

FRONTLINE

PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Spring 2010



**Indiana Represented
at Ten-State Conference**
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FRONTLINE PHYSICIAN

Volume 11 • Issue 1

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 IAFP is to improve the health of the people of Indiana, including its families and communities, by promoting and enhancing the practice of family medicine with professionalism and foresight. The IAFP will achieve this mission while working toward the following objectives:

Advocacy and Influence

Shape health policy through interactions with government, the public, business, the health care industry and other health care professionals.

Promotion of the Value of Family Medicine

Promote the specialty of Family Medicine and its value to the public, the business community, government and the health care industry.

Practice Enhancement

Enhance members' abilities to fulfill their practice and career goals while maintaining balance in their personal and professional lives.

Membership and Leadership Development

Foster the development of leadership within IAFP and encourage Family Medicine involvement at the community, state and national levels.

Education and Research

Provide high-quality, innovative education for physicians, residents and medical students that highlights current, evidence-based practices in Family Medicine and practice management.

Workforce

Ensure a workforce of Family Medicine physicians to meet the needs of all people in Indiana.



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On the Cover: French Lick Resort and Casino in French Lick, Indiana,
site of the 2010 IAFP Annual Meeting

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Ash Hanna, MD

Dear Colleagues

I hope this issue of the *FrontLine Physician* finds you thawed out from the winter cold.

As a part of my president initiative, I am still contacting family physicians across Indiana to talk about your needs and concerns. For those of you who have not yet taken me up on my offer, there is still time, and I'd love to hear from you. Call the IAFP at 317.237.4237 and let them know you are interested in hearing from me.

In the spring, the Academy and I look forward to connecting with you in your area. This year, the IAFP staff and I will be visiting all of the eight Academy regions in the state. As in years past, we are planning a dinner out for members who wish to network with other area family physicians. To enhance the experience, this year, we are also looking forward to visiting offices, IU School of Medicine regional campuses and residency programs while spending a day or two in each region.

The region meetings are important because they are the Academy's time to meet you face to face and hear from you. So please bring your concerns, questions and ideas to the region meeting dinner. Feel free to call the Academy staff ahead of time so that they can prepare and have solutions or answers ready for you. Or contact the office and request an onsite visit. Academy staff members and leadership are interested in visiting physician offices while they are in each of the regions.

We plan to utilize the time with residents to educate them on the Academy, its services and the importance of participating in organized medicine. We will be inviting students to come to dinner so they can meet practicing family physicians with different work environments.

Watch for information on when the Academy will be in your area. I hope to have the opportunity to meet you personally.

Before I end this message, I would be remiss if I did not ask you to remember that the Political Action Committee (PAC) and the Foundation need your help. The PAC identifies from both parties leadership and legislators who support family medicine to receive campaign contributions. The Foundation this year is focusing on student support and wrapping up a story collection for the *Family Practice Stories* book. If you are interested in hearing more about what the PAC and Foundation do and how they use your contributions, call the Academy at 317.237.4237, or visit our Web site, www.in-afp.org.

Sincerely,
Ash Hanna, MD
President
Indiana Academy of Family Physicians

Mark Your Calendar



March 19-20, 2010	March 19, 2010	March 20, 2010
Spring Breakaway	2010 Residents' Day/Research Forum SAM Study Group Coding and Billing Workshop for Office Staff	AAFP Live! Diabetes and Cardiovascular Care (followed by IAFP CME sessions)
Hyatt Regency, Indianapolis, Indiana		
March 21, 2010	July 22-25, 2010	
IAFP Board/Commission Cluster	2010 IAFP Annual Meeting	
Hyatt Regency, Indianapolis, Indiana	French Lick Hotel and Conference Center, French Lick, Indiana	

AAFP Meetings

April 29-May 1, 2010

AAFP Annual Leadership Forum (ALF)
Kansas City, Missouri

September 27-29, 2010

AAFP Congress of Delegates
Denver, Colorado

September 29-October 2, 2010

AAFP Annual Scientific Assembly
Denver, Colorado

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Join Us for Your Upcoming Region Meeting



In April and May, the IAFP will travel across the state to connect with members in their regions. To find out which region you belong to, please review this map. Join us and your colleagues for dinner, education and your region meeting. Watch your *e-FrontLine* newsletter and your fax machine for more details coming soon!



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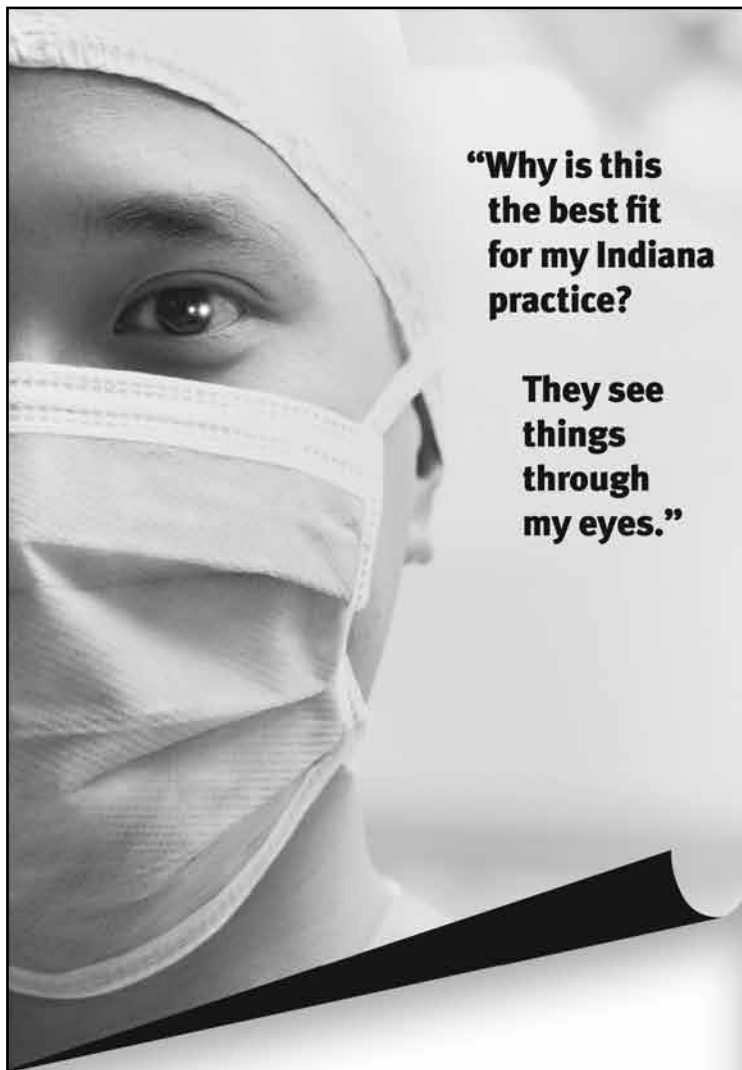
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— Indiana Represented at — TEN-STATE CONFERENCE

Staff members and leaders of your Academy recently traveled to Louisville, Kentucky, to attend the annual Ten-State Conference. The Indiana chapter has been a member of this group of state chapters for around 30 years, and this year, we were represented in Kentucky by Risheet Patel, MD; Tom Felger, MD; Jason Marker, MD; Windel Stracener, MD; Ash Hanna, MD; and Teresa Lovins, MD. IAFP staff members Deeda Ferree; Meredith Edwards; Missy Lewis, MS, CAE; and Doug Kinser, JD, also attended. Sharing of ideas, trends and new projects is always a theme of this conference. Included is a copy of Indiana's recap report that was presented to all attendees of the conference.

INDIANA ACADEMY TEN-STATE REPORT, FEBRUARY 2010

GOVERNMENT AFFAIRS

In March 2009, we hosted our first legislative breakfast. The breakfast featured a presentation on the family physician shortage titled "Breaking Point," which consisted of a video and paper. The presentation was well-received by the 17 legislators who attended. Later in 2009, the Indiana chapter was awarded the Indiana Society of Association Executives' STAR award for best government affairs program for our "Breaking Point" project.

Early in January 2010, we hosted our second annual legislative breakfast. This year, we had a shorter presentation by one of the new co-chairs for the IU Department of Family Medicine once again on the shortage at our legislative breakfast. We had 10 legislators in attendance, and all stayed to spend time to talk with the physicians at the breakfast.

Besides state legislation, the Indiana chapter has been following the federal health care reform legislation closely. During the August recess, the Indiana chapter arranged meetings between our physicians and Reps. Burton, Buyer and Carson.

LEGISLATION

In 2009, the Indiana General Assembly held its long session, during which it is constitutionally mandated to write a budget. The General Assembly failed to pass a budget by April 29, the last day of session, and was forced to go into special session in June.

After a monthlong special session, on June 30, the General Assembly passed a budget for the 2010 and 2011 fiscal years. In the health field, there were some winners and losers. The IAFP was able to keep the Medical Education Board's Family Medicine Residency funding in the budget at \$2.24 million, taking only a minor cut to the fund. Area Health Education Center funding remained in the final budget after initially being cut out completely by Gov. Daniels earlier in the special session. Unfortunately, the Indiana Tobacco Prevention and Cessation agency funding was not able to be completely saved and suffered a 32 percent cut from its current budget. In addition, the IU School of Medicine expansion project will have to work with the \$3 million provided in the final budget instead of the \$5 million the school

requested. The \$5 million was requested to enable all its centers to host students for four years of medical schooling, expanding the school by about 80 students.

2009 AND 2010 HEALTH LEGISLATION...

Primary Care Physician Loan Forgiveness: The IAFP government relations team worked to create a primary care physician loan forgiveness program during the 2009 session. Primary care physicians who practice in Indiana and have a student loan balance would be eligible to receive \$5,000 a year to pay for loans. This money is not tied to practicing in an underserved area, and there is no limit on how many years a physician is eligible for the loan repayment. This passed both houses and was signed into law by the governor; unfortunately, the program is currently not funded.

Midwifery: A bill to allow for the practice of direct-entry midwives (non-nurse midwives) for home births was introduced in 2009 and 2010. In 2009, it failed to pass out of the House, and in 2010, it was not heard in committee.

Open-Access Clauses: The house of medicine sought legislation to prohibit "open-panel" or "open-access" clauses in contracts between physicians and insurers in 2009. These clauses require a physician to continue to take patients from a particular insurer or completely close their panel. The issue was put to an interim study committee in 2009, which had positive results, and the bill was filed again in 2010. The open-access bill passed out of committee, but we are unsure if it will be heard on the floor.

Admitting Privileges: In 2009, a bill was introduced that would have included a mandate for all physicians who perform any surgical procedure (even minor derm) to have admitting privileges at a hospital in their county or adjacent county. It would have affected about 11 percent of our membership, and we were successful in having the bill killed. The issue does not look like it will reemerge in the 2010 session.

Regulation of Retail Health Clinics: The IAFP led on this 2009 bill, which would have put further scrutiny on retail health clinics and would have required JCHO accreditation, separate entrances from the retail stores, providing the patient's primary care provider with a clinical report and emergency response procedures. The bill faced tough opposition and was turned into a clinic reporting bill, and then we requested that it not move forward.

Smoking Ban in Public Places: The smokefree air bill failed to move forward in the second house in 2009, and in 2010, we once again have a smokefree air bill. The bill is still eligible for second reading in the House, and if it moves out of the House, we have confirmation it will be heard in its assigned Senate committee.

Indiana Tobacco Prevention and Cessation Agency: The Indiana chapter has been a longtime supporter of the work done by the Indiana Tobacco Prevention and Cessation Agency staff and their independent board. In 2009, ITPC saw substantial cuts to their program allocation, and in 2010, there is an imminent threat that the agency will be dismantled.

REGION AFFAIRS

In 2009, the Indiana chapter planned dinner meetings in each of our eight regions. The presentation topic for the evening was group visits for tobacco cessation. The Indiana chapter secured funding for the region meetings. Due to a very low number of RSVPs, four of the eight region meetings had to be canceled. In 2010, we will be visiting all eight regions but choosing locations and creating an agenda to attract students from the regional campuses of the IU School of Medicine.

HEALTH CARE SERVICES COMMISSION

In 2009 and 2010, the Indiana Health Care Services Commission sent letters to CMS concerning the proposed physician fee schedule changes and to the Indiana congressional delegation about the Indiana Medicaid Family Planning waiver CMS is still reviewing. The CHCS directed the staff to publish several articles

alerting members to the federal red flag rules. By direction of the commission on health care services, the Indiana chapter has been working with the Indiana State Department of Health (ISDH) on legalizing expedited partner therapy for gonorrhea and chlamydia. The Indiana chapter has been in discussions with ISDH on how to improve its proposed regulation.

PCMH

The Indiana chapter has been working with the Indiana chapter of the American Academy of Pediatrics and the Department of Health on a medical home grant. The grant began late summer with the recruitment of 12 practices from across the state. The practices receive support from a facilitator and a guided collaborative environment for transforming their practices.

The Indiana chapter used our annual meeting town-hall forum to offer up information on PCMH in health care reform and provide our members a chance to ask questions about PCMH and hear answers from staff members and physicians immediately.

EDUCATION

The IAFP is looking forward to March 19 and 20, when we will offer an entirely new educational program to our members. The Spring Breakaway will combine our annual Residents' Day/Research Forum, an MC-FP SAM session on Pain Management, the AAFP Live! Program and an afternoon of IAFP CME over the course of a Friday and Saturday. This marks a significant change from our usual schedule, whereby we would have a Family Medicine Update in January and host Residents' Day

ACADEMY RAMPS UP STANCE ON TOBACCO CESSATION, PREVENTION



The AAFP revised its policy statement on tobacco and smoking (<http://www.aafp.org/online/en/home/policy/policies/t/tobacco.html>) and issued a new position paper (<http://www.aafp.org/online/en/home/policy/policies/t/tobaccoprevcess.html>) on tobacco use, prevention and cessation during its annual Congress of Delegates, October 11-14 in Boston.

The revised policy statement calls for a ban on the sale of tobacco products in facilities that provide clinical patient care services, pharmacies and retail outlets with health clinics.

The statement also expanded on the Academy's stance on smoking in movies, calling on the film industry to take the following voluntary steps:

- Require movies that contain scenes depicting smoking to have an "R" rating unless the presentation of tobacco clearly reflects the dangers and consequences of use or tobacco use is necessary to represent smoking by a historical figure
- Require producers to certify on screen that no one in the production received anything of value in consideration for using tobacco
- Require antismoking ads before all movies that include tobacco use
- Stop identifying tobacco brands

The statement also supports the World Health Organization's Framework Convention on Tobacco Control treaty (<http://www.who.int/fctc/en/>) and urges its ratification by the Senate and signature by President Obama.



separately. We are also offering Saturday's CME completely free of charge for the first time, and so far, our registration numbers show considerable interest from members. We have decided to discontinue our annual Faculty Development Day, due to rising costs and falling participation from residency programs. Our webinar offerings are an area we are looking to enhance in 2010, with online CME for members, and the opportunity to take part in meetings via the web.

We are also excited to announce that we are partnering with the AAFP and the Medical Society of Virginia Foundation on the TO GOAL program. The Wisconsin and Virginia chapters are also taking part. TO GOAL is a multifaceted grant-funded educational program aimed at addressing heart disease and diabetes. We will be able to offer our participating members a whole host of fantastic learning opportunities, such as SAM sessions, Practice Enhancement Forums and quality improvement activities. We hosted an MC-FP SAM session in November 2009 that had great attendance, especially from many members who have not traditionally attended our CME events. Participants were guided through the ABFM's 60 questions on the subjects of hypertension and care of the vulnerable elderly. Our members provided input on ways we could make future sessions a richer learning experience, and we will put those changes into effect in March.

In July 2009, we revamped the schedule for our Annual Meeting in French Lick, Indiana, aiming to provide a leaner, meaner meeting for our members so they could participate fully while spending less time out of the office. Registration increased quite significantly over 2008, telling us that we were headed in the right direction. Many members brought their families along to enjoy a "staycation" at the totally re-

vamped French Lick facility. For 2010, we will continue the same condensed schedule.

COMMUNICATIONS

Our Web site usage is up almost 30 percent in the past year. Almost 9,000 unique visitors resulted in just under 24,000 page views, accessing information about our upcoming meetings, our commissions and committees, our legislative efforts and our programs for students and residents. We have added a Facebook Fan Box to the home page and have 93 fans. Facebook presents another opportunity to communicate with members on a wide variety of topics.

The Indiana Academy continues to produce our magazine, the *FrontLine Physician*, on a quarterly basis. The magazine features a message from our president, legislative and coding articles, notifications on upcoming events, membership news and much more.

We also send out our *e-FrontLine* electronic newsletter via e-mail as needed. This is a useful and effective tool to inform our members about upcoming events and meetings, legislative news, our foundation's public health efforts, Medicare changes and coding updates.

FOUNDATION

The focus of the IAFP Foundation remains (1) student and resident support and recruitment and (2) tobacco prevention and cessation.

The Indiana Tobacco Prevention and Cessation Agency has given IAFP the opportunity to renew our grant for the last time. Staff members submitted a new budget and scope of work for June 2009 through May 2010 in the amount of \$65,000 (the same as the current amount). We have been asked to decrease the amount spent on Tar Wars® again and put more toward cessation CME and tobacco cessation systems change. IAFP also agreed to serve as the fiscal agent for a Supplemental Media grant (ITPC) and a Rapid Response grant (Americans for Nonsmokers' Rights), which supported the Smoke Free Indy radio campaign in spring 2009. Missy Lewis has been in attendance at all region meetings to promote the Indiana Tobacco Quitline and the fax referral system and to distribute additional education materials for the CS2day program through the Indiana State Medical Association.

"As Physicians...", an ad campaign that featured family physicians reminding their peers about how important it is to discuss smoking and the benefits of quitting with their patients, was launched in June 2009. The campaign features print ads of health care providers urging their peers to make cessation a priority for patients who smoke. The ads appeared throughout the state in medical magazines such as *FrontLine Physician*, in local newspapers and on medical Web sites. This proactive peer-to-peer education campaign ran through September 2009. The project supports physician outreach to encourage talking to patients about quitting and referring to treatment services. Financial support for this project was provided by the Anthem Foundation.

The Foundation has continued its work on the *Family Practice Stories* book, with three authors conducting interviews and writing the stories. Response from the membership has been excellent, and fundraising to publish the book has been relatively successful.

STUDENTS AND RESIDENTS

Student interest and involvement in IAFP has grown during the last year, with a group of about 12 medical students who have worked to plan events and collaborate with the Academy on a variety of opportunities. The IAFPF once again hosted the Student Survival Skills Survival Day in June 2009. The event allows rising third-year medical students to learn skills they will need as they begin clinical rotations within days. Many of our residency programs participated and enjoyed the opportunity to interact with more students. Attendance continues to increase, although we have not been able to identify whether the event has been effective in drawing students into family medicine.

The Family Medicine Student Interest Reception occurred on September 30, 2009, at the Riverwalk. IAFP hosted 19 students, their guests and all nine residency programs for hors d'oeuvres and drinks. While attendance was relatively low, many of the residents, faculty members and IAFP members in attendance commented about the quality of the students and the energy in the room.

The students also held three lunch talks in fall 2009 — one in September from the co-chair of the Department of Family Medicine on "What is Family Medicine?", one in October during Na-

tional Primary Care Week about the primary care shortage and one in November about what health reform means for primary care. On average, about 40 students have attended each lunch. On November 7, the students hosted a procedures workshop and invited residencies to conduct the sessions. St. Vincent, Community and Fort Wayne residency programs participated, and others have expressed interest in participating in a similar activity next spring. Fifteen students were in attendance.

IAFPF received a \$1,250 grant from the AAFP Foundation for one student to participate in the Barnett Adopt-A-Student Program for summer 2009. The IAFPF contributed \$1,750 to complete the sponsorship of the student.

Our popular Residents' Day/Research Forum will be held in Indianapolis on March 19, 2010, in conjunction with our AAFP Live! and CME program that weekend. This program gives family medicine residents (and IAFP members) from across Indiana the chance to present case presentations or original research lectures to their peers, faculty members from residency programs and a panel of judges. Poster presentations are also included, and prizes are awarded at the end of the day.

STAFF

The Academy continues to operate with a staff of five full-time employees, in addition to the EVP. We also employ a staff person to serve as the campaign coordinator for Smoke Free Indy, using grant funds specifically designated for that purpose.

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The 2010 Indiana General Assembly

At the time of press, the General Assembly was in the midst of the 2010 short session. Of 833 introduced bills and resolutions, only 242 had passed their original chambers. If history is accurate, we should expect between 120 to 150 bills and ideas to ultimately pass and become law. March 14 is the statutory deadline for adjournment, but most legislators and pundits are expecting adjournment by March 5, 2010.

Out of character, General Assembly committees convened in mid-December 2009 to gain a head start on ethics reform and constitutional property tax caps. A few weeks later, on January 5, the General Assembly officially came into session. Since then, the session has been a rush of hearing, amending and passing bills.

February 3 was the final day for bills to be voted out of their original houses. The General Assembly worked late into the night on February 2 to meet the deadline. The bills that survived moved onto the next house, where committee hearings began on February 8 and ended on February 22.

Although the list of dead bills seems long, bills that pass out of their original house and fail to pass out of the second house are still considered eligible for conference committee. Any section of a bill that passed out of at least one house could possibly be amended into another bill during conference committee.

Below is the current status of the bills the IAFP has been monitoring and lobbying on your behalf.

Bills Still Alive...

National Health Care Legislation's Impact on Indiana (SCR 0015)

This resolution requests that a General Assembly interim study committee look into how health care reform will impact Indiana — specifically, the impact on our

Medicaid programs and how the increase in access to insurance will strain our already limited number of primary care physicians. The IAFP provided testimony in favor of the resolution in the Senate Health and Provider Services Committee and will continue to support the passage of the resolution in the House.

Various Health Matters (SB 175)

Among other provisions, this bill requires the state Department of Health to start a lead-based-paint poisoning prevention program, establishes procedures of local health department inspections and allows for the physician in last attendance of the deceased or the person in charge of interment to begin the document process for a death record. On second reading in the House, Rep. Charlie Brown amended into the bill the prohibition of smoking in public places, excluding casinos. The language added into SB 175 is the same that Rep. Charlie Brown introduced in HB 1131, which the IAFP supported.

Dead Bills...

State Administration (SB 298)

This bill, authored by Sen. Luke Kenley, came from the governor's office and merges the retirement fund for employees who are paid by the government (state employees, teachers, firefighters, police, judges, prosecuting attorneys, etc.), as well as abolishes the Indiana Tobacco Prevention and Cessation (ITPC) executive board and transfers all duties and budget to the state Department of Health. The IAFP feels it is unwise to disturb the current effective ITPC structure and is worried about the future of the money allocated for tobacco prevention and cessation. The bill passed through the Senate, and through an uprising of support for ITPC, the bill was not passed out of committee in the House. The sections of the bill pertaining to pensions were amended into House Bill 1205. The IAFP will be watching for amendments in conference committee that would eliminate ITPC.

Midwives (SB 232)

Last year, the IAFP opposed a similar bill, which almost passed out of the Indiana House of Representatives. The IAFP expected this bill would return during the 2010 session, and we are happy to report it failed to receive a hearing in committee. The legislation would allow the practice of certified non-nurse midwives in Indiana and sets the qualifications for licensure.

Insurer Access to Providers (HB 1022)

After a promising interim study committee and a positive House committee hearing, the IAFP was encouraged by the prospect of HB 1022 passing out of the House. The bill would have ended the unfair insurer practice of requiring physicians to continue taking patients from a particular insurer or close their patient panel to all new patients. These "open-access clauses," which are common in many large insurer contracts, prevent physicians from being able to manage their own practice payor mix. Unfortunately, the bill failed to be heard on the floor of the House and is dead.

Smoking Ban in Public Places (HB 1131)

The IAFP has been supportive of House Bill 1131, the smokefree workplaces law. The bill passed through the House, but establishments that limited patrons to 18 and older, private clubs and more were exempted from the law. The bill did not receive a hearing in its Senate Committee, but the language was amended into SB 175 during second reading in the House.

Health and Medicaid Fraud Matters (HB 1226)

HB 1226 would have originally required a \$50,000 surety bond from every Medicaid provider for the purpose of recouping fines for fraud and would have allowed the attorney general's office to seize medical records of physicians based on allegations of abandonment, without giving the physician a hearing. The IAFP worked with the author and the attorney general's office to remove these

offending portions of the bill. The bill failed to receive a hearing in the Senate, but the portion of the bill on the attorney general's ability to store truly abandoned medical records was amended into Senate Bill 356.

Texting While Driving (HB 1279)

At the 2009 Annual Meeting, the IAFP Congress of Delegates resolution urged the IAFP to take action on the issue of drivers distracted by wireless communication devices. This is the first year the IAFP has supported a ban on texting while driving, although the issue has been at the General Assembly for several years. The bill passed unanimously out of the House Public Policy committee and out of the House with a vote of 95-3; however, it was assigned to the Rules and Legislative Procedures committee in the House and never received a hearing.

If you have interest or questions about these bills or other bills, please contact Meredith Edwards at 317.237.4257 or Doug Kinser at 317.977.1454.

2010's Family Medicine Day Legislative Breakfast Is a Great Success

Two of your Academy's top priorities are to advocate for you in the Statehouse and to promote the value of family medicine to legislators. With those goals in mind, we welcomed several Indiana legislators to our annual Family Medicine Legislative Breakfast, held recently in downtown Indianapolis.

Legislators in attendance were: **Rep. Phyllis Pond, Rep. Ed Clere, Rep. Randy Truitt, Rep. Wes Culver, Rep. Mark Messmer, Rep. Sheila Klinker, Rep. Tim Brown, Rep. David Niezgodski, Rep. Ed Delaney and Sen. Jean Leising.** Members of the IAFP Board of Directors and representatives from our Commission on Legislation were also present.



Dr. Kevin Gebke, interim co-chair of IU's Department of Family Medicine, presented a talk entitled "Primary Care for Indiana," in which he underscored the importance of legislative support to fix Indiana's family physician shortage crisis and to enact payment reform.



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The Name of the Game Is the Claim

Part 1: The Gap in Long-Term Disability Plans

by Mark D. Mousty, President, Benefits Corporation of Indiana



As a physician, you have invested time, energy and money pursuing a lifelong dream — to practice in the field of medicine. Your lifestyle now reflects the income you have been earning as a physician, and your family is enjoying the benefits of what your skills, efforts and education can provide. **But what will you do if you become disabled and cannot perform the duties of your specialty?**

Most physicians purchase individual disability insurance (IDI) early in their careers, but most IDI policies are limited to providing just a small percentage of what physicians earn monthly — typically only \$10,000 to \$15,000. **As income increases, a “gap” may exist between a physician’s income and the income the IDI policy replaces.**

I have been in the disability income marketplace for about 20 years, and the questions many asked me about DI back then are the same ones I hear today. The two most commonly asked questions are, **“Do I really need disability income insurance?”** and **“What policy is the best one for me?”** Fortunately for me, and in the spirit of consistency, the answers to each of those questions haven’t changed.

When I am asked about the need for DI, I usually turn it around by asking my own question, which is: **“If you got sick or hurt and couldn’t go to work for a lengthy period of time and, therefore, couldn’t earn an income, how would you pay your bills?”**

The answers to that question can vary, but for the most part I hear:

- “I have savings I can use.”
- “I can always borrow money from the bank.”
- “Social Security will be there for me.”

These are all sincere answers, and they all have a flaw in one area or another, by pointing out:

- The length of time a disability could last
- The fact that borrowing money is predicated on repayment, and if you are disabled and not working, how can you set up a repayment plan?

- The definition of disability for Social Security is so restrictive that many will never qualify (and there is a five-month waiting period before the benefit is even payable)

Did You Know?

- While many people think disabilities are typically caused by freak accidents, the majority of long-term absences are due to back injuries and illnesses, such as cancer and health disease, causing major limitations in daily living for more than 25 million Americans¹
- One out of seven workers will suffer a five-year or longer disability before age 65²

The answer to why someone needs disability insurance is this — **when you get sick or hurt and cannot work (and earn an income), your DI policy is the best financial alternative available.**

Once you understand, the next question is about the policy itself.

Many want to know what they should look for in a DI policy. My reply to this is simply: **“The name of the game is the claim.”** That is, you should buy the policy that has the best chance of paying you at claim time.

So what factors go into this “claim-paying ability”? I look at four key factors – the **reputation** of the carrier, the **experience** that carrier has in the DI marketplace, the **financial stability** of the carrier and the **contract language**.

Let’s explore each of these in greater detail.

1. **Reputation of the carrier** — does this carrier have a good reputation of paying claims?

2. **Experience in the marketplace** — the fact is there are carriers that have been in and out of the market like a yo-yo the past 20 years.
3. **The financial stability of the carrier** — this ties into the previous factor. Look for a carrier that has the financial strength to sustain the ups and downs of the business. If a carrier has rates that are significantly lower than most of the other carriers, it is usually not because it knows something no one else does. It is usually because the carrier is trying to gain market share by buying business with low rates but will have no choice but to raise them in the next few years.
4. **Contract language** — this might be the most important factor of all. You want to look for a contract that gives you the best chance of getting paid. Unlike many other types of insurance, there are a few phrases and words that can mean the difference between a claim being paid or not being paid.
 - *Mental/Nervous/Drug/Alcohol Abuse Conditions* – most contracts (especially in the group LTD arena) will have a lifetime benefit period of 24 months for disabilities related to mental, nervous, drug abuse, or alcohol abuse conditions. Look for a contract that pays these **per occurrence** instead of lifetime.
 - *Offsets* – there are some contracts that will offset for other benefits payable and, in the group arena, may offset for any individual disability income policy owned. The best language here is the contract that has the least amount of offsets to the benefit.
 - *Exclusions* – this is really the same scenario as the last bullet on “Offsets.” You want to look for contract language that has the least amount of conditions and situations that exclude the benefit being paid.
 - *Rehabilitation Provisions* – look for policy language that gives the choice of going through a rehabilitation process to get back to work versus a contract that requires it.

The common factor in all of the above bullets is this — there are phrases and language that will either help you get paid at claim time or hinder that claim payment. That is why I counsel people looking for the “best” disability income policy to consider buying the one that gives them the best chance of getting paid.

In our next issue, Part 2 will cover what are probably the most important components of a long-term disability contract language: (1) Definition of Disability, (2) Definition of Earnings and (3) Residual or Partial Disabilities.

“The name of the game is the claim.”

References

1. *Council for Disability Awareness (Long-Term Disability Claims Review, 2007).*
2. “Benefits: Focus on Total Compensation.” www.salary.com.

About the Author

Mark Mousty is the president of Benefits Corporation of Indiana. Mark has been in the employee benefits business for more than 20 years and has committed himself to both personal and client education.

2010 Call for Nominations for Officers

At least 90 days prior to the IAFP Annual Assembly each year, the Nominating Committee shall announce nominations as required by the Bylaws. These nominations shall be formally presented at the first meeting of the Congress of Delegates, which this year will be July 23 and 24 in French Lick. At the time of the meeting, additional nominations from the floor may be made. The said election of officers shall be the first order of business at the second session of the Congress of Delegates on July 24.

Offices to be filled for 2010-2011 are: president-elect, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two-year term) and one AAFP alternate delegate (two-year term).

The Nominating Committee's objective is to select the most knowledgeable and capable candidates available. The committee is also responsible for determining the availability of those candidates to serve, should they be selected.

If you are an active member of the IAFP and are interested in submitting your name as a candidate, you must submit a letter of intent, a glossy black-and-white photo and a curriculum vitae. This information must be received prior to Monday, April 12. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.

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2010-2011 School Immunization Requirements

The following letter was sent out in January by the Indiana State Department of Health. Make sure you're aware of the new requirements for the school-age children you see in your office.

Dear School Superintendents, Principals, and Nurses:

During the 2009 legislative session, **Indiana Code 20-34-4-2** was revised, requiring the Indiana State Department of Health (ISDH) to "adopt rules under **IC 4-22-2** to require school age children to receive additional immunizations against the following: Meningitis, Varicella, and Pertussis (whooping cough). The additional immunizations required under the rules shall include an immunization booster if considered appropriate by the state department."

"(d) The state department of health may expand or otherwise modify the list of communicable diseases that require documentation of immunity as medical information becomes available that would warrant the expansion or modification in the interest of public health."

"(e) The state department of health shall adopt rules under **IC 4-22-2** specifying the:

- (1) required immunizations;
- (2) child's age for administering each vaccine;
- (3) adequately immunizing doses; and
- (4) method of documentation of proof of immunity."

As directed by law, ISDH updated the school immunization portion of its Communicable Disease Rule. The final adopted rule can be found at: <http://www.in.gov/legislative/iac/T04100/A00010.PDF>?

ISDH immunization program staff meets annually with representatives from the Indiana Department of Education (IDOE), the Indiana Association of School Nurses (IASN), practicing school nurses, and public health nurses to review immunization requirements under Indiana law and current recommendations published by the Centers for Disease Control and Prevention (CDC) and to discuss revisions to our school immunization requirements. The outcome of this year's discussion is summarized below.

Immunization Requirements

1. Changes to the school immunization requirements for school year **2010-2011** are as follows:
 - a. All preschool and kindergarten students will be required to have 2 doses of varicella vaccine, given on or after the first birthday and separated by 3 months, or a history of chickenpox disease.
 - b. All kindergarten students will be required to have one of the required doses of polio vaccine given on or after the fourth birthday, and at least 6 months after the previous dose.
 - c. All 6th-12th grade students will be required to have 2 doses of varicella vaccine, given on or after the first birthday, and separated by age-appropriate intervals as defined by the CDC, or a history of chickenpox disease.
 - d. All 6th-12th grade students will be required to have 1 dose of tetanus-diphtheria-acellular pertussis vaccine (Tdap) given on or after the 10th birthday.



- e. All 6th-12th grade students will be required to have 1 dose of meningococcal conjugate vaccine (MCV4).
2. Please be aware that if changes to school requirements are enacted during the current legislative session, we may not know about them until later in the spring.

For a current list of requirements, please go to: https://chirp.in.gov/chirp_files/chirp_docs.htm. To view current legislative activity, please go to: <http://www.in.gov/apps/lisa/session/billwatch/billinfo>.

3. We remind school administrative and nursing staff that **IC 20-30-5-18** requires schools to send information to ALL students, parents or guardians about meningitis and the meningococcal vaccine. Updated information is currently available on the Children and Hoosiers Immunization Registry Program (CHIRP) website.
4. We urge school administrative and nursing staff to send information about pertussis and the Tdap vaccine home with students who will be required to have the vaccine next fall. This information is available on the CHIRP website the week of January 11, 2010.

5. We urge school administrative and nursing staff to be proactive in collecting and recording the necessary immunization documentation for students to ensure compliance once these changes go into effect.
6. To help you with planning for the future, please be advised that we are considering the following changes in requirements for the **2011-2012** school year:
 - a. Two varicella vaccines, appropriately spaced, may be required for **ALL** students, including all elementary grades.
 - b. Two hepatitis A vaccines given on or after the first birthday and separated by 6 months may be required for all preschool, kindergarten and 1st grade students.
3. All schools reporting to ISDH under **IC 20-34-4-6** will be required to use CHIRP to report immunization data for all students in K, 1st and 6th grades. Schools that do not have the capacity to record immunization data electronically will be exempt on a case-by-case basis. Paper reporting will be accepted from exempt schools.
 - a. For those who have not yet begun entering immunization data into CHIRP, please call the CHIRP help desk at (888) 227-4439, and we will be happy to get you signed on and started.
 - b. The Federal Education Rights Privacy Act (FERPA) requires parental consent to release immunization information from your school to the Indiana immunization registry. Sample parent permission slips are available on the IDOE website. For questions about CHIRP and the Family Educational Rights and Privacy Act (FERPA), please contact your local legal counsel, or the IDOE.

Immunization Reporting Requirements

The following reporting changes *will be required* for the **2010-2011** school year:

1. Per Indiana Administrative Code, **410 IAC 1-1-4**, Section 4b, "Schools shall review and update all student immunization records annually."
2. Per Indiana Administrative Code, **410 IAC 1-1-4**, Section 4c, "All schools are required to report immunization data to the department, in compliance with **IC 20-34-4-6**, electronically through the use of the immunization data registry, as established by **IC 16-38-5**, annually."

ISDH looks forward to continued partnership with IDOE, IASN, and all school nurses and administrators as we work to provide healthy, safe learning environments for children and teachers in Indiana schools.

Sincerely,

Joan Duwve, MD, MPH
Medical Director, Public Health and Preparedness



The 2010 IAFP Annual Meeting returns to the totally revamped French Lick Hotel and Casino in 2010. We're sticking with the changes that made the 2009 meeting such a success:

- Shorter, streamlined schedule – spend less time out of the office to fully participate
 - Evidence-based CME – earn double CME credits
 - MC-FP SAM session on asthma – complete the Knowledge Assessment portion of your SAM at our group session
 - All-Member Congress of Delegates – help direct your Academy's future policy
 - Fellowship and networking opportunities – spend quality time with colleagues and friends from around the state
 - Exhibit Show – learn about the latest clinical advances and get practice management advice
 - Spectacular and luxurious hotel – French Lick is totally transformed
 - Fun events for the whole family – new programs for kids and activities for adults
- CME Sessions will include:
- "Reminder and Recall Systems to Improve Adolescent Immunization Rates"
 - "Overactive Bladder"
 - "Dyslipidemia Management: Five Issues to Consider Before You Treat"
 - "Strategies to Address Prescription Drug Misuse and Abuse"
- Check your *e-FrontLine* and mail for registration info coming soon.

Embracing Change in Private Practice

by Lisa Jerrells, MD



2008 was the year of my epiphany. I would go to work each morning with dread. I was on the patient wheel, seeing 30 to 35 patients a day, feeling stress with each encounter that there was never enough TIME to “take good care of patients.” After being at the local farmers’ market one Saturday, when I was actually able to sit by myself and have a cup of coffee, I

realized I did not have to live that life anymore. I was done with the treadmill. I left the market knowing that I would even go so far as to sell my home and live in an apartment with my family if that was what was necessary for me to spend more time with my patients and, therefore, more quality time with my family. That day, Joie de Vivre was born.

In December 2008, I opened Joie de Vivre — translated from the French as *Joy of Living*. I wanted a practice in which I could focus on my patients but recognized the need for another revenue stream to “subsidize” the family practice. I had been attaining certifications and additional training since 2006 in aesthetic medicine. I really enjoyed the art of changing people’s lives by giving them a more youthful appearance and improving their skin quality. I scheduled family medicine patients three and a half days a week and aesthetic patients one day a week total. Aesthetic services include Botox®, IPL, Laser Genesis, hair removal, Radiesse®, Juvederm®, facials, chemical peels and daily skin care. I have an aesthetician on staff with whom I work closely to provide this unique blend of services to the patient.



Wellness-Focused Care

Joie de Vivre’s mission is to assist each patient in attaining their individual joy of living. I wanted to step away from “sickness care,” so I incorporate health and wellness into each visit. For some patients, that means discussing smoking cessation — for others, demonstrating basic weightlifting techniques. I completed Cenegenics’ Age Management Tutorial training in April 2009. This was an investment in myself as much as in my patients. Armed with literature-based hormone-level maximization, I could approach each patient visit with renewed zeal, knowing I could truly improve patients’ energy levels.

Patient as Customer

Twenty-first-century medicine must embrace new concepts, such as viewing patients as customers. Patients can choose to be seen elsewhere, especially when a practice provides aesthetic services. At Joie de Vivre, we greet the patient with a smile, we answer 86 percent of phone calls, we return most phone calls the same day, and maximum waiting-area time is 10 minutes.

To set my practice apart, I actually do not have a nurse, MA or LPN on staff. I actually take my patients from the waiting area to the exam room! This equates to more time spent with the patient. I administer my own injections and vaccinations. As well, I am on call for myself 24/7, even on vacation. My patients are very respectful of this and really only call if they truly need assistance.

Incorporating Technology

Web site development has been an integral part of our marketing strategy this year. We use this as an educational tool. Patients can explore the scope of our services from the privacy of their home. We have before and after photos here also. The family practice services offered are also featured on the Web site.

Most exciting for me has been the incorporation of a Web-based portal to patient lab results. The data-gathering for the portal includes two phone numbers for the patient; usually the patient provides a work number and a cell phone number. I am able to log on and, within one or two hours, obtain most lab results. I can then call the patient at my convenience with their results, thus eliminating a nurse calling the patient, the patient having numerous questions the nurse or office staff cannot answer, pulling a chart, then it leaving on my desk for me to then respond to and give back to the nurse! Imagine the patient’s surprise and satisfaction when I call them with their results. Also, I am able to log in on vacation and either call the patient or forward to the staff to take care of this while I am gone, thus eliminating the dreaded “chart stacks” upon return from vacation.

The office staff sends my triage notes throughout the day to me by e-mail. They also do this when I am on vacation.

Staff Development

The old adage is still true: the doctor is only as good as the patients perceive the staff to be! As a new small business owner, I could not afford to offer insurance benefits; however, I did have staff appreciation days each quarter. The staff's job satisfaction is higher, and no doubt a happy staff person is better able to focus on customer service. As well, I was able to offer bonuses by the fourth quarter based on achievement of the practice's financial goals.

One of the best business decisions I made in 2009 was to hire a life coach. This person plays a unique role in our office. Not only does he streamline our work flow, but he also assists the staff members in conflict resolution. Perhaps most importantly, he teaches the office staff members about their own personalities, illuminating strengths and weaknesses, assigns job descriptions based on strengths and, through coaching and education, assists each staff member in self-improvement. By building this foundation, our ability to genuinely attend to patient needs is enhanced.

So, Did It Work?

Yes! Joie de Vivre has been a successful business venture thus far. Success is defined as a favorable or desired outcome, or, attainment of wealth. I certainly have a desired outcome: personal and professional fulfillment, five and a half weeks' vacation in 2009, a positive cash flow and a very pleasant work environment.

My definition of wealth changed when I had my epiphany in 2008. Wealth is more than just monetary; it is living within one's means. It is choosing to eat home-cooked food instead of eating out; it is playing board games and working puzzles with my children instead of seeing a theatre movie. It is digging a four-square garden with my family to help cut down on food costs. It is the satisfaction of being one's own boss.

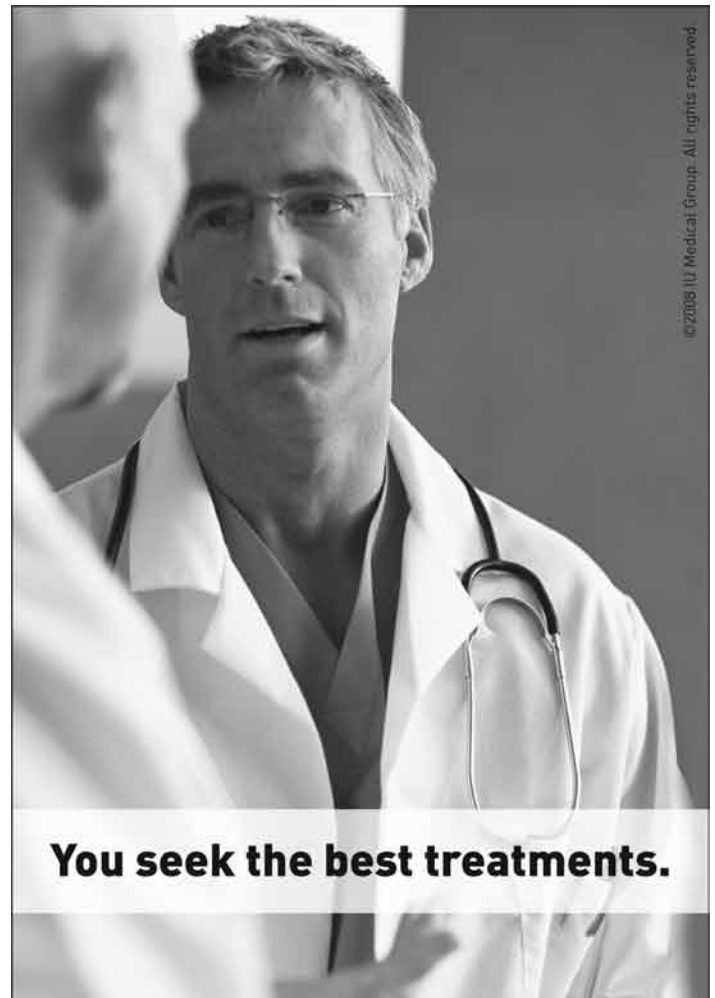
Looking Forward

So I have a private insurance-based practice, supplemented by my aesthetics practice. I have a staff of four. I practice in a 1,200-square-foot space, laid out to my specifications for maximization of work flow. My work environment includes warm, Mediterranean colors, decorated with all of my favorite paintings and textures. Patients comment they do not feel like they are in a doctor's office at all. A full day is assisting, on average, 20 patients. I go to work happy each day; I return to my family happy each day.

It is not enough.

I will continue to attend CME meetings and aesthetics training and give public lectures quarterly. I will add all of the new patient insurance forms and HIPPA forms to my Web site so that patients can have these filled out before their arrival to the office. I will incorporate social media into my advertising.

Look forward, my colleagues. Embrace change, and you will be wealthier for it.



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