>.*

7. Opinion Research Corporation for GTC Nutrition.

The Physician's Role in the Care of Students with Diabetes under HEA 1116 (2007)

by Julie Halbig, Esq., Hall Render

This past session, the Indiana General Assembly passed House Enrolled Act 1116, which provides for uniformity in the care of students with diabetes in schools. The bill also reinforced that a student who has been evaluated and determined to be capable of doing so should be allowed to manage and care for his or her diabetes while at school.

As with any new legislation, several questions and issues have been raised regarding the bill's implementation. The bill details the responsibility of physicians within the broader definition of "licensed health care practitioner." Licensed health care practitioners are those persons licensed to perform health care services and who have prescriptive authority under IC 25. **It is important to remember that the school and/or school nurse cannot provide medication without a physician's order.** The school or school nurse cannot take orders from the parent on what is the appropriate amount of insulin for the student.

Practical Guidance

Role of the Physician

- A diabetes management and treatment plan (DMTP) must be prepared and implemented for a student with diabetes for use during school hours or at a school-related activity. The plan must be developed by: (1) the physician responsible for the student's diabetes treatment and (2) the student's parent or legal guardian.
- If a physician collaborates with a nurse practitioner with prescriptive authority, the nurse practitioner could develop the DMTP.

What Should Be Included in the DMTP?

- Identify the health care services or procedures the student should receive at school
- Evaluate the student's ability to manage and the level of understanding of the student's diabetes
- Must be signed by the student's parent or legal guardian and the physician responsible for the student's diabetes treatment

When Should the DMTP Be Submitted to the School/School Nurse?

- Before or at the beginning of the school year
- Upon the student's enrollment in the school
- As soon as practicable following the child's diagnosis of diabetes

The DMTP is the foundation for the student's individualized health plan (IHP).

How Is the IHP Developed?

- The IHP is developed by the school nurse in collaboration with the physician responsible for the student's diabetes to the extent possible, the school principal, the student's parent or legal guardian and one or more of the student's teachers.

What Is Included in the Student's IHP?

- Performing blood glucose level checks
- Administering insulin through the insulin-delivery system the student uses
- Treating hypoglycemia and hyperglycemia
- Allow the student to possess at any time the necessary supplies or equipment to monitor the student's diabetes
- Provide that the student can attend to the management and care of his or her diabetes in the classroom, in any area of the school, on the school grounds and at any school-related activity.

While the goal of the law was to provide uniformity of care, the Department of Education has not developed standardized forms for the DMTP and the IHP. Therefore, each school is handling these requirements differently. Some schools are combining the DMTP and the IHP into one document. The key is for the school nurse to have the physician's signature in order to implement the medical order, and the signature of the parent or guardian provides the informed consent to the care as outlined in the DMTP and IHP.

Physicians with questions can call Julie at Hall Render at 317.977.1414

Mark Your Calendar

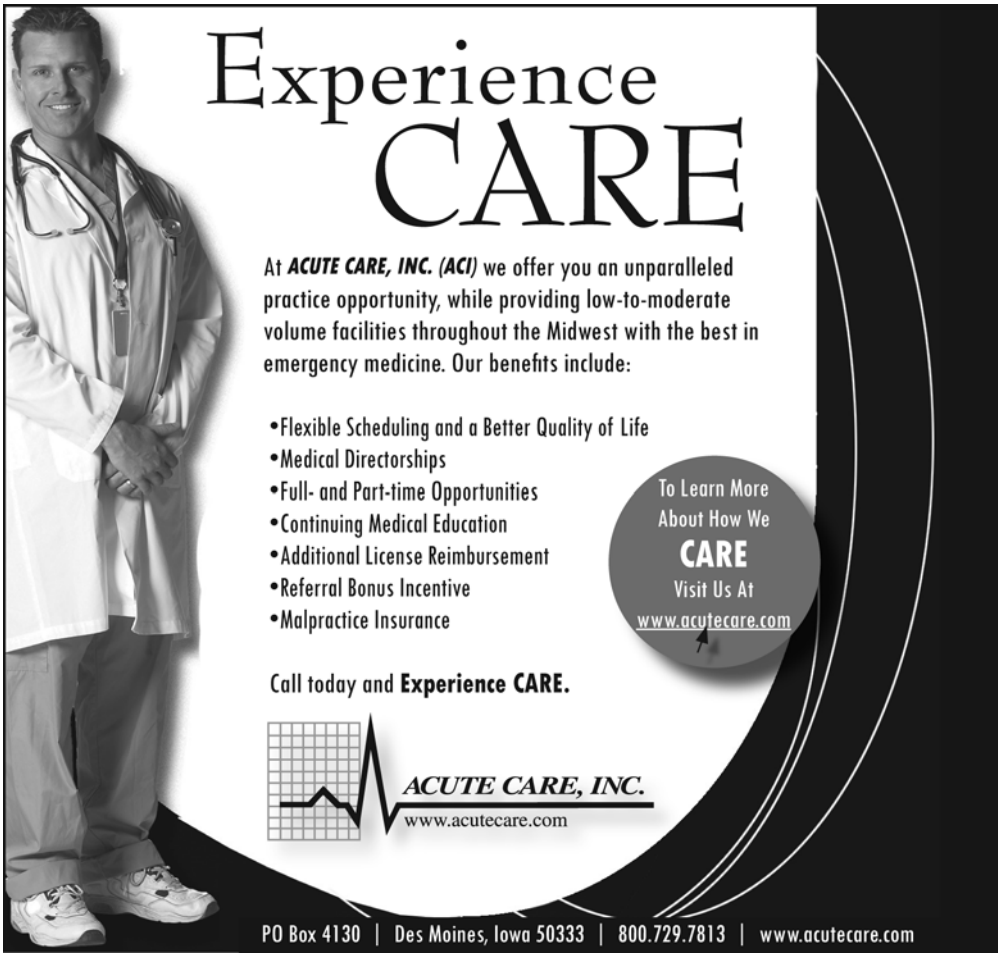
January 17-20, 2008
IAFP Family Medicine Update
Indianapolis

March 5, 2008
IAFP Faculty Development Day
Indianapolis

March 6, 2008
IAFP Residents' Day/Research Forum
Indianapolis

April 13, 2008
Board of Directors Meeting
Indianapolis

July 23-27, 2008
IAFP Annual Meeting
Fort Wayne



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Indiana Campaign for Smokefree Air

As expected at the close of the Legislature in April, the Indiana General Assembly has begun to discuss a statewide smokefree air bill. As reported in the Legislative Update in this issue, the Health Finance Commission has drafted legislation similar to the Indianapolis smokefree air law, exempting casinos, bars, bowling alleys and a number of other venues. Unfortunately, this leaves many workers without protection from the dangers of secondhand smoke, especially those most likely to be exposed at the workplace — many of which do not have health insurance.

IAFP has joined forces with many other statewide organizations to form the Indiana Campaign for Smokefree Air (ICSA), a coalition that will be supporting smokefree air legislation that completely eliminates secondhand smoke from ALL workplaces in Indiana. ICSA acknowledges the 22 states that have passed comprehensive smokefree air laws that include bars and the three states that count casinos among their smokefree venues. The coalition will work to ensure that those employees most likely to suffer health problems due to secondhand smoke are not exempt from potential legislation.

What Can You Do to Help?

- Ask patients if they work in an environment that allows smoking in any area of the workplace. Advise patients who are exposed to secondhand smoke in the workplace of the serious health hazards of exposure to secondhand smoke. Remind them that they can be catalysts for change in their communities and at the workplace.
- Volunteer to be a local media contact and serve as a medical spokesperson when smokefree air is in the news. Contact IAFP staff to do so.
- Contact your state legislators and let them know that ALL of your patients deserve to work in a smokefree environment, not just those that work in office buildings, restaurants and hospitals.
- Write a letter to the editor of your local newspaper. Share your knowledge of the damage caused by secondhand smoke. Make it personal. There is a human face to this epidemic.
- Visit www.smokefreefamilydoctors.org for more ways to take action and for supporting materials.
- Volunteer to visit a school, community center or church to present Tar Wars to fourth- and fifth-grade students. We are expanding to other community organizations — beyond schools — in an effort to fit the schedules of the students and our members. Complete and return the form below to indicate your interest in participating. The program is pre-written and preparation on the presenter's end is minimal.

Tar Wars®
A tobacco-free education program for kids from the American Academy of Family Physicians

Did you know that the tobacco industry spends over $400 million annually in advertising expenditures in Indiana ALONE? That's why we need your help! Tar Wars is a nationwide tobacco-free education program and poster contest owned by the AAFP, locally organized by the IAFP and funded in part with a grant from the Indiana Tobacco Prevention and Cessation (ITPC) Agency. The program brings fourth- and fifth-grade students together with family physicians and other health professionals so that they can learn more about the dangers of tobacco. Students actively participate in learning about the short-term effects of tobacco use, the advertising tactics of the tobacco industry, the financial impacts of smoking and the reasons why people smoke. The statewide and national poster contests that follow give youth the opportunity to share what they have learned with the rest of the community, empowering them with the opportunity to make a difference too!

Who can we contact at your office if a school in your area wants to participate?

Name _____

Phone _____ Fax _____

E-mail _____

City/County _____

Mail (55 Monument Circle, #400, Indianapolis, IN 46204), e-mail (mlewis@in-afp.org) or fax (317.237.4006) the info to Missy Lewis.

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Medicare Coding, Documentation and Compliance Related to CERT Requests

by Joy Newby, LPN, CPC; Newby Consulting, Inc.

Medicare Coalition Meeting – November 9, 2007

CERT Update – Fall 2007

The current error rate for Indiana's Comprehensive Error Rate Testing (CERT) program is 4.9 percent. This error rate is just over the Centers for Medicare and Medicaid Services' (CMS) goal of 4.0 percent. Unfortunately, evaluation and management (E/M) codes continue to be the majority of Indiana's errors. In fact, 50 percent of Indiana's errors are related to two E/Ms:

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A detailed history
- A detailed examination
- Medical decision-making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99223 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- A detailed interval history
- A detailed examination
- Medical decision-making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Unless the physician is selecting the level of care based on time, each of these codes have required key components (history, exam and medical decision-making) that must be documented. One problem is when the physician is unable to obtain the history from the patient. In this situation, it is imperative to document the reason the patient was unable to give a history.

Subsequent inpatient hospital records are especially problematic. Some physicians document statements like "stable-home tomorrow." In an audit, these brief statements will result in a refund request.

Legibility continues to be a problem in both inpatient hospital and office E/M codes. If you know your handwriting is difficult to read, copy the note(s) and also provide a typed transcript. Remember, the transcript must be the same as the handwritten note. Other than giving the description for any signs/abbreviations included in the note, do not embellish the information documented.

When reporting either of these codes based on the amount of **face-to-face** time with the patient, your documentation must include the total time you are personally face-to-face with the patient. More than 50 percent of the total physician face-to-face time must be spent in counseling or coordination of care activities. The documentation must also include a synopsis of the discussion or coordination of care activities. According to *CPT*,

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk-factor reduction
- Patient and family education

Simply stating: "spent a long time discussing the need to take her diabetic medication," is not sufficient for documenting an encounter based on time.

Medicare representatives also identified date span errors, which are typically related to inpatient hospital services. Date spans should only be used for continuous dates of service for the same level of care. For example, the physician provided inpatient hospital service 99231 for a seven-day span, September 1 through September 7, 2007. The charges could be reported on a single claim line with the from/to dates 09012007/09072007, 99231 in the CPT field of the claim and "7" in the unit field.

Each date/service must be individually reported if the dates of service are not continuous and/or if different *CPT* codes are needed to describe the services rendered.

Information Requested – No Documentation Received

While insufficient documentation and date span errors are the primary reasons for denial, Indiana continues to have too many denials due to physicians not sending the requested documentation. Be sure to correctly route and promptly open and respond to any mail containing the CMS logo, National Government Services, CERT Operations, Medicare Program Safeguard Contractor, CERT Documentation Contractor, etc.

The CERT Documentation Contractor Web site provides Medicare providers a source for verifying and updating of contact information for the CERT program. The contact information includes, but is not limited to provider name, street address, city, state, zip, multiple phone numbers, multiple fax numbers, point of contacts, medical record location and multiple e-mail addresses.

Medicare providers can confirm that the CERT Documentation Contractor has the most up-to-

date information at the following Web site: http://www.certcdc.com/certproviderportal/verifyAddress.aspx

Enter your Medicare Provider ID and initiate a search for your contact information. If changes are needed to the listed information, or if your information is not included in the CERT database, you should contact the CERT Documentation Contractor by phone at 301.957.2380 or e-mail by clicking "Contact Us" at the following Web site: http://www.certcdc.com/certproviderportal/verifyAddress.aspx

CERT Newsletters

Remember to include the patient's name on each page sent/faxed. *CERT Newsletters* have contained some helpful hints for physicians to assist CERT with legibility of images.

March 2007

In order to provide documentation that supports the services that are billed and readily offer legible and complete records, the provider can assist the process of medical review by reviewing the following problem situations related to imaging records from fax copies that are sent to the CERT Documentation Contractors:

- Medical records with any color of a gray or dark color will totally obscure or mostly obscure any lettering or numeric figures in the colored area. Examples are lab results that are highlighted; certain templates for documentation highlights; and EKG rhythm strips, reports, pictures and other graphics that have gray or other colors in them.
- Records that have been produced from microfiche or already copied that can produce a slightly double image after repeated copying.
- Larger than 11 X 8 paper scanned and reduced in size causes a loss in pixels, which reduces the readability of the image.
- Faxed records that are put in crooked end up with missing portions of the record on the image.
- Copies of copies will decrease the quality of the image.
- Certain types of paper (bond weight) do not copy or fax well, due to the thinness or thickness of the paper.
- Faxed carbon paper does not image well.

By recognizing these factors when you fax medical record information, the provider greatly increases the amount of quality-imaged records. The time spent in preparing the faxing documentation will be well worth it when there are considerably reduced contact requests for the information again due to unreadable or poorly readable images.

June 2007

1. **Question** Should the providers send hard copy records?
   Answer The preferable mode of transmission is fax, but CERT asks that a quality review of the documents be performed prior to faxing to assure the original document will fax in high quality.
2. **Question** If providers are using forms that are grayed, colored or highlighted, should the provider drop to hard copy?
   Answer Again, the preferred method of receipt is fax of legible documentation. One should remember that if it doesn't copy well, it doesn't fax well.
3. **Question** If documents are in legal-size paper, does CERT want those sent in on legal-size paper, and if so, can legal size be scanned by the equipment CDC is using?
   Answer CDC can accommodate and image legal-size paper. The faxes are routed to a fax server and are printed in the format in which they are submitted.
4. **Question** How can we know if a document is faxed crookedly, and when this occurs, is the provider being contacted in those instances?
   Answer If the document comes in illegible, CDC does contact the provider to obtain legible documents.
5. **Question** Can you provide us with any other suggestions to assure legibility?
   Answer Try making a photocopy of the document. If the photocopy is clear, it is likely that the fax will be clear. Another important consideration is that highlighting blacks out on the fax machine. One solution might be to minimize or introduce alternative types of forms within your institution or practice. This approach would also help in preparing for the transition to an electronic medical record.

September 2007

Here are a few more suggestions when preparing the medical record prior to faxing or mailing.

- If at all possible, do not staple, paper clip or mail documents in binders. Even though each page is reviewed before it is scanned in, the process can be dramatically improved if there is less time spent on preparation. It is not necessary to separate the pages unless they belong to more than one patient.
- Place the bar coded cover sheet on top of the medical records/documentation when mailing records in. That cover sheet, which has the CID number on it, can be recreated, but if it cannot be located, then the process may be affected.
- Avoid sending copies of copies. The nurse reviewers do a great job in deciphering the images, but to make their jobs easier, please try to only send copies of the originals. That will reduce the time it takes to lighten or darken a page for legibility.
- When sending copies of records, please try to not send double-sided pages. This will increase the time it takes to image the entire record.

Prolonged Services

National Government Services (NGS) Listserv 11/5/07

E/M services have the highest error rates as identified by both NGS and CERT. As a result, NGS' Medical Review Department is implementing a prepayment review of Prolonged Physician Services (*CPT* 99354-99357) and the related E/M service for Indiana and Kentucky Part B providers. Providers will receive an Additional Development Request (ADR letter) detailing the specific documentation being requested for the billed services. Providers who fail to provide the requested supporting medical documentation timely will receive a full claim denial.

It is important for providers to understand that, as the Prolonged Physician Service is considered an add-on code, the initial E/M service will also be reviewed. The documentation must reflect the medical necessity of the E/M service and the need for the prolonged service. The Prolonged Services are time-based codes and, therefore, the time of direct patient contact must be clearly identified in the record.

THANK YOU!

The Board of Trustees of the Indiana Academy of Family Physicians Foundation would like to thank the individuals and organizations that have donated to the Foundation in 2007. Your generosity has provided the Foundation with critical resources needed to fulfill its mission:

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