FRONTLINE PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Fall 2006

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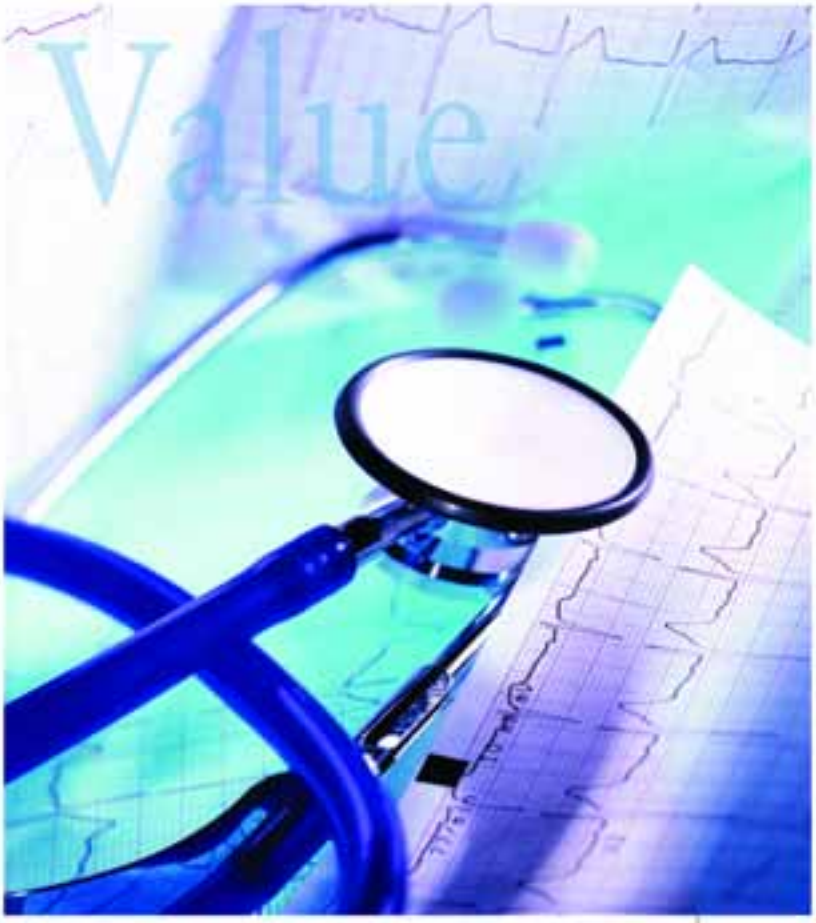
Doctors Know. . .

The Value of Uncompromised Standards



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FRONTLINE PHYSICIAN

Volume 7 • Issue 3

FrontLine Physician is the official magazine of the Indiana Academy of Family Physicians and is published quarterly.

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The MISSION of the Indiana Academy of Family Physicians is to promote excellence in health care and the betterment of the health of the American people. Purposes in support of this mission are:

- 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.

INDIANA ACADEMY OF FAMILY PHYSICIANS

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FrontLine Physician is published by Innovative Publishing Ink.
10629 Henning Way, Suite 8 • Louisville, Kentucky 40241
502.423.7272 or 866.423.7523
www.ipipublishing.com

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On the Cover: From L-R, Clif Knight, MD, Alternate Delegate; Worthe Holt, MD, Alternate Delegate; Ashraf Hanna, MD, 2nd Vice President; Windel Stracener, MD, President; Larry Allen, MD, President-Elect; Teresa Lovins, MD, 1st Vice President; Daniel Walters, MD, Chairman of the Board and Immediate Past President; Kenneth Elek, MD, Speaker of the Congress; Thomas Felger, MD, Delegate. Not Pictured: Andrew Deitsch, MD, Vice Speaker.

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President's Message

Greetings

Windel Stracener, MD

I would like to take this opportunity to thank the Academy for the opportunity to serve as your president for the coming year. I am certain that this will be an exciting and eventful year.

We just completed our Congress of Delegates and Scientific Meeting in July. For the first time in many years, this was held in Fort Wayne. We also had our first all member Congress as mandated by our recent bylaw changes and geographic realignment. Both meetings were well attended, and attendees seemed to enjoy the meetings.

As we have made changes to our Congress and the way that we do business in the Academy, we have also been concerned about participation and leadership development within the state. Like all volunteer organizations, the few often do the work for the benefit of the many. We have been very fortunate in the state to have an ample amount of people willing to pursue leadership roles. However, there is always room for new ideas and approaches to the problems that are facing family physicians across the state of Indiana and the nation. If you or someone you know is interested in becoming more active in the Academy, then contact the Academy or me and let us know of your interest. This will help to insure a continued supply of upcoming talent and leaders in the future.

Let me encourage each of you to become active in the Academy's Foundation and Political Action Committee. These organizations depend on donations and operate independent of dues revenue. The Foundation is the charitable arm of the Academy and helps to fund student and resident activities, the Barnett-Adopt-A-Student Program and the highly successful Tar Wars program. I realize that as physicians you are often asked to donate toward many worthy causes. I would ask each of you to consider a donation to the Foundation this year and to continue to donate, as you are able each year, so that we can continue the present programs and expand those programs as the Foundation grows.

Our political action committee has been active at the statehouse, allowing the Academy to influence the political process as much as possible for the good of family medicine and our patients. As I am sure most of you realize a PAC requires money to operate and to insure a seat at the table for health care discussions. Donations are welcome at any time, but in an election year they are critical. With all of our members contributing, we will have one of the most influential PACs in the state, but this requires everyone's participation.

Finally, let me encourage you to attend the National Congress and Scientific Assembly in Washington, D.C. This should be a great meeting, and the Rally on Capitol Hill will be a chance to show lawmakers what a presence family physicians have in the country. Also, our Academy will be supporting Dr. Tom Kintanar in his run for president-elect of the AAFP. See you in Washington.

IAFP GOVERNMENT AFFAIRS

by Allison Matters and Doug Kinser

Campaigns

As we gear up for the 2007 session of the Indiana General Assembly, Indiana's political climate is unsettled at best. There will be three to five competitive Senate seats and ten to fifteen competitive races in the House of Representatives this year.

With long-time President Pro-Tem Garton having lost in the Primary, nothing can be certain in the Senate until after November's election. President Pro-Tem Garton served in the Senate for thirty-six years and in leadership for twenty-six years. The new pro-tem will be elected by the majority caucus after the general election. After the election, the pro-tem will make key leadership and chair appointments. The Republicans will continue to hold the majority after the elections, although the Demos could pick up a seat or two.

In the House, Speaker Bosma and House Republicans have a 52-48 majority and Democrats are being led by Rep. Bauer. Over the last decade, there have been changes in House leadership because of changes in the majority. Many lobbyists expect the Democrats to regain control of the majority. Demos are running against Gov. Daniels and House Republicans over Daylight Saving Time, the toll road and property taxes. Republicans are running on positive changes for Indiana including economic development.

For those that follow campaigns, as do your lobbyists, the election cycle will be exciting.

Interim Study Committees

The Indiana General Assembly's interim agenda began with the meeting of its annual Legislative Council meeting in July. The committees/commissions have yet to conduct any significant business, and it is unlikely that the committees will meet more than once or twice during the next couple of months. For your reference, please see the committees and charges of interest below.

1. INTERIM STUDY COMMITTEE ON PUBLIC HEALTH AND SAFETY MATTERS
THE COMMITTEE IS CHARGED WITH STUDYING THE FOLLOWING TOPICS:

A. Railroad labor camps (Sen. Landske and HCR 68)
B. Coal mine safety (Sen. R. Young)
C. Smoke detectors and sprinkler systems in health facilities, including nursing homes (SR 34 and SR 42)
D. Food handling regulations for tax exempt organizations (HR 84)

4. INTERIM STUDY COMMITTEE ON CHILDREN'S ISSUES
THE COMMITTEE IS CHARGED WITH STUDYING THE FOLLOWING TOPICS:

A. Child labor (HB 1267 and HR 50)
B. Children's health issues, with emphasis on diabetes and obesity (SR 43 and part of SCR 31)

6. HEALTH FINANCE COMMISSION (IC 2-5-23)
THE COMMISSION IS CHARGED WITH STUDYING THE FOLLOWING TOPICS:

A. The cost of delivering health care services to diabetics (HR 34)
B. Adapting health coverage systems used in other jurisdictions to answer the needs of Hoosiers (SCR 42)
C. Monitor and report on the impact of the privatization of health-related services performed or administered by state agencies, including the impact on state employees who have been laid off (SR 51 and SR 56)
D. Certification of surgical technicians (Legislative Council)

7. HEALTH POLICY ADVISORY COMMITTEE (IC 2-5-23-8)
THE COMMITTEE IS CHARGED WITH STUDYING THE FOLLOWING TOPICS:

A. Restraint of trade issues associated with contact lenses (HR 73)
B. Advisability of consolidating certain study committees (Health Finance Advisory Committee, Health Policy Advisory Committee, Health Care Account Advisory Board, Medicaid Advisory Committee and Medicaid Work Incentives Council) into the Health Finance Commission (Legislative Council)

8. SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT (IC 2-5-26-1)
THE COMMISSION IS CHARGED WITH STUDYING THE FOLLOWING TOPIC:

A. Medicaid reimbursement rates (Rep. Cochran)

9. COMMISSION ON MENTAL HEALTH (IC 12-21-6.5)
THE COMMISSION IS CHARGED WITH STUDYING THE FOLLOWING TOPIC:

A. Social, emotional and behavioral health screening of children (HR 88 and HCR 69)

Additional Issues

Hoosier Healthwise. The Family and Social Services Administration recently selected three managed-care organizations to participate in a statewide contract to provide medical services to participants in the Hoosier Healthwise program. The state chose Anthem, MDwise and MHS from six applicants. Those insurers who were left out of the state's contract are CareSource, Harmony and Molina.

Please note that in 2007 physicians can contract with multiple plans; however, patients will select a PLAN first, then a PHYSICIAN within that plan. We urge our members to make a decision about which plan(s) to join and inform patients of the choice.

The three MCOs are currently negotiating with the state. The details of the plan must be worked out between now and January 1. The IAFP will keep members informed as more information is available.

UPDATE

2007 Legislation. During the '06 General Assembly, legislation was introduced regarding both Assignment of Benefits (AOB) and Prohibition of Most Favored Nations (MFN) Clauses. These bills/issues were tabled last year but have reemerged in the pipeline for the 2007 session.

A coalition of employers, physicians and hospitals are working together to reintroduce the prohibition of Most Favored Nation Clauses. *If you are in a contract with an insurance company that has a "Most Favored Nation" clause or an "Equal Rate" provision, please let the Academy know how this affects your practice.*

American Medical Association State Advocacy Roundtable. Allison Matters, director of legislative and region affairs, attended the American Medical Association's State Advocacy Roundtable during the first week of August. She joined representatives from almost 40 state medical associations from across the country, as well as many other national medical associations, including anesthesiology, emergency medicine, ophthalmology, plastic surgery and orthopedic surgery.

Medical liability reform was at the top of the agenda as recent developments and alternative reforms were discussed. Indiana's recent Apology Inadmissibility Statute was discussed, and speculation was had as to the effect the statute will have on physician/patient interaction.

Managed-care payment practices were also important items discussed at the roundtable. In particular, legislating fair contracting was discussed as the Colorado Medical Society shared its recent efforts with Standard Form Contracting, SB 198. The legislation would have prohibited contracts from dictating a physician's right to determine payor matrix and prohibited "all products" clauses, rental networks and waiver of rights. While the legislation did not make it into law, Colorado's efforts will serve as a model for other states to push for standard form contracts. The IAFP's Resolution # 06-10, introduced by Glenn Wheet, MD, was modeled after Colorado's recent legislation.

The AMA is currently undertaking a geographic mapping initiative to plot the service areas of all practicing physicians, then overlay the map with the service areas of all non-physician providers. This should offer some insight as to relationship between primary care physicians, NPs and rural access to care.

Other items discussed include: fee schedule transparency, the unregulated secondary market in physician discounts, expanding access to health insurance coverage and certificate of need. If you are interested in any of these issues, please let Allison know, as she can supply you with supplemental materials from the roundtable.

Legislative Update

2006 All Member Congress of Delegates

This year's first-ever All Member Congress of Delegates was a success, as members from across the state gathered in Fort Wayne to vote on issues important to family medicine. Resolutions passed by 2006 COD include:

Task Force on Leadership Development
A Task Force to develop methods for identifying and encouraging new leaders be appointed by President Stracener.

"Unhealthy Food in Hospitals" #06-01
RESOLVED, that IAFP encourage/work with the Indiana Hospital and Health Association, and other interested parties to eliminate unhealthy food from hospital vending and cafeteria areas.

"Pay for Performance" #06-02
RESOLVED, that the IAFP should not support the use of patient-centered clinical outcome measures for pay-for-performance incentives, and be it further

RESOLVED, that the IAFP should support the use of AMA endorsed process measures for pay-for-performance incentives that most accurately reflect the actual physician services offered during the clinical encounter, and be it finally

RESOLVED, that the IAFP should support pay-for-performance incentives for physicians and practices that implement clinical systems changes that enable higher quality care, and be further

RESOLVED, that the IAFP delegation carry a resolution to the AAFP that includes the intent of the above resolves.

"Use of Certified Nurse Practitioners and Physician Assistants" #06-03
RESOLVED, that this Congress direct the president of the IAFP to form a task force to develop a cohesive and comprehensive policy on physician's assistants and nurse practitioners and their role in health care.

"Increasing Business Awareness of the Importance of Family Medicine" #06-04
RESOLVED, that the IAFP Board of Directors develop a plan whereby Indiana business owners are educated about the benefits of having family physicians available to their employees.

"Immunization Reporting" #06-05
RESOLVED, that the IAFP work with retail pharmacies, grocery stores, churches, and other related entities to address the issue of requiring non-primary care entities which administer immunizations of any type (i.e. influenza) to notify a patient's self-identified Primary Care Physician that they have been immunized, and be it further

RESOLVED, that if the IAFP's efforts with related entities prove fruitless, the IAFP's Commission on Legislation work with our IAFP lobbyists and key contacts in the state legislature to introduce legislation on the issue, and be it finally

RESOLVED, that in such legislation, local health departments, other governmental agencies (such as Veterans' Affairs sites) and hospitals be encouraged to provide similar information to a patient's primary care physician.

"Revised Food Pyramid" #06-06
RESOLVED, that the IAFP Board of Directors work with the ISMA as well as other groups with an interest in childhood nutrition and obesity to support the transition of governmental agencies toward the use of the revised NIH food pyramid, and be it further

RESOLVED, that through its media outlets (*FrontLine*, *e-FrontLine*), the IAFP remind its membership of the importance of this transition in nutrition models that can substantially improve the health of their patients.

"Accurate Coding and Fair Reimbursements" #06-07
RESOLVED, that the IAFP takes the position: Fair contracting requires third-party payers to reimburse physicians for providing significant separately-identifiable problem-oriented evaluation and management services in addition to minor surgical procedures and preventive care examinations performed during the same encounter when a reasonably prudent physician would consider such services to be medically necessary and to meet identifiable guidelines for standard of care, and be it further

RESOLVED, that the IAFP will advocate to third party payers on behalf of IAFP members that bundling of services that have not been peer-reviewed and approved, blending of codes, and/or failing to acknowledge modifiers is not fair or acceptable; IAFP will communicate to third party payers that these policies should promptly be changed, and be it finally

RESOLVED, that the IAFP Delegates carry this resolution forward to the AAFP Congress of Delegates.

"ICD-10" #06-08
RESOLVED, that the IAFP recommends the AAFP to support the AMA's current effort to delay implementation of the ICD-10 system, and to modify the process to be less burdensome to physicians.

"Promotion of Family Physicians Providing Obstetrical Care" #06-09
RESOLVED, that the IAFP recommend changes in the recognition of and separate reimbursement for the work involved performing inpatient management and management of labor that occurs prior to operative delivery or other services performed by another physician, thus compensating the family physician for the work and risk involved in providing maternity care, and be it further

RESOLVED, that the Board of Directors will determine the most appropriate way that this should be accomplished.

"Standard Form Contracts" #06-10
RESOLVED, that the IAFP will begin working with other medical and non-medical organizations to pursue standard form contracts between insurance companies and physicians.

"Tar Wars Evaluation" #06-11
RESOLVED, that the IAFP direct its AAFP delegates to submit to the AAFP Congress of Delegates a resolution calling for establishment of an appropriate tracking system for downloading of the Tar Wars Program Guide, so that the AAFP can track data on a national level, and state chapters can track local levels of participation and interest in the hopes of securing funding to continue this critical program.

Good Ol' Family Doctor on Life-Support

by Richard Feldman

I have always been proud to be a family physician. My father, who was a family doctor for more than 45 years, served as a primary role-model in my life and career.

His family came to America through Ellis Island in 1920 seeking a new life free from poverty and anti-Semitism. He returned to Europe to attend medical school and witnessed the evils of Nazi Germany. My father endured the Great Depression and lived through Pearl Harbor as a young medical officer on that infamous day in 1941. Typical of that "greatest generation," his character and values as a person and a doctor were shaped by such experiences.

He called himself a general practitioner. In those days, there were no residency programs to train him in the core concepts of today's board-certified discipline of family medicine. The principles of comprehensive and continuous personalized patient care came to him and other general practitioners of his generation by experience and sensitivity to the needs of their patients.

The specialty of family medicine was created 37 years ago from the best traditions and attributes of general practice. But it was created out of necessity. The over-specialization of medicine in post-war America reached a point that threatened the existence of the primary care generalist. It was at a time when medical knowledge, research and technology were exponentially expanding, stimulating the development of the medical specialties. Graduating medical students flocked to the specialties that offered greater prestige and larger incomes.

The family doctor was fading. The trusted adviser and compassionate counselor who cared for everyone in the family from the beginning to the end of life, with the willingness to care for every need regardless of circumstance, was lamented by the general public. The time-honored general practitioner, who took the opportunity to talk and develop ongoing relationships with his patients, advocated for them and coordinated their health care, was still in high demand.

Across the country, primary-care access issues extended to all socioeconomic strata of our nation. It was evident to government, policymakers, organized medicine, and the public that something had to be done; thus, the new specialty of family medicine was born.

The establishment of formal training in family medicine reversed the trend away from primary care, and today patient visits to family doctors account for the largest proportion of doctors' office visits. They continue to be the heart and soul of medicine. More than any other specialty, family doctors humanize the health care experience. Focusing their attention on the person, not just the disease, they are driven by the need to make people whole.

Sure, I'm presenting the family physician as a romantic and idyllic figure in American culture. But I believe it is real and validated by anyone who has had a long-term, comforting and reassuring relationship with their family doc; however, the future of family medicine and primary care is once again threatened.

Medicine is again overspecializing, fueled by a market-driven health-care system that promotes the expansion of procedural medicine and specialty practices that create large profit margins. Primary-care physicians are increasingly employed by health-care corporations that judge and pay them mainly on the basis of productivity. Our reimbursement system is not designed to reward spending time with patients to counsel, educate and to develop the necessary therapeutic relationship by knowing the patient as a person. Medicine is becoming increasingly depersonalized as a system largely dominated by corporate interests and a business ethic. Primary care is today fragmented with overspecialization on one side and immediate-care centers and "minute clinics" providing episodic care on the other.

Career interest in family medicine, primary-care internal medicine and pediatrics is on the decline as the demand increases for the higher-paying subspecialties that promise a better work-life mix. Over the past eight years, the number of U.S. medical students choosing a career in family medicine has decreased by more than 50 percent. Family medicine simply can't compete.

When people learn that I am a family physician, they often ask, "Isn't the family doctor a dying breed?" I respond, "No, not really." But silently, I must admit, sometimes I do worry.

Richard Feldman, MD, is director of medical education and family medicine residency at St. Francis Hospitals and Health Centers and is a former state health commissioner. Contact him at richard.feldman@ssfhs.org.

This article was originally printed in The Indianapolis Star.

2006 IAFP Annual Meeting a Great Success

Windel Stracener, MD, IAFP president, with Warren Jones, MD, past president of the AAFP

Newly Installed IAFP Officers

Guests enjoy dancing and music at the All-Member "Luau" Party.

The 58th IAFP Annual Meeting was held at the Grand Wayne Center/Fort Wayne Hilton in Fort Wayne, Indiana, July 26-30. About 180 physicians and their families attended the meeting, which included CME sessions, Congress of Delegates, business meetings, an exhibit show and many social events.

About 170 physicians and ancillary personnel attended the CME sessions. Highlights included Neil Irick, MD's session, "Difficult Cases in Pain Management Made Easy"; a talk by Robert Graham, MD, a former executive vice president/CEO of the AAFP; and two lectures by well-known speaker Louis Kuritzky, MD, of Gainesville, Florida. In addition, Joy Newby presented a well-received coding workshop, and the television personality Jared Fogle, of Subway sandwiches, spoke about his weight-loss success.

The All Member Party had a luau theme this year, and guests were treated to delicious food, tropical cocktails, and wonderful music from the Marlins.

At the President's Banquet, Warren Jones, MD, past president of the AAFP, installed Windel Stracener, MD, as the president of the IAFP. The IAFP's new officers were also installed at this event.

IAFP Annual Award Winners

Special Thanks

Several companies donated prizes for Exhibit Hall drawings held during the IAFP Scientific Assembly on July 28-29, 2006 in Fort Wayne.

We would like to thank all companies and physicians that participated.

Prize	Donor	Winner
Friday's Winners		
$50 Gas Card	IAFP	David Hadley, MD
$50 Gas Card	IAFP	Risheet Patel, MD
National City Basket	National City	Verlin Houck, MD
iPod	Medical Protective	Kristina Kaufman, MD
Golf Balls	triPRACTIX	Kris Kaufman, MD
Golf Certificate Book	Martin Riley Architects Engineers	Jim Dearing, MD
Saturday's Winners		
$250 Visa Gift Card	Summitt Medical Technologies	Karen Davis, MD
$100 Gas Card	IAFP	Richard Boersma, MD
One Night Stay with Breakfast for 2	Fort Wayne Hilton	Melissa Walther, MD
iPod Nano	triPRACTIX	Rex Flenar, MD
SAS Shoemaker Certificate	SAS Shoemaker	Hahns Shin, MD
National City Basket	National City	Debra McClain, MD

IAFP Circle of Support Members

The Indiana Academy of Family Physicians would like to give special recognition to the following supporters. The companies listed below have supported special events and/or provided an educational grant that distinguishes them as IAFP Circle of Support Members.

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New Jersey Academy of Family Physicians
PA Labs/Midwest Coag
Pfizer

IAFP Annual

Richard Beardsley, MD, receives the Family Physician of the Year Award from Richard Feldman, MD.

IAFP Family Physician of the Year Award

The IAFP Family Physician of the Year Award is presented annually to a member who exemplifies the tradition of the family physician and contributes to the continuing good health of the citizens of Indiana.

Many words have been used to describe Dr. Richard Beardsley — "respectful," "sensitive," "motivated," "dedicated" and "compassionate" among them. He has been called an advocate, teacher, advisor, role model, friend, and even a living legend. Given the number of friends and colleagues that have chosen Dr. Beardsley as the family physician for their own families, these compliments should not come as a surprise.

Dr. Beardsley graduated from DePauw University before attending medical school at Indiana University. He completed his residency at St. Francis Hospital in Beech Grove and has continued in private practice while maintaining his position as assistant director of the St. Francis Hospital Family Practice Residency for nearly 25 years. He also serves as the medical director for the Altenheim Community, a large senior-care facility on the south side of Indianapolis, and has spent many hours volunteering for various organizations, including the Good News Mission Free Clinic and the Indianapolis Children's Choir. In April, he even completed the Boston Marathon!

An award-winning teacher and role model, Dr. Beardsley is without a doubt deserving of the title of Indiana Family Physician of the Year. His continued dedication to the specialty of family medicine, its students and residents, his colleagues and patients represent what we have all come to envision as representing the ideal family physician.

The IAFP congratulates Dr. Beardsley for being named 2006 IAFP Family Physician of the Year, and we thank him for the example he has set for our specialty.

Judith Monroe, MD, receives the Lester D. Bibler Award from Clif Knight, MD.

Lester D. Bibler Award

The Lester D. Bibler Award is named after the first president of the IAFP (IAGP) and is presented annually to an active IAFP member who, through long-term dedication and leadership, has furthered development of family medicine in Indiana.

Dr. Judith Monroe has served the specialty of family medicine in tremendous ways during a relatively short period of time. Appointed state health commissioner and Medical Director of Medicaid for the state of Indiana by Gov. Mitch Daniels in March 2005, she previously performed the duties of director of the St. Vincent Hospital Family Practice Residency, where she was also clinical assistant professor of family medicine for 13 years. Prior to her time at St. Vincent, Dr. Monroe was clinical director of the Indiana University School of Medicine for two years, and she practiced in Appalachia for four years.

Dr. Monroe earned her bachelor's degree from Eastern Kentucky University and worked at the Walter Reed Army Medical Center in Washington, D.C. before graduating from University of Maryland Medical School, where she was a National Health Service Corps Scholar. She completed her residency training at the University of Cincinnati, which she followed with fellowships at University of Wisconsin and East Tennessee State University. Dr. Monroe has provided much service to the IAFP, actively participating on the Commissions on Health Care Services and Education, on the Residency Directors and Medical School Liaison Committees, and as a delegate to the Congress. She has also spoken at countless meetings and scientific assemblies.

Dr. Monroe's activities and recognition to date are endless. Though it is hard to come by, she spends her "free time" volunteering for the Indianapolis Children's Choir, Girl Scouts, Wheeler Mission, Indianapolis Homeless Initiative, or a local medical clinic, among other actvities.

The IAFP congratulates Dr. Monroe for being selected to receive the 2006 Lester D. Bibler Award, and we thank her for her service in the name of family medicine.

Award Winners

Peter Nalin, MD, receives the A. Alan Fischer Award from Clif Knight, MD.

A. Alan Fischer Award

The A. Alan Fischer Award is presented annually to recognize persons who have made outstanding contributions to education for family practice in the undergraduate, graduate and continuing-education arenas.

Dr. Peter Nalin has been the residency director at the Indiana University Family Practice Residency since 2001, serving as an associate professor of clinical family medicine since 2004. He serves as a family physician with University Family Physicians, Inc. and is an active staff physician with Clarian Methodist Hospital of Indianapolis. Dr. Nalin attended Cornell University prior to earning his medical degree from the University of Vermont. He completed his residency in family medicine at Lancaster General Hospital.

Students, residents, and colleagues alike all praise Dr. Nalin for his continued support of the specialty of family medicine, emphasizing the importance of research for its future, and advocating for the best for its students. He is well respected among his peers, serving as the 2004-05 president of the Association of Family Medicine Residency Directors, but more importantly, the students and residents that he teaches admire him. Peter Nalin, MD, has truly set an example to follow.

The IAFP congratulates Dr. Nalin for being selected to receive the 2006 A. Alan Fischer Award, and we thank him for educating and inspiring the newest members of our specialty.

Karla Sneegas, MPH, receives the Jackie Schilling Certificate of Commendation from Missy Lewis.

Jackie Schilling 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. In 1999, the award was named after past IAFP Executive Vice President Jackie Schilling.

Karla Sneegas, MPH, has served as the executive director of Indiana Tobacco Prevention and Cessation Agency (ITPC) since its inception in 2001. Prior to this, she was a consultant for various clients, including The Robert Wood Johnson Foundation, The Advocacy Insititute, Tobacco Smart Indiana, and the University of North Carolina Center for Health Promotion, and she was the volunteer chairperson for the Indiana ASSIST Coalition for a Tobacco Free Society. Karla earned her bachelors degree from Western Kentucky University before completing graduate coursework at UNC-Charlotte and University of South Carolina, where she eventually earned her master's degree in public health.

ITPC has gained much recognition around the country and is highly respected among the tobacco control community nationwide. While this success is very much a collaborative effort, experts agree that the program would not be what it is today without Karla's outstanding leadership and strategic vision — especially when faced with budget cuts of 67% soon after the agency was up and running. Additionally, Karla has successfully kept family doctors involved in the process, forging a valuable relationship between medicine and public health.

The progress that Karla has made has significantly reduced the burden that tobacco has on Indiana residents, and evidence-based research tells us that the impact that she has made in reducing exposure to secondhand smoke, offering services to help tobacco users quit, and preventing youth from starting to smoke will significantly influence the toll that tobacco takes on our state.

The IAFP congratulates Ms. Sneegas on receiving the 2006 Jackie Schilling Certificate of Commendation and thanks her for her continued leadership in the battle against tobacco.

IAFP Annual Award Winners

Richard Feldman, MD, receives the Raymond W. Nicholson Award from Deborah McClain, MD.

Raymond W. Nicholson Award

The IAFP Foundation presents the Raymond W. Nicholson Award to recognize the recipient for outstanding support of the Foundation, financially and/or personally.

Richard Feldman, MD, has been an active member of the IAFP Foundation Board of Trustees since 2002 and currently serves as its vice chairman. Having completed his pledge as a member of the Founders' Club, Dr. Feldman continues to give graciously to the Foundation, and is one of our strongest long-term supporters of Tar Wars.

Most recently, however, Dr. Feldman championed the campaign to create the IAFP Historic Family Doctors Office at the Indiana Medical History Museum, which was dedicated on September 17, 2005. He recognized the opportunity that was before us, and made this dream a reality. The mid-20th-century family doctor will now be preserved for generations to come. With this project behind him, Dr. Feldman is now leading the way on the Family Practice Stories Book, which will serve to carry on the story of the family doctor through the words of our own members.

The IAFP Foundation Board of Trustees thanks Dr. Feldman for his unique ideas, continued and dedicated support of our Foundation, and contributions, both personal and financial, over the years.

Jared Basham, MD, receives the Outstanding Resident Award from Clif Knight, MD.

IAFP Outstanding Resident Award

The IAFP Outstanding Resident Award is presented annually to a family medicine resident who demonstrates exceptional interest and involvement in family medicine and exemplifies the qualities of a family physician.

Jared Basham, MD, earned degrees from DePauw University, Purdue University, and Indiana University prior to entering medical school at Indiana University. He currently serves as chief resident at the Community Health Network Family Medicine Residency Program and is finishing out his term as the resident director of the IAFP Board of Directors. Throughout Dr. Basham's service to the IAFP, he has provided great insight from a resident's perspective. Additionally, he was instrumental in developing the medical student survival-skills workshop for students beginning their third-year rotations. This project has not only been a help to the students but also has served as an excellent introduction to family medicine.

Dr. Basham has been commended for many traits, but his leadership, eagerness to learn, and attention to patient care are most often mentioned when describing him. From the time that he was a medical student, residents and faculty recognized his desire to learn — always reading, asking questions, and listening to teachers, patients, and fellow students. He has used these listening skills to the benefit of both his patients and peers and no doubt will continue to do so in a long and productive career in family medicine.

The IAFP congratulates Dr. Basham for being named the 2006 Outstanding Resident and looks forward to working with him for many years to come.

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Get them

IN ON TIME

through the 1st year

Birth	Age 2 months	Interval	Age 4 months	Interval	Age 6 months	Interval	Age 12 months	Interval
	RGE (Rotavirus)		RGE (Rotavirus)		RGE (Rotavirus)			
HepB	HepB	Not earlier than 6 weeks of age			HepB	at least 4 months after first dose		
	DTaP		DTaP	1-2 months	DTaP	1-2 months	DTaP	6 months after the third dose
	Hib	Not earlier than 6 weeks of age	Hib	1-2 months	Hib	1-2 months	Hib	2 months
	Polio (IPV)		Polio (IPV)	1-2 months	Polio (IPV)	1-2 months		
	PCV (Pneumo)		PCV (Pneumo)	1-2 months	PCV (Pneumo)	1-2 months	PCV (Pneumo)	6-8 weeks and on or after first birthday
							MMR	On or after first birthday
							Varicella	On or after first birthday
							HepA	2nd dose 6 months later

CHIRP
Children and Hoosiers Immunization Registry Program

indiana immunization coalition

Indiana State Department of Health

Every Fall: Flu Vaccine

- All children 6 months to 5 years of age.
- All children 6 months and older with asthma, diabetes, or other chronic high-risk condition.
- Others in the household of both the above.

Note: Children 6 months through 8 years old need 2 doses, one month apart, in their first year of flu shots.

Before Kindergarten:

- DTaP, Polio, MMR#2, also, unless already given, HepB and Varicella

Indiana's "IN ON TIME" Childhood Immunization Schedule is compatible with the recommendation of the Advisory Committee on Immunization Practices (ACIP) of the US Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). If you have any questions, call the Indiana State Department of Health, 800-701-0704.

Combined vaccines may decrease the number of shots.

CHIRP

Children and
Hoosiers
Immunization
Registry
Program

What is CHIRP?

CHIRP is a statewide, confidential, Internet-based system designed to keep track of immunization records.

EASY TO ENROLL! EASY TO USE!

What are the benefits of the Children and Hoosiers Immunization Registry Program (CHIRP)?

- Helps to reduce under and over immunization of patients
- Improves immunization rates by providing a more complete and current immunization history
- Contains Indiana State Department of Health Lead screening test results
- Reduces staff time spent searching and calling for immunization records
- Simplifies vaccine management by tracking inventory and automatically creating the Vaccines for Children (VFC) reporting document
- Creates reminder/recall notifications for parents and patients
- Prints Official Immunization Cards
- Exports records to use in Clinical Assessment Software Application (CASA) to check your immunization coverage rates

Web Site

https://chirp.isdh.state.in.us

For more information, contact the:

CHIRP SUPPORT CENTER

Phone: (888) 227-4439 Fax: (317) 233-8827

Email: chirp@isdh.in.gov

Lead Poisoning
Potential Hazard to All Children

There are a number of public health issues that require the attention and action of health professionals to manage. New public health issues are emerging while old ones have been forgotten but still present a threat to our health. In an effort to improve communication and education from the Indiana State Department of Health with your organization and the professionals throughout Indiana, I will be sending you a monthly article and prescription. I invite you to use these articles however you wish. You may want to insert them into your newsletters or distribute electronically to your members or staff.

Below you will find a prescription and an article for decreasing lead poisoning in Indiana. Lead poisoning continues to be a problem in Indiana and places hundreds of children at risk for learning disabilities. We cannot afford to ignore this issue, and we need everyone to understand the risks and solutions.

If you have suggestions for topics, please contact Kathy Weaver at kweaver@isdh.in.gov. If, for some reason, you do not wish to receive these monthly communications or they should be sent to someone else, please let us know.

Judith A. Monroe, MD
State Health Commissioner

In February of this year, a 4-year-old boy was taken to the emergency department of a Minneapolis hospital due to complaints of vomiting. He was sent home with what was thought to be flu symptoms.

According to the Centers for Disease Control and Prevention's Mortality and Morbidity Weekly Report, two days later his family returned with him to the emergency department, this time with vomiting, a "sore tummy," and listlessness. He was admitted to the hospital. The next day, a CT scan was performed that revealed a heart-shaped object that was later determined to be a foreign body and triggering a request for heavy-metal testing. The blood lead level reported the following day was 180 ug/dL. It was on the fourth day of hospitalization that the 4-year-old child was removed from life-support and died.

The object the child digested was discovered to be a charm used as a promotional item with the purchase of Reebok shoes. Tests on similar Reebok charms showed varying levels of lead up to 67%. According to the Consumer Products Safety Commission, the limit for lead in jewelry is no more than 0.06%. These Reebok charm bracelets were voluntarily recalled on March 23, 2006.

Admittedly, this case is an extreme one, and death by lead poisoning is rare. With the removal of lead from fuels and residential paint, we have seen a marked decrease in the levels of lead showing up in children's blood. Lead poisoning is, however, more common today than most people, including health care professionals, realize.

Lead is a potential hazard to all children, regardless of economic status, as evidenced by nine product recalls that have occurred just since January 1, 2006, due to hazardous levels of lead. These recalls range from bracelets sold by Oriental Trading Company for $0.50 to ones manufactured by Liz Claiborne and retailing for about $95.00.

Still, with increased attention to an alarming number of consumer products that contain lead, we must be careful not to lose sight of the most common source of lead exposure: lead-based paint and the dust it generates. The older the home is, the greater the chances that lead-based paint is present. Because Indiana ranks 11th in the nation for housing built pre-1950, Hoosier children are especially at risk. Many of these homes that have lead hazards do not appear to be deteriorating. In addition, renovation and remodeling activities of homes built prior to 1978 can pose an even greater risk as paint is disturbed and may not be properly contained.

Recent research has shown that lead absorption may cause irreversible health effects on children with blood lead levels as low as 5 ug/dL. Without the symptoms that may accompany extreme lead levels to trigger lead testing, at-risk blood lead testing is necessary to identify poisoned children. Risk factors include:

- Living in or regularly visiting a house or child-care center built before 1978,
- Siblings or playmates who have lead poisoning,
- Contact with an adult who works in an industry or has a hobby that uses lead,

- Status as a recent immigrant, member of a minority, or Hoosier Healthwise recipient, or
- Use of some folk or ethnic home remedies and cosmetics.

If a child meets any one of the risk categories and is under the age of 7, a blood lead test is necessary.

In order to limit the adverse effects on health and mental development, it is important that we identify those children who have been exposed to lead hazards and remove the sources of exposure. The existing testing rate for at-risk children in Indiana is discouragingly low, as demonstrated in 2004, when 92% of Hoosier children under 7 years old did NOT receive blood lead tests. With such inadequate testing, it is impossible to tell just how many children are being affected.

We simply cannot accept that an estimated 14,000 Hoosier children below the age of 7 years may suffer irreversible adverse effects on their IQs, cognitive abilities, and behaviors that will likely reduce their academic success and lifelong potential.

Actions for Health Care Providers:

- Provide anticipatory guidance in accordance with the American Academy of Pediatrics' policy statement, Lead Exposure in Children: Prevention, Detection, and Management. http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/4/1036.pdf

- Sign up with the Indiana State Department of Health Childhood Lead Poisoning Prevention Program (ICLPPP) to receive training and supplies to perform blood lead testing of at-risk children. Phone: 317-233-1250. E-mail: lead@isdh.in.gov.

- Refer families of children under 7 to local health departments for environmental assessments if they indicate they live in a home built prior to 1978.

- Recommend lead safe work practices when patients' families are considering remodeling and renovations of older homes.

http://www.hud.gov/offices/cpd/affordablehousing/training/web/leadsafe/keyrequirements/safepractices.cfm.

Lead Toxicity

1. Prevent
provide anticipatory guidance to parents of all infants and toddlers about preventing lead poisoning in their children.

2. Detect
identify children exposed to lead hazards and perform blood lead testing on at-risk children.

3. Manage
for levels over 10 ug/dL, remove sources of exposure and monitor response to intervention through follow-up testing.

What Is Taboka?

Phillip Morris/Altria Corporation is test-marketing a smoke-free and spit-free tobacco pouch product, called Taboka, targeted towards adult smokers interested in smokeless tobacco alternatives to smoking.

Smoke Free Indy believes it is important to inform you about this new product so that you can share with your patients.

What is Taboka?

Taboka Tobaccopaks™ are smoke-free, spit-free tobacco pouches and come in two versions — Original and Taboka Green, which is their menthol version. They will be sold in containers of a dozen pouches for about the same price as a pack of Marlboros, the company's most popular cigarette brand.

Why this new product?

- Indianapolis and 23 other Indiana communities have passed smoke-free air laws, eliminating smoking in most public places within these communities. The move indicates that cigarette-makers are looking for ways to cope with stricter laws against indoor smoking and possible federal government regulation of tobacco products.
- Indiana also ranks second in the nation for the number of tobacco users at 27.3 percent, also making it a good target audience for Taboka.

The Health Effects of Smokeless Tobacco, According to the Centers for Disease Control and Prevention:

- Smokeless tobacco contains 28 cancer-causing carcinogens. It is a known cause of human cancer, as it increases the risk of developing cancer of the oral cavity. Oral health problems strongly associated with smokeless tobacco use are leukoplakia and recession of the gums.
- Smokeless tobacco use can lead to nicotine addiction and dependence.

Please inform your patients and staff that this new product is tobacco and that it is not a safe or better alternative to smoking. Please also inform them that the only way to break the nicotine addiction and avoid tobacco-related disease is to quit smoking and refrain from all tobacco use. For more information about Smoke Free Indy, please visit www.smokefreeindy.com. For a listing of cessation resources, please visit www.mchd.com/tobcess.htm.

Tar Wars®

Holly Swick traveled with her parents from Rosedale, Indiana, to Washington, D.C., in July to participate in the Tar Wars National Poster Contest. While there, Holly visited Sen. Richard Lugar's office, where she shared with his staff what she has learned from Tar Wars. The visit was followed by a tour of the U.S. Capitol and sightseeing in the capital city. Later that evening, Holly was honored with a certificate of "Special Recognition" at the Tar Wars Banquet and Awards Ceremony.

Runners-up in this year's Tar Wars State Poster Contest were:
Shay Oldham
Shelbie Gossett
Corbin Gregory
Brookelyn Seibert

The IAFP Foundation was honored to be selected as a recipient for one of a few statewide grants from the Indiana Tobacco Prevention and Cessation Agency (ITPC) for the Tar Wars program this school year. Expectations are high, as we have been charged with reaching many communities that have not traditionally participated in Tar Wars this year. Additionally, we hope to be able to connect participants (physicians AND schools!) with smokefree air campaigns in their communities. Smokefree air is something that the entire community must work on together!

Though ALL counties are encouraged to participate, we have some priority areas that we will be focusing on in 2006-07. If you — or your staff — would like to present the Tar Wars program to one or more fifth-grade classrooms in your area, please contact Missy Lewis (mlewis@in-afp.org) to sign up. The Tar Wars Program Guide can be viewed at:
http://www.tarwars.org/PreBuilt/tarwars_0506programguide.pdf.

2006 Tar Wars "Priority Areas"

Dekalb County	Jasper County	Gibson County
Martin County	Floyd County	Scott County
Jay County	Noble County	Pulaski County
Warren County	Orange County	Franklin County
Union County		

* We will also be looking toward the IUSM Regional Campuses and the Residency Programs to participate in their local areas!

2006 Annual Meeting Exhibitors

2006 Annual Meeting Exhibitors

The IAFP would like to extend its appreciation to the following exhibitors and sponsors. Without their help and generous support, the 2006 Annual Meeting would not have been possible.

Please thank the company's representatives when they visit your office.

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Indiana Child Care Health Consultant Program
Indiana Spine Group
Indiana State Department of Health
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Congress of Delegates Break

The Grand Wayne Center
Board of Directors Refreshment Break
CME Afternoon Refreshment Break
CME Refreshment Break

The Indiana Hand Center
President's Reception

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- INET—Indiana Family Practice Research Network
- Indiana Spine Group
- Indiana State Department of Health
- Jared Foundation
- OMEW
- Sanofi-Aventis Pharmaceuticals
- New Jersey Academy of Family Physicians
- Boehringer-Ingelheim Pharmaceuticals

THANK YOU!

The Board of Trustees of the Indiana Academy of Family Physicians Foundation would like to thank the individuals and organizations that donated to the Foundation in 2006. Your generosity has provided the Foundation with critical resources needed to fulfill its mission:

> *"to enhance the health care delivered to the people of Indiana by developing and providing research, education and charitable resources for the promotion and support of the specialty of Family Practice in Indiana."*

FOUNDER'S CLUB MEMBERS

Founder's Club members have committed to giving $2,500 to the IAFP Foundation over a 5-year period. Members noted with a check mark (✓) have completed their commitment. The Board would also like to acknowledge that many of these individuals give to the Foundation in addition to their Founder's Club commitment.

Deborah I. Allen, MD ✓
Dr. Jennifer & Lee Bigelow
Kenneth Bobb, MD ✓
Douglas Boss, MD
Bruce Burton, MD ✓
Kalen A. Carty, MD
Clarence G. Clarkson, MD ✓
Dr. Robert & Donna Clutter ✓
Dianna L. Dowdy, MD
Richard D. Feldman, MD ✓
Thomas A. Felger, MD ✓
Fred Haggerty, MD ✓
Alvin J. Haley, MD ✓
John L. Haste, MD ✓
Jack W. Higgins, MD ✓
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Richard Juergens, MD ✓
Thomas Kintanar, MD ✓
H. Clifton Knight, MD ✓
Edward L. Langston, MD ✓
Teresa Lovins, MD ✓
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Jackie Schilling ✓
Paul Siebenmorgen, MD ✓
Kevin Speer, JD (IAFP EVP)
Daniel A. Walters, MD ✓
Deanna R. Willis, MD, MBA

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Ralph E. Barnett, MD
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Dr. Jennifer W. & Lee Bigelow
Douglas Boss, MD
Bruce Burton, MD
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by Joy Newby, LPN, CPC
Newby Consulting, Inc.

Hold on Medicare Payments

Family physicians need to be aware that a brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last nine days of the federal fiscal year. This hold was mandated by §5203 of the Deficit Reduction Act (DRA) of 2006.

No payments on claims will be made from September 22, 2006 through September 30, 2006. All claims held as a result of this one-time policy that would have otherwise been paid on one of these nine days will be paid on October 2, 2006. No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.

This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Medicare contractors will continue to apply the 14-day electronic claim payment floor and the 29-day paper claim payment floor for claims received from September 22, 2006 through September 30, 2006.

NPI Reminder — Countdown Has Begun

Do you have your NPI? Don't risk disruption to your cash flow. Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about NPI and how to apply by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site.

Ending the HIPAA Contingency for Electronic Remittance Advice

This article only applies to those family physicians receiving electronic remittance advice. We strongly recommend asking your computer vendor to verify you are receiving HIPAA-compliant Electronic Remittance Advice (ERA) transactions. Effective October 1, 2006, Medicare will send only HIPAA-compliant ERA transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

Medicare has aggressively worked with providers and vendors to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners. CMS ended the contingency plan that addressed inbound claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Currently, 99% of all ERA receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERAs. Further, the overall compliance rate for all Medicare providers in May 2006 was 96%.

Effective October 1, 2006, CMS will end the contingency plan for the remittance advice transaction. After that date, all Medicare Carriers will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

Invalid Diagnosis Code Editing

For claims processed on or after July 31, 2006, if the claim includes an invalid diagnosis code, the entire claim will be rejected and returned as unprocessable. Diagnosis codes are updated annually with new, revised, and deleted codes becoming effective with dates of service on or after October 1.

HIPAA rules require Medicare to ensure submitted diagnosis codes are HIPAA-compliant, especially because these diagnosis codes are passed on to other payers under Medicare's Coordination of Benefits process. To be compliant, regardless when the claim is submitted, the diagnosis code must be valid for the date the service is rendered.

New ICD-9 Codes Effective October 1, 2006

A complete list of the *ICD-9* changes for dates of service October 1 and after has been posted. For more information, please go to www.in-afp.org and click on "Practice Management."

Anthem Advance Directives and Physician Office Reviews

Advance Directive: a legal document (as a living will) signed by a competent person in order to provide guidance for medical and health care decisions (as the termination of life support or organ donation) in the event the person becomes incompetent to make such decisions. (www.m-w.com/dictionary)

Anthem Blue Cross and Blue Shield of Indiana, Kentucky, and Ohio reviews advance directive policies and documentation during a Physician Office Review. Anthem evaluates physician offices for advanced directive policies, as well as for copies of the signed advance directive or documentation of advance directive discussions with appropriate members. Appropriate members are defined as all Senior and/or Medicare Advantage members and those with chronic or catastrophic illness.

Over the past three years, physician offices in Indiana, Kentucky, and Ohio have scored under the 80% threshold for advanced directive policies and documentation. Anthem Blue Cross and Blue Shield's Quality Improvement department will distribute an informational handout for physicians to distribute to appropriate patients at the time of the physician office review. This handout is intended to promote a heightened awareness of advance directives.

If you have any questions, please contact Cindy Purtell, RN, at (513) 336-4733 or cynthia.purtell@anthem.com. For additional information regarding state-specific documents, please refer to www.ama-assn.org, then search for keywords "Advance Directives." (Anthem Rapid Updates — May 23, 2006)

IAFP Membership Update

KEEP US INFORMED

Members, please keep all of your contact information up to date with the AAFP and the IAFP:
This includes:
Your address
Phone/Fax
E-mail

To update, please call:
Amanda Bowling at the IAFP:
(888) 422-4237
AAFP: (800) 274-2237

Membership Status Totals as of July 31, 2006

Active 1,702
Supporting (non-FP) 5
Supporting CME (FP) 3
Inactive 20
Life 189
Resident 201
Student 187
Total 2,307

New Members

The Academy wishes to extend a warm welcome to our new members:

Active

Joseph Mattox, MD
Fort Wayne

Active (Residents Upgraded)

Yuliyan Donchev, MD
Carmel

Shahriar Setoudeh-Maram, MD
Fishers

David Schweck, MD
Fishers

Justin Wright, MD
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Indianapolis

Cynthia Williams, MD
Indianapolis

Louis Landman, MD
Indianapolis

Melissa Erickson, MD
Indianapolis

Roopam Shyam, MD
Indianapolis

Jared Basham, MD
Indianapolis

Rachel Shockley, DO
Indianapolis

Carrie Caraco, MD
Indianapolis

Michelle McCarthy, MD
Indianapolis

Sunita Premkumar, MD
Indianapolis

Josephine Lilla, MD
Indianapolis

Azra Abdullah, MD
Indianapolis

Manish Manna, MD
Indianapolis

Kevin Hartzell, MD
Crown Point

Jeffrey Huxford, MD
Demotte

Mazhar Zaidi, MD
Gary

Franklin Ademodi, MD
Merrillville

Imad Alizray, MD
Merrillville

Robin Whitaker, DO
Granger

Lashunda Williams, MD
Mishawaka

Rebecca Brice, DO
Mishawaka

Martin Baur, MD
South Bend

Brandon Zabukovic, MD
South Bend

Timothy Gerst, MD
South Bend

Sarah Davis, MD
South Bend

Gregory Shaskan, MD
South Bend

Joseph Nicholas, MD
South Bend

Surekha Bavirti, MD
South Bend

Paul Osmun, DO
Fort Wayne

Mary Ellen Mason, DO
Fort Wayne

David Hall, DO
Fort Wayne

Curtis Carter, MD
Fort Wayne

Joshua Kline, MD
Fort Wayne

Farhat Usman, MD
Fort Wayne

Dawn Lagerkvist, MD
Marion

William Hoover, MD
Peru

Nathan Berger, MD
Floyds Knobs

Jami Rayles, MD
Muncie

Cody Wagner, MD
Seima

Evelyn Bose, MD
Newburgh

Djenita Butulija, MD
Evansville

Cristian Pantea, MD
Evansville

Mike Gerald Sebastian, MD
Evansville

Thurman Alvey, DO
Terre Haute

Elizabeth Henriott, MD
Terre Haute

Students

Ms. Brooke Edwards
Fishers

Mr. Benjamin Shepple
Greenwood

Mr. Brandon Hayes
Indianapolis

Ms. Akeira Johnson
Indianapolis

Ms. Christina Bennett
Indianapolis

Mr. Joseph Cerjak
Indianapolis

Ms. Rebecca Bowman
Warren

Ms. Elizabeth Schowe
Fort Wayne

Mr. Christopher Grindle
Fort Wayne

Ms. Nicole Ramig
Bloomington

Ms. Margaret Hainline
Evansville

Ms. Amanda Hall
Evansville

Ms. Kathryn Wannemuehler
Evansville

Mr. Kile Carter
Evansville

Ms. Mallery Neff
Lafayette

Residents

Jessica Eckerle, MD
Westfield

Theresa Krueger, MD
Indianapolis

Robyn Fean, MD
Indianapolis

Christopher Louck, MD
Indianapolis

Emily Abernathy, MD
Indianapolis

John Beerbower, MD
Indianapolis

Chirag Patel, MD
Mishawaka

Elizabeth Gullone, MD
South Bend

Matthew Gullone, MD
South Bend

Amy Hogue, MD
South Bend

Robert Galbraith, DO
South Bend

Keyna Martinez, MD
South Bend

Andrew McAfee, MD
South Bend

Jon Shull, MD
South Bend

Pamela Somervell, MD
South Bend

Matthew Brady, MD
South Bend

Deitrick Gorman, DO
Fort Wayne

Tatyana Sarkisova, MD
Fort Wayne

Crystal Strong, MD
Fort Wayne

Sebastian Ksionski, MD
Fort Wayne

Hahns Shin, MD
Fort Wayne

Duane Johnson, DO
Fort Wayne

John Pagonis, MD, MPH
Fort Wayne

Jessica Ottenweller-Butcher, MD
Fort Wayne

Anna Bukhman, MD
Fort Wayne

Randeep Gill, MD
Terre Haute

Laurie Joy, Valera, MD
Terre Haute

Physician of the Day Volunteers Needed for February and April 2007!

The Indiana Academy of Family Physicians (IAFP) and the Indiana State Medical Association (ISMA) will once again sponsor the Physician of the Day program at the 2007 General Assembly. Your assistance is needed! In this session, it is most important that family medicine make an impression on our legislators. This important program allows you to observe the legislative process firsthand and to meet with your area representatives.

The Physician of the Day Program is one in which IAFP members volunteer to spend one or more days at the Statehouse during the legislative session. The purpose of the Physician of the Day Program is to provide episodic primary-care services, as a convenience, for the governor, legislators and their staffs during the time the state Legislature is in session. The Physician of the Day will be introduced at the beginning of the day. Your day at the Statehouse will be from 8:30 a.m. to 4:30 p.m.

We are in the process of scheduling physician volunteers for the months of February and April. If you are interested in serving as the Physician of the Day, please circle the day or days that you want to serve, fill out the information below the calendar and return it to the IAFP office no later than Nov. 11, or feel free to call the IAFP office at (888) 422-4237 (toll-free, in-state only) or (317) 237-4237 to schedule your Physician of the Day shift.

Thank you in advance for your assistance with this important program.

Please note: Only the shaded dates are available.
Physician of the Day does not operate Friday-Sunday.

Calendar for February 2007

Sun	Mon	Tues	Wed	Thur	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

Calendar for April 2007

Sun	Mon	Tues	Wed	Thur	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Please fill out and mail to: IAFP, 55 Monument Circle, Suite 400, Indianapolis, IN 46204

Name: _____

Phone Number: _____

Malpractice Insurance Carrier: _____

Day(s) Requested: _____

Barnett
Adopt-A-Student Program Update

Three students from the Indiana University School of Medicine recently completed eight-week externships with family physician preceptors in Indianapolis, Franklin, and Connersville, Inidana. The Barnett Adopt-A-Student program was able to offer support to three students due to strong family physician support as well as grant funds provided by the American Academy of Family Physicians.

The Foundation Board of Trustees would like to thank all IAFP members who supported this program throughout 2005 and those that continue to support it in 2006. This has become an invaluable program that helps to introduce outstanding first-year medical students to the world of family medicine, and has repeatedly produced students that eventually go on to choose the specialty of family medicine. Below are the medical students and IAFP members who participated in the Barnett Adopt-A-Student program in 2006:

Students
Christina Holmes
Benjamin Shepple
Brian Coppinger

Preceptors
Dr. Wayne White, Connersville
Dr. Jill Beavins, Franklin
Dr. Mark Fakhoury, Indianapolis
Dr. Martha Yoder, Indianapolis

It's not too early to get started for next year! If you would be willing to host a student in your office — for the summer or as a one-time shadow — contact Missy at the IAFP (mlewis@in-afp.org).

"This experience has really opened my eyes as to how necessary and helpful the specialty is. We often hear about how desperately primary-care physicians are needed, but this really drove that point home."
— A 2006 Barnett Adopt-A-Student Participant

Member News

Richard D. Kiovsky, MD, Appointed New AHEC Program Director

Richard Kiovsky, MD, is the new Indiana AHEC program director. He has been with the Department of Family Medicine, IU School of Medicine, for 18 years and is a professor of clinical family medicine. He also serves as director of undergraduate medical education and as president of UFP, Inc., the department's practice plan.

Member Physician Presenting Harvard Collaborative Study at the National Assembly

Indiana family physician **Dr. Vipin Jain** was the recipient of the Harvard scholarship last year for various chronic disease initiatives serving underserved communities. He will present his study on September 29 at the 2006 AAFP scientific assembly in Washington, D.C., during the family medicine research session.

Dr. Jain implemented Chronic Kidney Disease (CKD) approach in a primary care setting based on Harvard's Brigham CKD care model. In this study, CKD clinic approach resulted in aggressive disease management for patients with diabetes and improved glycemic, blood pressure and lipid outcomes. Dr. Ajay K. Singh, who is the clinical chief of the renal division at the Harvard's Brigham and Women's Hospital, is very pleased with these results and would like to further explore underlying reasons behind refractory versus positive outcomes.

2006 Medical Student Survival Skills Workshop *Another Success*

by Mecca Maxey-Smartt, MD
PGY-2
Community Health Network
Family Medicine Residency Program
Secretary of IAFP Resident District

On June 10, the annual medical student survival-skills workshop took place at the Indiana University Family Medicine Center in Indianapolis. Designed to expose medical students to various procedures performed by family physicians, the workshop was funded by the IAFP Foundation and attended by 42 eager medical students from Indiana University School of Medicine.

The day began with an opening talk by Dr. Curt Ward from the St. Vincent Family Medicine Program. He addressed issues such as the scope of family medicine, the IAFP, and how students can become involved in the IAFP. Multiple procedure stations then ensued throughout the almost seven-hour day. These stations included delivering a baby, scrubbing in, casting, radiology, suturing, skin biopsies, admission orders, and central lines. Seven family-medicine residency programs participated in running the stations: Community Health Network, St. Vincent, St. Francis, Indiana University, Ball Memorial, Memorial South Bend, and St. Joseph South Bend.

Survey results returned by participating students showed that the majority found the workshop stations very helpful and informative. The casting, radiology, and scrubbing-in stations were found to be most valuable to the students. Furthermore, according to general comments, the workshop not only exposed students to procedures commonly performed within the scope of family medicine, but it also helped students with their current clinical rotations and directly exposed them to various in-state residency programs. A pizza lunch provided by the IAFP Foundation gave students further opportunity to speak with family medicine residents from around the state.

This hands-on workshop continues to be an annual success. Special thanks to the IAFP Foundation for funding this interactive workshop, and to all participating residency programs, residents, and faculty for making it possible. Extra-special thanks to the numerous IAFP members who generously donated funds towards this event. The next survival skills workshop will be held at a similar time in 2007. We hope to continue to expose medical students to our specialty and the wide range of practice possibilities that it offers.

Ball Memorial Hospital residents demonstrate the art of suturing.

Dr. Curt Ward of St. Vincent delivers the day's opening talk.

Residents from St. Joseph South Bend Family Medicine Residency Program instruct a student on proper casting technique.

Congratulations

We would like to congratulate the following first-year Indiana family medicine residents. We hope to see each of you at future IAFP meetings/events and look forward to you being involved in the IAFP and the "family of family medicine" in Indiana.

Ball Memorial Family Medicine Residency
Joseph Binfet, MD
Melissa Cain, MD
Julie Gunther, MD
John Heflin, MD
Sheirlie LaMantia, MD
Roy Miner, Jr., MD
Bradley Morin, MD
Darin Winn, MD

Community Health Network Family Medicine Residency
Adrienne Bedford, MD
Vandana Duggal, MD
Lisa Hoffhaus, MD
Mery Kendall, MD
Praveen Rajanahalli, MD
Mona Saifullah, MD
Maureen Sampson, MD

Deaconess Family Medicine Residency
Rami Fasheh, MD
Holly Heichelbech, DO
Alison Johnson, MD
Mitra Khalafgeigi, MD
Christina Lee, MD
Tim McGhee, MD

Fort Wayne Family Medicine Residency
Anna Bukhman, MD
Melinda Fritz, MD
Deitrick L. Gorman, MD
Duane P. Johnson, DO
Sebastian J. Ksionski, MD
Jessica Ottenweller-Butcher, MD
John J. Pagonis, MD
Tatyana S. Sarkisova, MD
Hahns Shin, MD
Crystal L. Strong, MD

Indiana University Family Medicine Residency
Antoinette Barnes, MD
Huma Bhatti, MD
Neil Gamilla, MD
Susan Jablonski, MD
Mushkbar Khan, MD
Daniela Lobo, MD
Roya Mojarrad, MD
Phumeza Miskikinya, MD
Bonnie Wong, MD
Mitra Yazdi, MD

Memorial Hospital Family Medicine Residency
Matthew Brady, MD
Michael Galbraith, DO
Elizabeth Gullone, MD
Matthew Gullone, MD
Amy Hogue, MD
Keyna Martinez, MD
Andrew McAfee, MD
Andy Shull, MD
Pamela Somervell, MD

Saint Francis Hospital Family Medicine Residency
Emily Abernathy, MD
John Beerbower, MD
Jessica Eckerle, MD
Robyn Fean, MD
Theresa Krueger, MD
Christopher Louck, MD

Saint Joseph Regional Medical Center Family Medicine Residency
Stephen Drye, MD
Tonya Duguid, D.O
Laura Foudy, MD
Trixy Franke, MD
Tiffany Franke, MD
Kevin Kaufhold, MD
Jacklyn Kiefer, D.O
Timothy Nush, MD
Chirag Patel, MD
Matthew Schwartz, MD
Jason Sharp, MD

Saint Vincent Family Medicine Residency
Amanda M. Armey, MD
Rachel C. Lackey, MD
Julie A. Moll-Tillman, MD
Souhaila A. Richardson, MD
Seth D. Rinderknecht, MD
Haley N. Trambaugh, MD
Jamie R. Ulbrich-McLain, MD

Union Hospital Family Medicine Residency
Randeep Gill, MD
Kenneth Kigorwe, MD
Love Kasule, MD
Anju Menon, M.D
John Richards, MD
Laurie Valera, MD

Are Your Fe

by Thomas A. Felger, MD

A few years ago, as I was doing an annual adjustment to our residency fee schedule, I discovered a very disturbing fact. Our best- and worst-paying insurance companies were not just paying procedures more than our cognitive E/Ms, but it was a very organized process and for a big differential. While the process is boring to read, I need to give you some background information on the process used so you can understand the outcome of the survey.

In the late '80s, the "Harvard Study" was released and, for the first time in health care economics, an attempt was made to compare the relative work of a large number of medical events to each other, for example: an office visit vs. an appendectomy, a hysterectomy vs. a cardiac bypass, etc. After this was published, most of those interested in health care financing were pleased with the effort, and it became formalized by Congress in directing Medicare to create a Resource-Based Relative Value System (RBRVS) to be used to create the Medicare physician fee schedule. The system was put into place in 1992.

At the same time, the American Medical Association created the Relative Value Update Committee (RUC), which was composed of 26 voting specialties tasked with continuing to refine the relative value of some 7,000 *CPT* codes, as well as assign values to new *CPT* codes. This relativity is expressed in Relative Value Units (RVUs). The RUC started out with all the errors of traditional health care — namely paying more for such activities as cutting, injecting, and imaging than thinking (E/M).

From these original values of RVUs, the RUC worked hard over 13 years to refine the RVUs by using surveys of various specialties and the collective wisdom of the RUC members. Despite those efforts, there are many observers who feel that the RUC has actually further increased the relative differential between cognitive work and procedural work. While this may well be true, if one assumes that the RVUs assigned to our CPT codes are "relatively relative," then there should be a reasonable progression of dollar values among codes that actually are more work than others.

Medicare, formerly under the Health Care Financing Administration (HCFA) umbrella and currently under the Centers for Medicare & Medicaid Services (CMS), is at the helm of overseeing all of the RUC deliberations and RVU value recommendations. Medicare has always had the authority to accept, revise, or reject the RUC's RVU recommendations. Over time, HCFA and CMS have accepted well over 90% of the RUC recommendations.

What Medicare will eventually pay for any given code is based on the total RVU value of a code and the Conversion Factor (CF) that Medicare is using that year. In 1997, Medicare went from two different CFs to one CF for all codes. The current Medicare CF is $38.89 per RVU. In other words, if code X is worth 1 RVU, then Medicare would pay $38.89. If code Y is worth 2 RVUs, then Medicare would pay $77.78 and a 10-RVU code would pay $388.90. The range of code values is 0.XX to 4X.XX for cardiovascular codes. Under Medicare, this progression is stable and only changes as the RVUs change.

Since I have been fortunate to represent the AAFP on the AMA's Practice Expense Advisory Committee and the RUC, I understand the RVU process fairly well, and I have access to the RVU values of all of our *CPT* codes. As I was processing the residency program's fee schedules, I decided to look at them from a RVU basis. What I discovered was that both the best-paying and worst-paying insurer fee schedules used a RVU basis for their payment of codes. The E/M codes progressed based on the RVU value of the codes, and procedural codes had the same progression based on RVUs. What caught my attention was that the dollars per RVU were quite different between cognitive codes and procedural codes. In my first survey of fees, I found a 36% higher payment per RVU for procedures vs. cognitive (E/M) codes. For our better-paying insurer, the average $/RVU for E/M codes was about $55, and the procedural $/RVU was about $72. For our lower-paying insurer, the average $/RVU for E/M codes was about $39, and the procedural $/RVU was about $53.

Using this information as a basis for concern, the IAFP Commission on Health Care Services (CHCS) decided to survey our state and see if this was an unusual local occurrence or a statewide phenomenon that our members and leadership should know about. Using 10 E/M codes and 14 procedural codes, a spreadsheet was created for the CHCS members to complete. While our sample is limited by 24 codes and five insurers, the data does represent large-urban, medium-urban, and rural-family-physician practices.

As expected, we found the exact same pattern as mentioned above — procedural codes were being paid by the insurers' fee schedules at a much higher $/RVU than E/M codes. The range of a differential reimbursement was 31% to 86%. To restate the bottom line, all of these insurers were paying physicians using the RBRVS system as a basis but using different CFs for cognitive physicians than they were using for proceduralists.

On top of this, there is an interesting pattern of different CFs within the E/M codes and procedural codes. For some reason, inpatient hospital care was significantly less than office visits. In fact, three were even below the Medicare CF of $38.89 ($29.57 to 34.04). There was also a noticeable reduction in $/RVUs for preventive codes. To further confuse the picture, Emergency Service codes had an increase in their RVU values. Within the procedural codes, there seems to be three levels of payment: office procedures at the lowest, a jump up to general surgery and OB/GYN, and the highest $/RVU for orthopedics. This ultimately ends up representing about six different CFs.

To compound this problem, under the global surgical payment policies for 10- and 90-day procedures, a surgeon is paid for a number of

e Schedules Fair?

office visits (E/Ms) post-operatively for every procedure they perform that has a global time period attached to it. For example, 47562, laparoscopic cholecystectomy, has 2.5 level 99212 post-op visits included in the global payment. Not only is it questionable that all these visits are actually performed, but the surgeon is being paid at a much higher $/RVU for his/her post-op E/M visits than we cognitive physicians are being paid for our daily E/M visits.

Obviously, even when insurers use the RBRVS approach to setting payments, none of the insurers we reviewed are using the RBRVS system as it was intended. As a result, the value of the RBRVS system in valuing health care services is significantly reduced. By the use of multiple CFs, insurers essentially make the relative value of those services meaningless.

How do we fix this? My first hope is to simply make family physicians aware of the unfair insurer use of multiple CFs. Beyond that I have no one fix, but I do have some suggestions:

1. Every family physician can discuss this problem with his or her insurers' provider-relations representatives. If you would like to confirm what is happening in your fee schedules, a spreadsheet to figure your own $/RVU is available at www.in-afp.org. If you would like to add codes to your search, the total RVUs of all CPT codes are available at www.cms.hhs.gov/PhysicianFeesched/.
2. As you are negotiating a new contract, there may be value in asking (insisting) on one CF for the fee schedule you are offered.
3. As members become aware of this, notify your state chapter of the problem and see if a more transparent (public) approach to this problem may shame your insurers into equalizing the CFs.
4. As state chapters succeed or fail, these concerns should be passed to the AAFP or put into resolutions to the AAFP Congress of Delegates.

I would like to thank Dr. DeDe Willis for her technical help and various state CHCS members for participating in the survey.

Cognitive vs. Procedural Reimbursement Comparison

		E&M Code	Descriptor	TRVU	Plan A Fee	$/RVU
Cognitive Codes	Office	99212	Est. Ofc Visit- minor	1.02	$ 56.21	$ 55.11
		99213	Est. Ofc Visit- Low	1.39	$ 77.23	$ 55.56
		99214	Est. Ofc Visit- Mod	2.18	$ 121.31	$ 55.65
		99202	New Ofc Visit-Low	1.72	$ 95.48	$ 55.51
	Inpt	99238	Hosp Disch < 30 mins	1.87	$ 105.73	$ 56.54
		99221	Initial Hospital-Low	2.98	$ 101.43	$ 34.04
	Prev	99384	New Prev Med 12-17 yo	3.14	$ 174.75	$ 55.65
		99395	Est Prev Med 18-39 yo	3.70	$ 143.62	$ 38.82
	ER	99283	ER visit-mod	1.64	$ 109.90	$ 67.01
		99396	ER visit-high	2.56	$ 268.61	$ 104.93
			Average $/RVU			$ 57.88

		CPT Code	Descriptor	TRVU	Plan A Fee	$/RVU
Procedural Codes	Office Proc	11400	Exc Benign <0.5cm	2.91	$ 209.55	$ 72.01
		11402	Exc Benign 1.1-2.0 cm	3.87	$ 279.63	$ 72.26
		12001	Lac. Repair Scalp < 2.5cm	3.84	$ 278.17	$ 72.44
		12031	Lac Repair scalp/layered <2.5 cm	4.61	$ 335.13	$ 72.70
		17000	Destruction, Benign lesion, 1st lesion	1.60	$ 116.30	$ 72.69
		57454	Colposcopy w biopsy	4.25	$ 326.69	$ 76.87
	OB	59400	OB Global	43.87	$ 3,164.78	$ 72.14
		59410	Delivery & Postpart only	24.59	$ 1,771.34	$ 72.03
	Office	58100	Endometrial biopsy	3.03	$ 232.65	$ 76.78
		25600	Colles fx-no reduction	7.15	$ 593.22	$ 82.97
		27786	Distal Fibular fx-no reduction	7.77	$ 644.37	$ 82.93
	Major	47563	Laproscopic Cholecystectomy	18.81	$ 1,445.09	$ 76.83
		47600	Cholecystectomy	21.49	$ 1,651.12	$ 76.83
		27442	Knee Arthroplasty	22.90	$ 1,897.61	$ 82.87
	Office	45378	Colonoscopy, without biopsy	10.15	$ -	$ -
			Average $/RVU			$ 75.88

Plan Differential	Average $/RVU for Cognitive Codes	$ 57.88
	Average $/RVU for Procedural Codes	$ 75.88
	$ Differential for Procedural vs Cognitive Codes	$ 18.00
	% Differential for Procedural vs Cognitive Codes	31.1%

Average by Type of Code	Average $/RVU for Office E&M Codes	$ 52.72
	Average $/RVU for inpatient	$ 45.29
	Average $/RVU for ER	$ 85.97
	Average $/RVU for office procedures	$ 75.74
	Average $/RVU for OB Care	$ 72.09
	Average $/RVU for major procedures	$ 78.84

Helping Your Patients with Obesity

by Beth Yegerlehner, MD

For the past thirteen years, I have been a family physician in rural Indiana. In that time, I have seen an explosion in patients suffering from obesity. It is especially troubling to see obesity in my pediatric patients. We are now seeing adult-onset diabetes in the adolescent patients. Insulin resistance is now a problem with school-age children.

During my time in practice, I have seen the different diets come into popularity. First there was the "no-fat" diet, followed by the different versions of the "low-carb" diet, all while America's waistline continues to expand. I myself have struggled over the years to find a diet that worked for me that I can tell my patients about.

Initially, I tried an aggressive weight-loss program, utilizing strong appetite suppressants and a caloric intake of just 500 per day. I would follow my patients with weekly weights, blood pressure, and urinalysis and chart their progress. Not one of the patients who tried this program over a seven-year period was able to maintain the weight loss.

I continued to look for a diet program that would allow my patients to lose and maintain their weight loss. In 1999, on the *Today* show, they had creators of three popular diet programs: the Atkins Diet, the Sugar Buster's Diet, and a third. Each creator talked about the values of his diet plans. I felt the Sugar Buster's Diet made the most sense, and I purchased the book.

The original Sugar Buster's Diet worked well but did not include an exercise program. I encouraged my patients to go out and read the book, but they kept giving me excuses: "I cannot find the book," "I don't have time to read the book," "I don't understand the book," etc. So trying to get my patients to use the book did not help.

So I tried to make a condensed version using the principles of the book. I was finally able to come up with a single page explaining the diet and give examples. In addition, I would hand out a page on metabolic syndrome and insulin resistance. When I explain the diet to patients, I tell them this is a low-glycemic-index diet, not a no-carbohydrate diet, and explain the difference between good versus bad carbohydrates as well as good and bad fats. If you convey that bad high glycemic carbohydrates cause higher insulin levels, which will make them feel hungry and are less satisfying, then explaining this diet will give them an advantage to help them believe so they will be motivated to succeed.

It is hard to get someone excited about a healthy, balanced diet unless you disguise it as a fad diet. One thing that has never worked is to tell patients to "eat less, exercise more, and here is a pill to help you!" There are lots of people out there willing to take your patients' money on a gimmick diet. Instead, you can offer them an alternative that can really work.

Also, you must be aware of the fad diets, because your patients will be aware of them. If we don't advise our patients about these diets, they won't know where to look. I had a decent amount of success with my diet plan. One of the keys is in the delivery of the plan. Patients need you to write it down, make it simple, and follow up with them in your office. If the patients don't start losing weight, have them write down what they are eating and bring it into the office to discuss if changes are needed. I also try to give them examples of how to fit this into their lives.

Labs to check when you are seeing the patient include a lipid panel, TSH and fasting insulin or fasting glucose. Always check their blood pressure, waist circumference and BMI. These can be helpful to see if they have metabolic syndrome.

I spend a lot of time emphasizing their need for exercising and increasing their muscle mass. I ask my patients what types of exercise they do now and what they like to do. We talk about getting their heart rate up and keeping it up for 30 minutes. Exercise is the most difficult part to get patients to be compliant with, and is an important component of the diet plan.

Another difficult area with patients and diet plans is to get the patients out of the idea that a pill is all they need to fix their weight problem. The diet pills that have been out may cause short-term weight loss. Appetite suppressants cause an artificial drop in metabolism and rebound weight gain. It will be worth watching if we get some meds in the future that attack the mechanism of metabolic syndrome. There is a new drug soon to be released that is an endocannabinoid blocker. It will be interesting to see how it helps metabolic syndrome. Even if this medication is helpful, we must remember to include these guidelines. Any medication will not replace diet and exercise for long-term weight loss.

If you would like a copy of my diet sheet, or you have any questions, my e-mail is byegerlehner@mcm.net. This is a serious epidemic that family medicine, more than any other specialty, can have a direct effect on.

Mark Your Calendar

2006

September 26-28, 2006
AAFP Congress of Delegates
Washington, DC

September 27-October 1, 2006
AAFP Scientific Assembly
Washington, DC

October 26-29, 2006
IAFP Strategic Planning Retreat
Phoenix, AZ

November 5, 2006
Board of Directors
Indianapolis, IN

November 10-11, 2006
AAFP State Legislative Conference
Austin, TX

2007

January 25-28, 2007
Family Medicine Update
Marriott North
Indianapolis, IN

February 9-11, 2007
Ten State Regional Conference
Indianapolis, IN

July 25-28, 2007
Annual Scientific Assembly
French Lick, IN

FLP Tips

Beating the Spam Filter

Have you ever sent an e-mail that went unreturned, only to find that it wound up in the recipient's spam folder? Chances are, your messages have telltale spam qualities. Modern filters such as SpamAssassin look for patterns and give your e-mail a spam score; if the score is high enough, your e-mail gets purged.

Following are some tips on how to lower your spam score, from Dr. Ralph S. Wilson, e-business expert.

USE CAPITALIZATION CAREFULLY. Turn off the caps when writing, and be cognizant of overcapitalizing. As an added bonus, your recipient won't think you're yelling.

WATCH YOUR HYPERLINKS. Hyperlinks without an http:// prefix will likely increase your spam score.

AVOID TROUBLE WORDS. Try to avoid using red-flagged terms like *free* or *guaranteed*. Also avoid subject lines mentioning "savings" or "pounds" — even when referring to British currency.

KEEP IT PLAIN. In general, don't use colored or abnormally large fonts.

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Indianapolis, IN 46204

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