

FRONTLINE

P H Y S I C I A N

A Publication of the Indiana Academy of Family Physicians • Summer 2007



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A. Alan Fischer, MD Pg. 15

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PQRI Info Pg. 26

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Indiana 46204
317.237.4237 • 888.422.4237
Fax 317.237.4006
E-mail: iafp@in-afp.org
Web site: www.in-afp.org

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FRONTLINE PHYSICIAN

Volume 8 • Issue 2

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.



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Children aren't concerned about osteoporosis.

But their physicians should be.



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

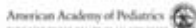
The U.S. Surgeon General's report on Bone Health and Osteoporosis recognizes the role that nutrients in dairy foods – including calcium, magnesium, phosphorus, potassium, protein, and vitamin D – play in helping to build and protect bones.

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

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

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

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- from Warren Buffett's Letter to Shareholders, February 28, 2006

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- from Warren Buffett, April 26, 2006

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- from Warren Buffett, May 30, 2006



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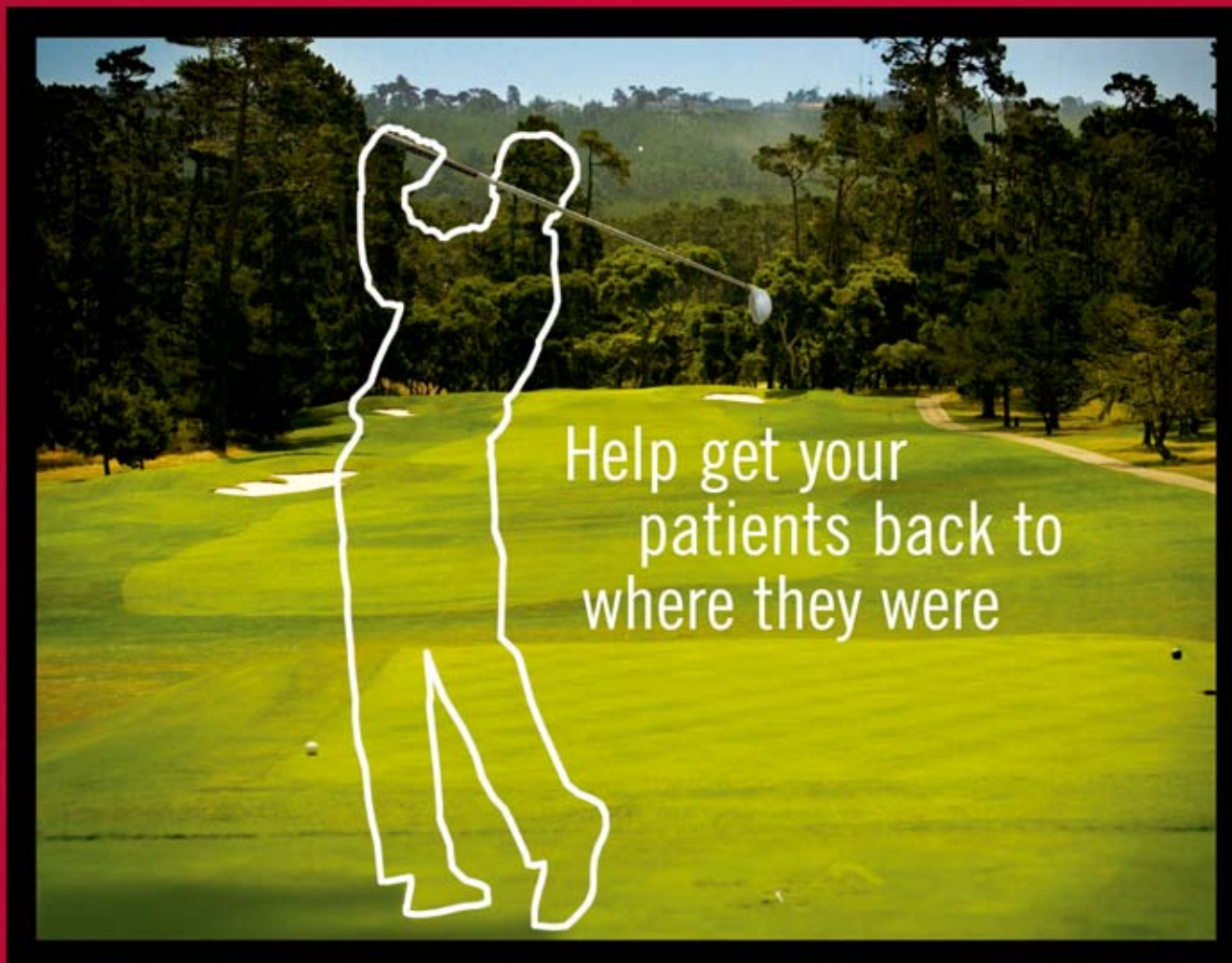
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President's Message

A Productive Year for IAFP

As I write this, I realize that this is my last update as president of the Indiana Academy of Family Physicians. While this will be a great relief to the staff (especially Chris, who has to remind me I am behind deadline), it is amazing how quickly the year has passed. It seems like just yesterday that we were in Fort Wayne and getting ready for the year ahead. It has indeed been a very productive year for the Academy and its members. I would like to thank everyone who has actively participated in our activities throughout the year.



Windel Stracener, MD

In the fall, we began the task of strategic planning. This started with a long weekend of brainstorming and discussions, which led to many ideas for the future of our organization. This then led to a follow-up meeting in the spring, where these ideas were then molded and shaped into the new strategic plan that is now under the care of our president-elect, Larry Allen. This was a large undertaking for the staff and other participants and required a good deal of effort. I applaud your efforts and look forward to our future as we work together to continue to develop the role of family medicine statewide.

Once again, this spring, many of our leaders and others took advantage of the opportunity to attend the AAFP Annual Leadership Forum and National Conference of Special Constituencies. This was again an outstanding forum to gain insight into leadership

and organizational leadership. At this convention, Dr. Teresa Lovins and Dr. Jason Marker ran for leadership positions. I would like to thank both of them for their interest and initiative in seeking these positions. **Special congratulations go to Dr. Marker, as he was elected to the new Physician Director position on the AAFP Board of Directors.** The abilities of members like these make for a brighter future for family medicine in Indiana.

As we think of these doctors, perhaps you are asking yourself how you can become more active in the Academy. The most important thing is to be available and willing to work. That is now even easier, as we have adopted an All Member Congress of Delegates to conduct the business of the Indiana Academy. This allows you to come and participate in the decisions affecting the direction of our future.

I would encourage everyone who has ever thought of becoming more active in the Academy to pick this year to start. This may be the first step to a bright and promising future in the Academy for you.

With that in mind, mark your calendars to attend the Congress of Delegates and Scientific Assembly in French Lick, Indiana. The dates will be July 25-29. The resort has undergone a major renovation at the hotel and its facilities. For those who have attended in the past, it will be interesting to see all the changes. If it is your first time to attend, come see what French Lick and the Academy have to offer you.

Again, let me thank everyone for the opportunity to serve the Academy this year.

See you in French Lick!

Mark Your Calendar

July 25-29, 2007

IAFP Annual Meeting
French Lick

July 26-27, 2007

IAFP All Member Congress
of Delegates
French Lick

January 17-18, 2008

Family Medicine Update

March 5, 2008

Faculty Development Workshop

March 6, 2008

Residents' Day/Research Forum

Board of Directors Meetings

July 25, 2007

French Lick

July 29, 2007

French Lick

AAFP Meetings

October 1-3, 2007

Congress of Delegates
Hyatt Regency
Chicago

October 3-6, 2007

Scientific Assembly
Chicago Convention Center
Chicago





Please Join Us for the 2007 IAFP Annual Meeting

at the *Totally Restored* Historic French Lick Hotel and Conference Center!

Congress of Delegates

Thursday, July 26 and Friday, July 27

Scientific Assembly

Thursday, July 26 through Sunday, July 29

Exhibit Show

Friday, July 27 and Saturday, July 28



New for 2007

- Enhance your educational experience — bring your laptop computer and enjoy **complimentary high-speed wireless Internet access** throughout the hotel and conference center, free of charge.
- Enjoy our **Continuous Refreshment Break** as you learn — drinks and extensive light fare will be available all day, every day outside CME sessions.
- Earn extra CME credit at our **CME Cybercafe** — earn many more hours of free CME after the daytime CME sessions have ended, both in print and online with your laptop!

Indiana's Premier CME Event!

Planned Especially *for* Family Physicians *by* Family Physicians

More than 23 CME Credits with lectures, hands-on learning, clinical topics and practice management sessions

General Information

Register Early

Special sessions and workshops fill early, as does the hotel. **Take time TODAY to plan your attendance.**

Special Needs

Please check the box on the registration form if you require special accommodations, or please attach a written description of your needs.

Location and Hotel

The French Lick Hotel and Conference Center is nestled in beautiful southern Indiana. Join us this summer to experience the amazing changes that have taken place in this historic resort.

Everything from sleeping rooms to meeting space, golf courses, spa, and swimming pools have been totally renovated. Amenities now include:

- 443 guest rooms and suites with modern furnishings to complement the rich history of the resort
- 45 holes of golf, including the fully restored Donald Ross Course, designed in 1920, where new tee boxes, additional bunkers and enhanced native area return this classic course to its original, demanding layout. The 1907 Valley Course is a championship nine-hole course with extensive practice facilities, including a driving range.
- 27,000-square-foot full-service spa, salon and health club with 24 treatment rooms
- A new pool complex and fitness center
- New dining options, including 1875: The Steakhouse, The Power Plant Lounge, Grand Colonnade Buffet, Pluto's Pizzeria, Scoops Coffee and Creamery, and Spring #8 — the new pool bar
- Six-lane bowling at Pluto's Alley, riding stables, an indoor tennis center and extensive retail shops

The room rate for IAFP registrants is \$139. Call 866.379.2202 today to make reservations. Be sure to identify yourself as being with the IAFP, or go online at www.frenchlick.com and use our group ID: INAFP.

Cancellation Policy

Notice of cancellation must be sent in writing (by fax or mail) to the IAFP and must be received (not postmarked) by July 21, 2007, to be eligible for a full refund. Cancellations received after July 21 and before July 25 will be subject to a \$50 administrative fee. No-shows are not eligible for a refund.

Bring the Whole Family

Youth Activities

The IAFP Annual Meeting creates a great opportunity for your children to make new friends with whom they can reconnect each year and for you to enjoy valuable family time. At the newly renovated French Lick Hotel, your children can enjoy the beautiful new indoor pool with fun porpoise fountain, the exciting game arcade, the bowling alley, riding stables and the pizzeria.

Spouse/Guest Activities

Activities for adults include a superb new fitness center, expanded shopping, the pool area, the spa, the golf course, riding stables and the tennis center. Your spouse will also enjoy the All-Member Party, the Annual President's Banquet, Award Ceremony and our Fun Walk/Run

on Saturday morning. No special registration is required for the spouse or guest of a physician registrant. However, a fee will apply for those wishing to attend CME sessions and other special activities. We encourage spouses and guests to register on the Spouse/Guest section of the registration form for these activities and others, such as the Jerry Stuckey Memorial Luncheon, All-Member Party, Banquet, etc.

Special Events

All-Member Party – “1920s Flappers and Gangsters”

Friday, July 27

This year's All-Member Party theme is “Flappers and Gangsters.” Come and join in the fun for all ages! There will be a buffet, dancing, drinks, games and prizes for the best flapper costume, the best gangster costume, the best couple and the best family! **The Marlins** will be there to play all our favorites. Dress in party theme or resort casual. Put on your dancing shoes, bring the kids (or grandkids), and come ready to have a great time! Purchase tickets on the registration form.

Fun Walk/Run

Saturday, July 28, 7 a.m.

Registration is not necessary for this event. The grounds of the French Lick Springs Hotel might not be quite finished yet, but that won't stop this year's Fun Walk/Run! Join us inside the Convention Center lobby at 7 a.m. Saturday, and we'll run alongside the golf course on a scenic country road. Water, T-shirts and other necessities will be provided to all participants. All are welcome!

Annual President's Banquet, Award Ceremony and Installation of Officers

Saturday, July 28

This elegant evening and dinner is held to honor our incoming and outgoing president and the 2007 IAFP award winners, including the 2007 Family Physician of the Year. An afterglow party will follow the banquet so attendees may congratulate the newly installed president. Purchase tickets on the registration form. A special party is offered simultaneously for children so parents may have a “night out.”



CME Schedule

Thursday, July 26, 2007

- 7:45 a.m. Opening of IAFP 59th Scientific Assembly
Windel Stracener, MD, IAFP President
- 8 a.m. **Atopic Dermatitis vs. Psoriasis: A Tale of Two Diseases**
Jeffrey B. Travers, MD
- 9 a.m. **Contact Dermatitis for the Primary Care Physician**
Nico Mousdicas, MD
- 9:45 a.m. Break
- 10:15 a.m. **Understanding Back Pain**
Jonathan Gentile, MD
- 11 a.m. **Probiotics: the Health Impact of Active Cultures**
Mary Ellen Sanders, PhD
- 12 p.m. **CME Luncheon:
Ask and Act Smoking Cessation Program**
Tom Houston, MD
- Concurrent Sessions – *Choose either:*
- 1:15 p.m. **Tocolytics**
Doug Boss, MD
- 2 p.m. **OB Update**
Shannon Joyce, MD
- 3 p.m. **Infertility**
William Gentry, MD
- Or:*
- 1:15 p.m. **Coding Workshop**
Joy Newby, LPN, CPC
- 4:15 p.m. CME sessions adjourn for the day
- 8-9 p.m. CME Cybercafe



Friday, July 27, 2007

- 7:45 a.m. **Understanding RVUs**
Thomas Felger
- 8:30 a.m. **Chronic Pain: A Chronic Illness**
Barbara P. Yawn, MD, MSc, FAAFP
- 9:30 a.m. **Safety and Security in the Office Setting**
Michael D. Pisano, PhD
- 10:30 a.m. Break to view exhibits
- 11:15 p.m. **New Medications Update**
Tracy Bottorff, PharmD
- 12 p.m. Physician and Exhibitor Luncheon
Trends in Family Medicine in Indiana
Deborah I. Allen
- 1:15 p.m. **Appropriate Management and Imaging
Workup of a Breast Mass**
David Carlson, MD
- 2 p.m. **Direct Renin Inhibition for the Treatment
of Hypertension**
David Kovacich, MD
- 2:45 p.m. Break to view exhibits
- Concurrent Sessions – *Choose either:*
- 3:30 p.m. **How to Grow a Profitable Practice**
Kam McQuay
- Or:*
- 3:30 p.m. **What You Need to Know About MOC ... And Tips for
Taking the SAMs**
Joseph W. Tollison, MD
- 4:15 p.m. **Family Medicine: Where Will We Be in the Future?**
Doug McKeag, MD
- 4:45 p.m. CME sessions adjourn for the day
- 8-10 p.m. CME Cybercafe

Saturday, July 28, 2007

- 8 a.m. **Update on Child and Adolescent
Immunizations and Registries**
William Geiger, MD
- Concurrent Sessions – *Choose either:*
- 9 a.m. **Is a Good Death Still Possible? Ethics and End of Life Care**
Gregory P. Gramelspacher, MD
- 10 a.m. Break to view exhibits

- 10:45 a.m. **Overactive Bladder in Family Medicine**
Clif Knight, MD
- 11:30 a.m. **Tipping the Scales: Pediatric Obesity**
Sandeep K. Gupta, MD
- Or:*
- Building a Feasible and Effective Process for Early Detection And Management of Patients with Dementia in Primary Care**
Malaz Boustani, MD, MPH, and J. Eugene Lammers, MD, MPH
- 9 a.m. **Current State of Dementia Care and Research**
- 10 a.m. Break to view exhibits
- 10:45 a.m. **The PREVENT Study: A Cadillac Model of Dementia Care in Primary Care**
- 11:30 a.m. **Translating the Lessons of PREVENT into Your Clinic & Care for Your Patients with Dementia**
- 12:15 p.m. ***Jerry Stuckey Luncheon:***
Developmental Milestones and Screening/Referral for Developmental Delay and Autism
Georgina Peacock, MD
- 1:15 p.m. **Improving *H. pylori* Management Through Appropriate Diagnosis**
Colin Howden, MD
- 2 p.m. **Non-Traumatic Knee Pain – What Can I Really Do?**
John Turner, MD
- 2:45 p.m. Break
- 3 p.m. **Advanced Diabetes Management for Primary Care Providers**
Jane M. Bridges, MD
- 4:15 p.m. **Indiana Medicaid Program: A Conversation with the Director**
Jeffrey M. Wells, MD, MBA
- 4:45 p.m. CME sessions adjourn for the day

Sunday, July 29, 2007

- 7:30 a.m. **Practical Strategies for Diagnosing and Treating Depression in Women at Midlife and Beyond**
Theresa Lovins, MD

AAFP Credit: Application has been made to the American Academy of Family Physicians (AAFP) for a total of 23 Prescribed credits. In addition, portions of the program will be approved by the AAFP for Evidence Based Medicine (EBM) Credits. Attendees of EBM-approved presentations may claim double credit for those sessions. Updated credit verification certificates will be included in registrant packets on-site.

AMA Credit: The Indiana Academy of Family Physicians is accredited by the Indiana State Medical Association to provide continuing medical education for physicians. The Indiana Academy of Family Physicians designates this educational activity for a maximum of 23 Category 1 credits toward the AMA Physician Recognition Award.

Schedule at a Glance



Wednesday, July 25

- | | |
|-------------|--------------------------------|
| Noon-8 p.m. | Registration Open |
| 2 p.m. | Executive Committee |
| 4 p.m. | Board of Directors |
| 6:30 p.m. | Board/VIP Reception and Dinner |

Thursday, July 26

- | | |
|---------------------|--|
| 7 a.m.-8 p.m. | Registration Open |
| 7:45 a.m.-4:15 p.m. | CME Sessions |
| 6 p.m. | Regions' Caucus Dinner |
| 7 p.m. | First Session of Congress of Delegates
Reference Committees to follow |

Friday, July 27

- | | |
|---------------------|---|
| 7 a.m.-8 p.m. | Registration Open |
| 7:45 a.m.-4:45 p.m. | CME Lectures |
| 8 a.m.-4 p.m. | Exhibit Show Open |
| 5 p.m. | Second Session of Congress of Delegates |
| 7 p.m. | All-Member Party |

Saturday, July 28

- | | |
|------------------|-------------------------------------|
| 8 a.m.-4:45 p.m. | CME Lectures |
| 8 a.m.-noon | Exhibit Show Open |
| 3 p.m. | Foundation Board of Trustees |
| 6:30 p.m. | Annual Reception and Awards Banquet |

Sunday, July 29

- | | |
|------------------|----------------------------|
| 7:30 a.m.-9 a.m. | CME Lectures |
| 9 a.m. | Board of Directors Meeting |

Don't Forget the All-Member Congress of Delegates

The IAFP will hold its All-Member Congress of Delegates July 26 and 27. All members are invited and encouraged to attend the Congress, because every member is now considered a delegate, and every participant will have a vote and voice at the Congress. The Academy looks forward to each and every member's participation in this year's Congress of Delegates. *Come make your voice heard!*

Meet colleagues from around the state, and visit with old friends. Call on them! Visit the **exhibit show** to learn about the newest clinical advances, and practice management tips & services.

All arrangements, from selection of CME offerings to family activities and special sessions, are based on previous attendee evaluations and IAFP Member CME Needs Assessments. Every effort is made to improve the program each year.

Nomination of IAFP 2007-2008 Officers

The 2007 IAFP Nominating Committee met via conference call at noon on Monday, May 14. The following slate of nominees was prepared for presentation to the 2007 meeting of the Congress of Delegates, July 26-27, in French Lick, Indiana.

President-Elect: Teresa Lovins, MD, Columbus
1st Vice President: Ash Hanna, MD, Fort Wayne
2nd Vice President: Scott Frankenfield, MD, Portland
Speaker: Ken Elek, MD, South Bend
Vice Speaker: Andrew Deitsch, MD, Richmond
AAFP Delegate: Clif Knight, MD, Indianapolis (Expires 2009)
AAFP Alternate Delegate: Richard Feldman, MD,
Indianapolis (Expires 2009)

Committee Chair
Daniel Walters, MD

Committee Members
Debra McClain, MD
Fred Ridge, MD
Jason Marker, MD
Christopher Doehring, MD
Tom Jones, MD
Judy Monroe, MD

New IAFP Summer Intern Morgan Matters

Morgan Matters will be working as the IAFP's intern this summer and will coordinate our exhibitors at the Annual Meeting. Morgan also will support the IAFP staff in day-to-day tasks at the IAFP headquarters.

Morgan says, "I was born and raised in Indianapolis, Indiana, and just recently graduated from Indiana University with a degree in studio art along with an art history and business minor.

"I have a strong passion for photography that I hope to turn into a full-time career someday.

"I also enjoy spending time with my family and two adorable golden retrievers!"



IAFP Membership Update



Please remember to keep all of your contact information up-to-date with the AAFP and the IAFP. This includes your address (home and office), phone number, fax number and e-mail address.

To update your information, call the IAFP Headquarters at 888.422.4237 or e-mail iafp@in-afp.org.

Membership Status Totals as of April 30, 2007

Active	1,632
Supporting (non-FP)	6
Supporting CME (FP)	3
Inactive	12
Life	195
Resident	261
Student.....	213
Total	2,322

IN MEMORY

A. Alan Fischer, MD

Indiana Loses a Champion for Family Medicine

A. Alan Fischer, MD, a nationally known family physician, passed away Thursday, March 9, 2007.



Dr. Fischer served in the U.S. Army Air Force during World War II, which he entered after already being an accomplished pilot. He learned to fly at a young age and was a

private pilot throughout his life. Dr. Fischer met and married his wife, Beverly, while they were both attending IU, and he went on to graduate from the IU School of Medicine.

Dr. Fischer served the Indiana Academy of Family Physicians in many capacities as both member and chairman of several committees and commissions and as president in 1964-65 and again in 1966. He also served family medicine at the national level as director of the AAFP Board of Directors from 1968-1971 and was AAFP vice president in 1971-72.

In 1971, Dr. Fischer took a virtually nonexistent family practice program at the IU School of Medicine and developed it into the school's first Family Practice Residency program. In 1974, the Department of Family Medicine was established, and Dr. Fischer was named chairman. He served as chairman for 14 years, and while there, he helped develop

programs taught during the first two years of medical school and recruited hundreds of family physicians to teach fourth-year medical students. He was also an advisor and counselor to medical students, helping them form and achieve their career goals.

In 1984, the Indiana Academy of Family Physicians established the A. Alan Fischer, MD, Award, designed to "recognize members who, in the opinion of the Board of Directors of the IAFP, have made outstanding contributions to education for family medicine in undergraduate, graduate and continuing education spheres." In 1971, Dr. Fischer was the first physician in Indiana appointed to the National Academy of Sciences Institute of Medicine in Washington, D.C. He was a member of the U.S. Congress's Biomedical Ethics Advisory in 1987. He was a member of the Board of Directors of the American Heart Association. He was a member and past

president of the Westside Optimist Club, and had many other national, state and county honors and affiliations.

Dr. Fischer also had several articles published in medical literature. Dr. Fischer retired from IU in 1991 and continued to serve as medical director and staff physician at Lakeview Manor Nursing Home until he retired from there in May 2001 with the title of "Medical Director Emeritus." On March 20, 2002, Dr. Fischer was presented with a Certificate of Distinction for his 50 years in the practice of medicine, and he was recognized for his "unselfish devotion to patients and loyalty to the medical profession."

During his retirement, Dr. Fischer remained active with the IAFP and National Academy of Sciences. He loved life with his wife, children, grandchildren and close friends. He enjoyed nature, his many pets and traveling around Indiana. Surviving him are his wife, Beverly, and their four children and six grandchildren.



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Family Physician Workforce Survey:

A Matter of Urgency for the Discipline of Family Medicine

Many health care decisions, including the need for family physicians and other health care providers, reimbursement issues, etc., are being made in Indiana. To best represent family medicine, **it is critical that we have current data** on where family physicians are practicing and the types of care (services) they provide.

Working together, the **Indiana Academy of Family Physicians and the Indiana University Department**

of Family Medicine (Debbie Allen, MD, is the project director) will be asking you for general information about your practice.

Our goal is to report **aggregately** on the Indiana Family Physician workforce — including how many of us practice in Indiana, whom we take care of, and where we work!

Please help us protect our discipline by completing this survey, which takes about 12

minutes to finish. Complete it today and mail it to the IAFP at 55 Monument Circle, Suite 400, Indianapolis, IN 46204.

Alternatively, you may wish to complete it electronically. Please visit the following Web site for a convenient way to fill out the survey and save on mailing costs! <http://www.surveymonkey.com/s.asp?u=301323614971>

Did You Know...?

Family Physicians

- Have the highest proportion of office visits of **all types of doctors**
- See approximately 50 percent of all children
- Make up the majority of the rural physician workforce
- Serve more of the disadvantaged at a time when there has been an increase in the number of patients who are uninsured or underinsured

Providing Care

- A workforce of 139,531 family physicians will be required by 2020 to help meet the nation's need for primary care — to achieve this target, 3,725 family physicians will need to be produced annually by ACGME-accredited family medicine residencies, and 714 family physicians will need to be produced annually by AOA-accredited family medicine residencies.

- An increase from 2,077 family physicians in Indiana currently to 2,691 in 2020 will be required.

In Indiana

- Mobilize family doctors in Indiana to better understand what Indiana needs and make informed decisions for **our discipline**

Source: AAFP Board of Directors Report to the 2006 Congress of Delegates Family Physician Workforce Reform: Recommendations of the American Academy of Family Physicians

Thanks to the 500 Physicians Who Have Already Sent Data!



Section I – Clinician Information

1. Name _____
First Name Middle Initial Last Name

2. Your e-mail address _____

3. What is the name of your practice? (for example, Methodist Medical Group, Flat Rock Family Physicians LLC, Memorial Hospital Family Medicine)

4. What is the name of your office or practice manager? _____

5. What is the e-mail address of your office or practice manager? _____

6. Specialty: Please indicate your specialty and if you are board-certified.

SPECIALTY	BOARD CERTIFICATION	
	YES	NO
Family Medicine	<input type="checkbox"/>	<input type="checkbox"/>
General Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Pediatrics	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

7. How many years (total) have you been in practice? _____

8. What is your sex? ☐ Male ☐ Female

9. What year were you born? _____

10. Medical school you attended: _____

a. Year of graduation: _____

b. COUNTRY of school: _____

11. Residency Program you attended: _____

Residency Program City: _____ State: _____

a. Year Completed: _____ ☐ Not applicable/Did not complete a residency

12. Your ethnicity (check only one):

☐ Hispanic or Latino

☐ NOT Hispanic or Latino

13. Your race (check only one):

☐ White

☐ Black

☐ Native American/Alaska Native

☐ Asian/Pacific Islander

☐ Other (specify): _____

Family Physician Workforce Survey

14. Indicate the percentage of time **you** spend in **each** of the following professional activities (**total should equal 100%**)

Administration.....	_____ %
Direct Patient Care.....	_____ %
Research.....	_____ %
Teaching.....	_____ %
Service (Community, Church)....	_____ %
Other.....	_____ %

15. Do you provide prenatal care? ☐ YES ☐ NO

16. Do you deliver babies? ☐ YES ☐ NO (If NO, go to item 17.)

a. If YES, what is your average number of deliveries per year? _____

b. If YES, do you manage your own patients who have gestational diabetes? ☐ YES ☐ NO

c. If YES, do you perform Caesarean sections? ☐ YES ☐ NO

17. Do you perform colonoscopies? ☐ YES ☐ NO (If NO, go to item 18.)

a. If YES, how many do you perform per year? _____

Section II – Procedures

18. Please identify from the **Office Setting Procedures List** what procedures and services **you** provide in your medical office (**Check ALL that Apply**)

Office Setting Procedures List

- | | |
|---|--|
| <input type="checkbox"/> Ambulatory blood pressure monitoring | <input type="checkbox"/> Laryngoscopy |
| <input type="checkbox"/> Anoscopy | <input type="checkbox"/> Loop electrosurgery |
| <input type="checkbox"/> Audiometry | <input type="checkbox"/> Management of epistaxis |
| <input type="checkbox"/> Botox injection | <input type="checkbox"/> Manipulations |
| <input type="checkbox"/> Cardiac stress testing | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Casting/splinting | <input type="checkbox"/> Musculoskeletal injections |
| <input type="checkbox"/> Closed reduction of fractures | <input type="checkbox"/> Nasopharyngoscopy |
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Obstetric ultrasound imaging |
| <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Office Sedation |
| <input type="checkbox"/> Cyst aspiration | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Pulmonary function tests |
| <input type="checkbox"/> Dermatologic procedures | <input type="checkbox"/> Reductions of dislocated joints |
| <input type="checkbox"/> DEXA Scan (bone density) | <input type="checkbox"/> Rigid sigmoidoscopy |
| <input type="checkbox"/> Echocardiography | <input type="checkbox"/> Thrombosed hemorrhoids |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Trigger point injection |
| <input type="checkbox"/> Electrosurgery | <input type="checkbox"/> Tympanometry |
| <input type="checkbox"/> Endometrial sampling | <input type="checkbox"/> Ultrasound (other than OB) |
| <input type="checkbox"/> Esophagogastroduodenoscopy | <input type="checkbox"/> Varicose vein sclerotherapy |
| <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Holter monitoring | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> Ingrown toenail procedures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lacerations/minor trauma | |

19. Please identify from the **In-Hospital Setting Procedures List** what procedures and services **you** provide.
(Check ALL that apply.)

In-Hospital Setting Procedures List

- | | |
|---|---|
| <input type="checkbox"/> Abdominal paracentesis/peritoneal lavage | <input type="checkbox"/> Suprapubic taps/aspirations |
| <input type="checkbox"/> Bladder catheterization | <input type="checkbox"/> Swan-Ganz (pulmonary artery catheterization) |
| <input type="checkbox"/> Central line placement | <input type="checkbox"/> Thoracentesis |
| <input type="checkbox"/> Chest tube insertion and removal | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Electrical cardioversion | <input type="checkbox"/> Transtracheal catheter insertion |
| <input type="checkbox"/> Endotracheal intubation | <input type="checkbox"/> Venous cut-down |
| <input type="checkbox"/> Intraosseous venous access | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nasogastric tube insertion | |

20. Please identify from the **OB/GYN Procedures List** what procedures and services **you** provide.
(Check ALL that apply.)

OB/GYN Procedures List

- | | |
|--|---|
| <input type="checkbox"/> 4th degree laceration repair | <input type="checkbox"/> Fitting diaphragms or cervical caps |
| <input type="checkbox"/> Bartholin's cyst/abscess | <input type="checkbox"/> Fitting for pessaries |
| <input type="checkbox"/> Cervical ripening/vaginal prostaglandins (induction of labor) | <input type="checkbox"/> Forceps assisted deliveries |
| <input type="checkbox"/> Caesarean section | <input type="checkbox"/> Inserting and removing a cervical cerclage |
| <input type="checkbox"/> Circumcision (infant) | <input type="checkbox"/> Intrauterine device insertion & removal |
| <input type="checkbox"/> Colpocentesis | <input type="checkbox"/> Intrauterine monitoring |
| <input type="checkbox"/> Diagnostic hysteroscopy | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Dilation and curettage | <input type="checkbox"/> Umbilical vessel catheterization |
| <input type="checkbox"/> Episiotomy and 1st-3rd degree laceration repair | <input type="checkbox"/> Vacuum assisted deliveries |
| <input type="checkbox"/> External cephalic version | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fetal movement counting, non-stress test, and contraction stress test | |

21. Do you have hospital admitting privileges? ☐ YES ☐ NO (If NO, go to 22.)

a. If YES, do you admit and care for your patients in the hospital? ☐ YES ☐ NO (If NO, go to a.1.)

a.1 Do you admit your patients to a hospitalist or hospital service? ☐ YES ☐ NO

b. How many patients of yours are admitted to the hospital per year? _____

22. Do you have ICU admitting privileges? ☐ YES ☐ NO

23. Can you see your patients in your hospital's Emergency Room? ☐ YES ☐ NO

24. Do you regularly see patients in a nursing home/skilled-care facility setting? ☐ YES ☐ NO (If NO, go to item 25.)

a. If YES, what is your personal average daily census? _____

Section III – Information about Your Practice

25. How many years have you been at your current site? _____

Family Physician Workforce Survey

26. Please identify the type of your practice site (if applicable):

TYPE

Solo Practice	<input type="checkbox"/>
Two-person Partnership	<input type="checkbox"/>
Small Group Family Medicine Practice Group (2-4 partners)	<input type="checkbox"/>
Large Group Family Medicine Practice (5 or more partners)	<input type="checkbox"/>
Multispecialty Group	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

27. Who is the majority owner of your practice?

MAJORITY OWNER

Self	<input type="checkbox"/>
Medical Group Practice (single or multi-specialty)	<input type="checkbox"/>
Hospital or Health System	<input type="checkbox"/>
Managed Care Organization	<input type="checkbox"/>
Federal, State or Local Government	<input type="checkbox"/>
Community Board, etc.	<input type="checkbox"/>
Other	<input type="checkbox"/>

28. Please indicate the **number** of each type of provider in your practice site.

PROVIDERS

Primary Care Physicians	_____
Specialty Physicians	_____
Nurse Practitioners	_____
Physician Assistants	_____
Nursing Staff (RN and LPN)	_____
Medical Assistants	_____
Allied Health Staff (lab, X-ray, EKG tech, therapists)	_____
Administrative Staff	_____
Psychologists	_____
Social Workers	_____
Nutritionists	_____
Other	_____

Section IV – Practice Population Characteristics (based on all active charts)

YOU MAY WANT YOUR OFFICE MANAGER TO COMPLETE ITEMS 29-33

29. How many active patients are in your patient panel? (actual number of active charts) _____

30. How many active patients are in your entire practice? (if not a solo practice) _____

31. What percentage of **your** patient population are **(total should equal 100%)**:

	PERCENT
Male	_____ %
Female	_____ %

32. What percent of **your** patient population are in **each** age category (**total should equal 100%**):

	PERCENT
Under 1 year	_____ %
1-5 years	_____ %
6-10 years	_____ %
11-15 years	_____ %
16-20 years	_____ %
21-30 years	_____ %
31-44 years	_____ %
45-64 years	_____ %
65-74 years	_____ %
75 years and older	_____ %

33. What percent of **your** patient population is Hispanic or Latino?

PERCENT
_____ %

34. What percent of **your** patient population is (**total should equal 100%**):

	PERCENT
White	_____ %
Black	_____ %
Native American/Alaska Native	_____ %
Asian/Pacific Islander	_____ %
Other: _____	_____ %

35. What percent of **your** patient population is (please check **all** applicable categories that you see on a regular basis – at least two patients per week – in your practice):

	PERCENT
Gay/lesbian/bisexual/transgender	_____ %
Migrant workers	_____ %
Immigrants/refugees	_____ %
Homeless	_____ %
HIV/AIDS	_____ %
Other: _____	_____ %

36. What percent of **your** patient population use the following payment methods?
(**total should equal 100%**)

	PERCENT
Private health insurance	_____ %
Medicare	_____ %
Medicaid/other government assistance	_____ %
Self-pay	_____ %
Other: _____	_____ %

Family Physician Workforce Survey

37. Where do the majority of your patients go for routine lab work?

SITE FOR LABS

Lab located within the office (Go to 37a.)	<input type="checkbox"/>
Lab located outside the office but within the same building	<input type="checkbox"/>
Lab located away from the building where your practice is located	<input type="checkbox"/>
Specimen is drawn onsite and couriered to outside lab	

37 a. If lab is located within your medical office, indicate level of complexity:

COMPLEXITY

CLIA Waived	<input type="checkbox"/>
Low	<input type="checkbox"/>
Medium	<input type="checkbox"/>
High	<input type="checkbox"/>
No lab in practice	<input type="checkbox"/>

38. Where do a majority of your patients go for routine X-rays?

SITE FOR X-RAY

X-ray equipment located within the practice.....	<input type="checkbox"/>
X-ray facility located outside the practice but within the same building.....	<input type="checkbox"/>
X-ray facility located away from the building where your practice is located.....	<input type="checkbox"/>

39. Describe the source of the information you have just provided about your practice sites:

- ☐ Electronic health record
☐ Billing data
☐ Best guess
☐ Other: _____

Section V – Electronic Medical Record/Electronic Data Gathering Capabilities

40. Is your practice currently using an EMR?

- ☐ Yes, I am using an EMR **(Go to question 41.)**
☐ No, but I am in the process of looking for an EMR now **(Go to question 43.)**
☐ No, and I am not looking for one. **(Go to question 43.)**

41. What software are you using?

- ☐ Allscripts Healthcare Solutions
☐ e-MDs
☐ eClinical Works
☐ GE Centricity
☐ NextGen Healthcare Information Systems
☐ PMSA (Practice Partners)
☐ SoapWare
☐ Other: _____

42. How satisfied are you with your EMR?

- ☐ Very satisfied ☐ Satisfied ☐ No Opinion ☐ Dissatisfied ☐ Very dissatisfied

Family Physician Workforce Survey

43. What practice management software are you using?

- ☐ A4 Healthmatics
- ☐ IDX Flowcast
- ☐ IDX Groupcast
- ☐ GE Centricity
- ☐ Medisys
- ☐ Misys
- ☐ NextGen
- ☐ Not using practice management software (**Go to 45.**)
- ☐ Other _____

44. How satisfied are you with your current practice management system?

- ☐ Very satisfied ☐ Satisfied ☐ No Opinion ☐ Dissatisfied ☐ Very dissatisfied

45. Would you be interested in participating in a program that provides a reduced-price EMR to facilitate your participation in research projects through INET?

- ☐ Yes, definitely
- ☐ Yes, maybe
- ☐ No

46. Do you use the Internet/e-mail for patient care activities (check all that apply)?

- ☐ Yes, I allow patients to contact me by e-mail
- ☐ Yes, I currently use e-prescribing to write and refill medications
- ☐ Yes, I order laboratory reports electronically
- ☐ Yes, I communicate laboratory results via Internet/e-mail to my patients
- ☐ Yes, my patients can schedule appointments by accessing my schedule on the Internet
- ☐ Yes, we use the Internet to send electronic billing claims
- ☐ No, I do not use the Internet for patient care activities
- ☐ Other: _____

SECTION VI – Indiana Academy of Family Physicians Services

47. Please indicate the top five (5) Indiana Academy of Family Physician services you feel are most important for your dues dollars.

- ☐ Clinical CME Conferences
- ☐ Practice Management Education (Help with Contracts, EHR, Practice Re-Design, Medical Home Concepts, Reimbursement, etc.)
- ☐ Keeping CME Records
- ☐ Medical Student Interest in Family Medicine
- ☐ Advocacy with payors (Medicaid, Medicare, Private Insurance Co.)
- ☐ Advocacy with legislative and regulatory bodies
- ☐ Representation with the Medical Licensing Board
- ☐ Patient / Public health Advocacy (tobacco cessation, obesity, vaccination)
- ☐ Publications and communications (Front Line Physician and e-Frontline)
- ☐ Not a member of the Indiana Academy of Family Physicians
- ☐ Other: _____

THANK YOU!



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Health Law Alert

by Adele Merenstein, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.

CMS Physician Quality Reporting Initiative Begins July 1, 2007

On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 ("TRHCA") into law. The TRHCA authorized the establishment of a financial incentive program for physicians and other eligible health care professionals participating in a voluntary quality reporting program. CMS has titled the statutory program the Physician Quality Reporting Initiative ("PQRI").

Eligible professionals successfully reporting on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a lump-sum bonus payment of 1.5 percent of their *total allowed charges* for that period, subject to a cap. To get the bonus, eligible professionals must report at least 80 percent of the time on up to three different "quality measures" applicable to the professional's practice. When four or more measures are applicable to the services provided, the 80-percent threshold must be met for at least three of the measures reported. The 1.5-percent bonus is calculated based on *all services rendered and eligible for reimbursement* during the reporting period, not just on services rendered in connection with reported quality measures.

Of note, in some cases, a participating professional may report on only one or two measures because only one or two measures apply to that professional's patient population. CMS is in the process of establishing a "validation strategy" to ensure no other measures potentially apply. Professionals who report fewer than three measures when other measures apply risk possible nonpayment of the bonus. CMS promises to provide additional information on the validation process on its Web site.

The PQRI incentive payment is an all-or-nothing bonus. The "cap" may apply when relatively few instances of quality measures are reported. Eligible professionals' caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80-percent threshold); by (2) a constant of 300 percent; and by (3) the national average per-measure payment amount. CMS recommends



that eligible professionals report on every quality measure that is applicable to their patient populations to increase the likelihood that: (1) the 80-percent-threshold reporting requirement is met; and (2) eligible professionals are not affected by the bonus payment cap.

Last month, CMS unveiled detailed specifications for the 74 quality measures eligible professionals may report. The quality measures and specifications may be found at http://www.cms.hhs.gov/PQRI/Downloads/Specifications_2007-02-04.pdf. Not all measures will be relevant to all providers. Other helpful resources, including FAQs, transcripts of national conference calls related to PQRI and PQRI MLN Matters Articles, may be found at www.cms.hhs.gov/PQRI. The CMS PQRI resources are user-friendly and designed to help eligible professionals navigate the voluntary reporting process. Below, please find additional information clarifying the scope and mechanics of the PQRI.

PQRI – Everything You Need to Know to Begin

1. Who may participate? The following health care professionals are eligible to participate in the PQRI:

- *Medicare Physicians*, including: doctors of medicine, doctors of osteopathy, doctors of podiatric medicine, doctors of optometry, doctors of oral surgery, doctors of dental medicine and chiropractors;
- *Practitioners*, including: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians and nutrition professionals;
- *Therapists*, including: physical therapists, occupational therapists and qualified speech-language pathologists.

All eligible professionals wishing to participate must have an NPI. All claim forms submitted with quality data must include the individual NPI at the line item level, otherwise such claims will not be included in the analysis of satisfactory reporting for PQRI and the bonus payment. An eligible professional wishing to participate in the 2007 PQRI need not "register" prior to submitting quality data.

2. Why participate? Quality reporting is here to stay. The PQRI is a "first step" toward linking Medicare health professional payments to quality. Likely, the PQRI represents an incremental shift toward pay-for-performance for physicians and other professionals. What

takes hold under Medicare often trickles down to the commercial payor sector. Clinicians choosing to participate in the voluntary PQRI will gain experience in capturing and submitting quality data via the claims submission process.

3. How does the PQRI program work? The eligible professional should review the 74 quality measures and specifications and **choose at least three** measures (as possible) applicable to his/her patient panel.

For example, clinicians providing the primary management of patients with coronary artery disease might choose to report Measure 6, “Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease.” This measure describes the percentage of patients ages 18 and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy. Per instructions in the specifications, the measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The measure is reported using CPT Category II codes. CPT II 4011F (Oral antiplatelet therapy prescribed) would be disclosed as a “numerator.” If oral antiplatelet therapy is not prescribed, the clinician appends a modifier (1P, 2P, 3P or 8P) to the base CPT II code. For the “denominator” of the measure report, the clinician reports an ICD-9 diagnosis code for coronary artery disease (e.g., 414.00-414.07) and a CPT E/M service code (e.g., 99201-99205 (E/M)). CMS has included a “Rationale” section in the quality measure specifications explaining why oral antiplatelet therapy is recommended. “Clinical Recommendation Statements” offering detailed information for use of oral antiplatelet therapy for different conditions also are specified.

The level of detail described for Measure 6 is provided for each quality measure. PQRI quality measure data derived from services provided between July 1 and December 31, 2007, is reported on Part B professional services claims. Of note, if there are no appropriate measures for a clinician to report, due to the unique nature of the services provided to beneficiaries, such clinicians should not report for the 2007 PQRI. Such clinicians should submit measures through their specialty societies for future inclusion in the program.

4. What services are covered under the PQRI? Only services paid under the Physician Fee Schedule are covered. Other Part B services and items that may be billed by eligible professionals but are not paid under the Physician Fee Schedule, such as clinical laboratory services, pharmaceuticals billed by physicians and Rural Health Center/Federally Qualified Health Center services, do not apply

to the bonus. PQRI data analyses exclude all **denied** line items (i.e., services denied for lack of medical necessity or inadequate documentation) from the calculation of bonus payment eligibility and amount.

5. How and where do eligible professionals place the quality data codes on the claim?

The 2007 PQRI quality data codes are HCPCS codes (CPT Category II codes or G-codes) and should be reported like other HCPCS codes. On the ASC X12N 837 professional health care claim transaction, HCPCS procedure codes are submitted in the SV1 “Professional Service” Segment of the 2400 “Service Line” Loop. The data element for the procedure code is SV101-2 “Product/Service ID.” It is also necessary for the clinician to identify in this segment that he/she is supplying a HCPCS code by submitting the “HC” code for data element SV101-1. For claims submitted on the CMS 1500 form, procedure codes are reported in field 24D. The CPT Category II code or G-code quality data must be reported on the same claim as patient diagnosis and service to which the quality-data code applies. Otherwise, the quality data codes will not count toward successful reporting or calculation of a potential bonus payment.

For PQRI quality-data codes, a charge for \$0 must be submitted. Although the PQRI quality-data codes will be “denied” (the codes do not correspond to reimbursable services or items), such codes still will be accepted into the system for purposes of calculating bonus payment eligibility.

6. How does quality reporting work if the eligible professional is in a group practice?

It is *not* necessary for all members of the group practice to participate. A professional wishing to report quality measures will need to provide his/her NPI data on the ASC X12N 837 professional health care claim transaction or the CMS 1500 form. In group practices where all claims contain the group practice NPI, the individual performing professional’s NPI also must be indicated for quality-data codes and related services. Bonuses, however, get paid to the holder of the Taxpayer Identification Number (TIN). Thus, if several professionals in a group practice report, bonuses are paid to the holder of the TIN, aggregating individual bonuses for groups that bill under one TIN. If a professional or group has assigned Medicare Physician Fee Schedule billing to an employer or facility, such as a hospital, the TRHCA requires that any bonus payment earned will be paid to the employer or facility. Finally, eligible professionals providing services for more than one health care entity could end up earning a separate bonus from each entity, since bonuses are paid to the holder of the TIN.

7. When is the cut-off for PQRI data submission? Claims for services provided between July 1, 2007, and December 31, 2007, must be processed by the Medicare Part B Carrier or Part A/B Medicare Administrative Contractor (“MAC”) and in the National Claims History file by February 29, 2008, in order to be included in the 2007 PQRI analyses.

8. Whom should the eligible professional call to get more information? CMS suggests that clinicians first consult the CMS PQRI Web site, as it is continually updated. The clinician also may contact the local carrier or MAC. The Provider Call Center Toll-Free Numbers Directory may be found at <http://www.cms.hhs.gov/MLNGenInfo>.

9. Will PQRI results be publicly reported?

No. However, CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump-sum bonus payments are made in mid-2008. Access to confidential feedback reports may require eligible professionals to obtain a login identification and password.

10. What’s on the horizon for 2008? For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. Proposed 2008 quality measures must be published by August 15, 2007, and finalized by November 15, 2007. Specialty physicians will have the opportunity to submit quality measures relevant to their practices. CMS is considering the use of registry-based or electronic health record-based reporting mechanisms for 2008.

Conclusion

Quality Reporting is the “brave new world” in health care. Representatives of the CMS Office of Special Programs and Value-Based Purchasing believe the industry is heading toward a pay-for-performance system with public reporting of performance results. While, at this time, the value of potential bonus payments may be limited considering the amount of effort required to get started, eligible professionals stand to gain valuable experience by participating in the PQRI. Those wishing to participate should check the CMS Quality Web site frequently for updates on the program.

Should you have any questions, please feel free to contact your local counsel or Adele Merenstein at amerenst@hallrender.com or 317.977.1469 at Hall, Render, Killian, Heath & Lyman.

This publication is intended for general information purposes only and does not and is not intended to constitute legal advice. The reader must consult with legal counsel to determine how laws or decisions discussed herein apply to the reader’s specific circumstances.

Coding and Billing Update

Implementation of the 2007 Physician Quality Reporting Initiative

by Joy Newby, LPN, CPC
Newby Consulting, Inc

After reading the excellent article on Medicare's Physician Quality Reporting Initiative (PQRI) included in this issue, physicians can use this information to create a process for capturing data to report the quality measures. All physicians should verify the information with the measures posted at http://www.cms.hhs.gov/PQRI/downloads/Measure_Specifications_060107.pdf on the Centers for Medicare & Medicaid (CMS) Web site.

Performance Exclusion Modifiers

According to the American Medical Association's CPT 2007 Appendix H: "Performance measurement exclusion modifiers may be used to indicate that a service specified by a performance measure was considered but, due to either medical or patient circumstance(s) documented in the medical record, the service was not provided. These modifiers serve as denominator exclusions from the performance measure."

Performance Modifiers for Performance Measure CPT Category II Codes

Please note that a new performance modifier has been added. The 8P modifier will be appended to the Category II CPT code to indicate that the process of care was not provided for a reason not otherwise specified. It allows allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

- 1P Medical Reasons:
 - a. not indicated (absence of organ/limb, already received/performed, other)
 - b. contraindicated (patient allergic history, potential adverse drug interaction, other)
- 2P Patient Reasons:
 - a. patient declined
 - b. economic, social or religious reasons
 - c. other patient reason
- 3P System Reasons:
 - a. resources to perform the services are not available
 - b. insurance coverage/payor-related limitations
 - c. other reasons attributed to health care delivery system
- 8P Performance Measure Reporting Modifier
 - a. action not performed, not otherwise specified

Performance modifiers are only appended to CPT Category II codes. Not all measures allow

use of all exclusion modifiers. For example, the measure primary open-angle glaucoma patient who has an optic nerve head evaluation during one or more office visits within 12 months does not include the 2P performance modifier.

In some measures, the 1P modifier can be used when a physician is asked to report on the measure but is not the clinician providing the primary management for the patient's condition.

CMS Issues Clarifications and Frequently Asked Questions on PQRI

Several clarifications that were included in the March 27, 2007, CMS PQRI teleconference and listed in the frequently asked questions posted at the CMS Web site are important for ophthalmology reporting.

- If you report a 12-month measure in July, and then the patient comes back in four months (November) with the same diagnosis code, do you have to report again using the 1P modifier, or will CMS be able to track that the patient was reported on before? CMS response: Only report once. CMS is able to track that the measure has already been reported for the patient.

Follow-up clarification was requested from Dr. Susan Nedza, CMS. Physicians may choose to report 12-month measures each time the patient is seen during the reporting period. However, the system will automatically drop the additional visits for the same measure reported on the same patient. For a single patient, the physician will get credit for reporting only one encounter per measure. This clarification means physicians are not required to maintain an internal record of previous reports.

- Quality-data codes should be submitted for any measures that are applicable to each Physician Fee Schedule claim, as determined by all the diagnosis (ICD-9) and service (CPT Category I) codes submitted on the claim for payment. Thus, if a patient presents with three diagnoses that reflect three measures, all three measures can be reported on the claim for the visit code.

- No charge should be submitted with the code used for the measure. However, if your practice management system will not allow you to submit a procedure code with \$0, you may assign a nominal charge to the code. Remember, if you apply a nominal charge to the measure code, you will need a process to write off that amount. Patients may not be charged for reporting.



- Measure code(s) must be submitted on the same claim as the “denominator.” There is no going back or adding these codes after the claim has been submitted.

- Because there is no payment allowed for PQRI line items, the line items containing the PQRI quality-data codes will be denied for payment but tracked for the analysis of satisfactory reporting and the bonus calculation. PQRI analyses will include the quality-data code line items, but will exclude all other denied line items from the basis of the calculation of bonus-payment eligibility and amount.

- Although CMS cannot give any guidance regarding how commercial insurers will process claims including these quality measures submitted with Category II codes, at this time, CMS will include all Medicare Secondary Payer claims in determining if the physician successfully reports PQRI measures.

Reporting

1. Test your billing system by submitting the test code. See the article “CMS Announces

Testing Opportunity for the Physician Quality Reporting Initiative (PQRI),” which is posted on the IAFP Web site, for instructions on how to test.

2. Create a process for reporting.

For example (not all-inclusive), since there are more than four measures applicable to family physicians, select at least three measures to report. Remember, CMS recommends reporting on as many measures as possible to increase the likelihood of successful reporting and to raise the cap amount.

- Create a cheat sheet for capturing the measures.
- Decide if you want to report measures on all patients or just those patients having original Medicare (remember, PQRI does not apply to Rural Health Clinics Services or patients covered by Medicare Advantage Plans [also known as Medicare Replacement Plans]).
- Assign staff to put cheat sheets with the superbills.
- When marking the superbill, determine if the diagnosis or diagnoses pertinent to the encounter are applicable to PQRI – e.g., diabetes mellitus.
- Check applicable measure statements for the patient’s specific encounter.

- Posting staff should post the visit code for the encounter, then post the applicable measure code(s), and, finally, post any additional charges for the specific date.
- If a charge has to be put on the measure code, the amount should be written off when the payment is posted.

Measures

CMS posted the complete specifications for the 74 measures that make up the 2007 Physician Quality Reporting Initiative (PQRI). Additional changes were published June 1. The information is found at the CMS Web site: http://www.cms.hhs.gov/PQRI/downloads/Measure_Specifications_060107.pdf.

Physicians can report either the temporary “G” codes or CPT Category II codes. Since the “G” codes are temporary codes, whenever possible, NCI recommends using CPT Category II codes to report measures.

NCI drafted sample cheat sheets for all 74 measures. This information is available at the IAFP Web site.

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Legislative Update

Sine Die

The 115th Indiana General Assembly adjourned *sine die* at midnight on Sunday, April 29. Legislators worked down to the wire hashing out a biennial state budget, a property-tax reform plan and a plan to provide health coverage for many uninsured people. This session proved to be one of the most productive health care sessions in recent memory. The House of Medicine was fully aligned on many issues and worked diligently to put physician reimbursement, insurance contracting issues and positive public health policy at the top of the Legislature's agenda. Health Commissioner Dr. Judy Monroe was an eloquent and persuasive leader in calling for increased funding for ITPC, childhood immunizations and a cigarette-tax increase under the governor's uninsured plan. The governor's office and the administration truly helped the Legislature make this a winning session for health care.

Important Milestones

Perhaps most significantly, the governor's uninsured plan, HEA 1678, after many additions by the House, passed by a significant margin in both the House (70-29) and the Senate (37-13). The IAFP participated in the governor's Healthy Indiana Plan coalition and fought fervently for the increased cigarette tax of 44 cents. Staff members Allison Matters and Missy Lewis joined the governor and a number of other partners in celebrating his signing of HB 1678 on May 10. Among those in the picture are Zach Cattell, with the Indiana State Medical Association; Aaron Doeppers, with the Campaign for Tobacco-Free Kids; Tim Filler, consultant; and Karla Sneegas, with Indiana Tobacco Prevention & Cessation. FSSA Secretary Mitch Roob kicked off his thanks by first mentioning IAFP at the public signing. The 44-cent increase in Indiana's cigarette tax almost brings us to the national average of \$1.046. While funding for the Indiana Tobacco Prevention & Cessation Agency (ITPC) will be just short of half of the minimum recommended by the Centers for Disease Control & Prevention (CDC), the increase in funding shows renewed



confidence in the program and a growing understanding in the Legislature of the toll tobacco takes on lives and health care in Indiana. In addition, the IAFP, along with others in the House of Medicine, were able to tie much-needed physician reimbursement into the plan. FSSA Secretary Mitch Roob said that, during the 2008 and 2009 budget cycle, approximately 2 cents of every dollar of the tax will be appropriated for physician reimbursements, and 1 cent will be provided for dentist reimbursement. On a side note, physicians can also expect a stipend for the '07 budget year. FSSA is still hammering out the details on terms of distribution and amount. However, the IAFP has urged that the money be distributed for primary care services. Details on this stipend probably will not be available until August.

The plan includes many other significant and positive changes for Indiana health care, including \$11 million for childhood immunizations. The additions to the governor's plan by both sides of the aisle will ultimately allow hundreds of thousands of people to get coverage. As the governor stated during the bill-signing ceremony, this is only the beginning of the process to provide health care for the uninsured. A Request for Services (RFS) was issued May 4 by FSSA and the Department of Administration (DOA) seeking insurers to bid on the plan. IAFP submitted official questions to DOA regarding the RFS's use of physician extenders and marketing initiatives. IAFP will be participating on FSSA's marketing task force to ensure effective announcement and marketing of the plan. IAFP looks forward to working with the administration to further develop HEA 1678, and we will continue to carry the message of the importance of the medical home in this program. While the bill becomes effective July 1, 2007, it will not be fully operational until January 2008. Secretary Roob hopes as many as 50,000 people will be signed up by the end of the first year.

IAFP is also pleased to report that after threats of Medicaid cuts, the House of Medicine effectively lobbied for an increase in the Budget's Medicaid funding of 5 percent. Indiana Tobacco Prevention and Cessation (ITPC) was funded at \$15 million — \$5 million more than last budget, but still \$18 million less than the CDC's minimum recommended level. The Uninsured Plan calls for a very minimal amount for ITPC funding as well, bringing the total ITPC funding to

around \$16 million. Also important to our members, the line item for Family Medical Education Board Family Practice Residency Fund was funded at more than \$2.3 million — a bump of \$80,000 from last budget. For the first time, the Area Health Education Centers (AHECs) received a \$3 million boost from the Legislature. The money will be used to bolster the number of people pursuing health careers in medically underserved areas. The effective date is July 1, 2007.

Other Significant Pieces of Legislation to Pass This Session Include:

Motor vehicle restraint systems — after five years of trying, the Legislature was finally able to pass legislation requiring all drivers to wear seat belts — including those driving trucks. The effective date is July 1, 2007.

Prescriptive authority for physician assistants was once a daunting proposal, but with input from the IAFP and the Indiana State Medical Association (ISMA), the bill was significantly fine-tuned, as it requires physicians to be immediately available, which is narrowly defined. This becomes effective once the Medical Licensing Board adopts the rule necessary to implement this act.

Immunizations by pharmacists was another problematic bill in the beginning, but ISMA and IAFP worked with the author to ensure this bill was significantly restricted to allow only yearly flu vaccines be administered by pharmacists. The Indiana Board of Pharmacy, in consultation with the Medical Licensing Board, must adopt rules for this initiative by January 1, 2008, in order for this to be effective.

HPV vaccinations for school-age girls will require schools to educate parents on the prevalence of cervical cancer and inform them of the HPV vaccine. IAFP and Dr. Richard Feldman were instrumental in the execution of this piece of legislation. The effective date is July 1, 2007.

Health provider reimbursement agreements prohibit "most favored nations clauses" frequently used by Wellpoint/Anthem. This will allow our physicians to better and more freely contract with insurers. The effective date is April 26, 2007.

Automated external defibrillators in health clubs — this requires such devices to be available in health clubs. The effective date is July 1, 2007.

Emergency procedures training for teachers and Diabetes management – this requires schools to train nurses and staff to help manage students' diabetes. The effective date is July 1, 2007.

The Budget

In the House, the budget bill passed along party lines. It also passed handily in the Senate on a bipartisan basis.

One key initiative in the budget was property-tax reform. Because of a variety of events, it was expected that property taxes would increase 15 percent in May. During the week, it appeared the average increase could be 25 percent. In certain counties, such as Hendricks County, it could go up sub-stancially higher. As a result, \$550 million of property-tax relief was included in the final budget. The intent is to get the average increase down to 8 percent. While nobody will like an overall 8-percent increase, it is much better than would have happened otherwise. The general concerns were whether the relief was enough and the methodology of returning money to the taxpayers.

Looking Forward

Interim study committees at the Statehouse will begin later this summer. We expect the Health Finance Commission to look at important issues, such as the relevance of the Indiana's Tobacco Prevention and Cessation Program and the state's requirements for mid-level providers, including nurse practitioners and physician assistants. Please be sure to check IAFP's e-frontline often, as IAFP's legislative staff will update members as these study committees are announced.

IAFP Political Action Committee

The time has come again to raise money for the IAFP PAC. To all of those who contributed last year, thank you. This past year the IAFP has worked diligently to be at the table with the governor's office and the administration and before the Legislature. Your past contributions have paid off, as the IAFP is gaining a louder voice each session.

But we can't stop here. The IAFP needs your help to continue to promote family medicine and the importance of the medical home. As the administration calls for expanded use of mid-level providers, the IAFP must remain strong and fervently fight for increased awareness of the importance of primary care physicians.

If you have not given to the IAFP PAC this year, please consider doing so. The Indiana General Assembly can and will affect your practice. Financial participation in the political process is another step the IAFP must take in order to build strong relationships with the legislature. Donate today!

For questions about the PAC or other legislative activities, please contact Allison Matters or Doug Kinser at 317.237.4237.

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TIP #9

Know their approach to protecting physicians.



There is a big difference in operating philosophy among medical malpractice carriers. With some, defense against claims may be half-hearted at best. Many good physicians have been hurt by frivolous lawsuits when their good work went undefended in favor of quick-fix settlements. Clearly, this does not serve you or the profession well.

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New Residents at Indiana's Family Medicine Residency Programs

More residency programs will be featured in the fall issue of *FrontLine Physician*.

The IAFP wishes the very best of luck to all new residents who have chosen to complete their residencies in family medicine.

Community Family Medicine Residency *Class of 2010*



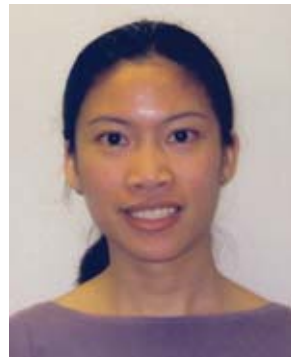
Amy Olin

Amy is a graduate of Indiana University School of Medicine. Amy completed her undergraduate work at Butler University, and while at IU, she helped to restart the school's medical Spanish classes. She also participated in fundraisers for local homeless shelters and in Spring House Calls, which involves medical students going out in the community to help individuals with spring yard work.



Gloria Brelage

Gloria comes to us from Indiana University School of Medicine and is a Hoosier native. She is one of 10 children in her family. As a student, she has been involved in the IAFP and in Habitat for Humanity.



Mary Pawlak

Mary comes to us from the University of Wisconsin School of Medicine. She recently completed a cross-country trip in a car powered by vegetable oil and biodiesel fuels! She and her fiancé, Sacha, spoke to different groups of school children and adults about eco-friendly fuels.



April Gish

April is a graduate from the Indiana University School of Medicine. April is originally from Minnesota, but now resides in Indianapolis with her husband, Josh.



William Robinson

J.R. is a graduate of the University of Louisville in Kentucky. During his college years, he worked as a therapeutic child and family support staff member, mentoring children who had been abused. He and his wife, Jennifer, will be moving to Indianapolis for his residency.



Matthew Main

Matt is a graduate of Wayne State University in Michigan. He and his wife recently welcomed a new son, Josiah, and will be moving to the south side of Indianapolis before beginning residency.



Jill Rogers

Jill is an Indiana University graduate and a new mom to her daughter, Hannah. She and her husband, Michael, live in Indianapolis.

St. Joseph Family Medicine Residency



Dana Anglund, DO

Graduated from: University of Medicine and Dentistry of New Jersey
Born in: Denver, Colorado
Has a passion for osteopathic medicine
Participated in outreach ministry to the deaf community
Fluent in sign language



Omer Ansari, MD

Graduated from: King Edward Medical College
Born in: Yazd, Iran
Member of the Pakistan Medical Association
Fluent in Urdu, Hindi, Punjabi and Persian



Zhaijun Fan, DO

Graduating from: New York College of Osteo Medicine
Born in: Suzhou, China
Graduated cum laude from Andrews University, where he studied medical technology
Fluent in Mandarin Chinese and Cantonese



Brad Isbister, MD

Graduating from: Indiana University School of Medicine
Born in: Milwaukee, Wisconsin
Previous careers included being a chemist and a high school teacher



Jeff Kindred, DO

Graduating from: Kirksville College
Born in: Sandy, Utah
Went on a two-year mission trip to Louisiana and Mississippi
Chosen the first year of medical school to be student ambassador



Jennifer Maya, MD

Graduating from: Indiana University School of Medicine
Born in: Merrillville, Indiana
Fluent in Spanish
Member of the Indiana Primary Care Scholarship and awarded the Gerald E. Smith, MD, Award



Mike Sanderson, MD

Graduating from: University of Utah
Born in: Mount Pleasant, Utah
Member of the Pre-Medical National Honor Society
Awarded a Subspecialty Award for his involvement in a research fellowship from the Endocrine Society



Madiha Saeed, MD

Graduating from: Army Medical College
Born in: Aurora, Illinois
Fluent in Urdu, Hindi and Punjabi
Medical school awards include graduating in the First Division and receiving three merit scholarships for outstanding performance



Ashlee Warren, MD

Graduating from: Ohio State University
Born in: Cleveland, Ohio
Notre Dame University Alumna
Medical school awards include: letter of commendation for FM Sub-Internship and letter of commendation for physician development

Congress Has Historic Opportunity to *Protect Children and Save Lives* by Granting FDA Authority over Tobacco Products

On February 15, 2007, legislation was again introduced granting the FDA authority over tobacco products. Similar legislation has come forth on a number of occasions in recent years, but the key pieces are aligned to make this the year success will be reached! A strong coalition of national partners, including the AAFP, have been diligently working to pass this federal legislation. While both Sens. Richard Lugar and Evan Bayh have signed on as cosponsors of S. 625, the only two cosponsors (out of 160) in the House of Representatives from Indiana are Reps. Julia Carson and Brad Ellsworth. Academy members in Indiana can make a difference! Contact Missy Lewis (mlewis@in-afp.org, or call the IAFP Headquarters) to find out how you can help.

What does FDA regulation of tobacco products really mean?

1. Protecting kids
2. Protecting public health
3. More information for consumers
4. Decisions based on sound science

Limiting Marketing and Sales of Tobacco Products to Children

Effective regulation of the tobacco industry would lower rates of tobacco use among children and adolescents by: (1) imposing limits on industry marketing and promotions and (2) restricting sales to children by limiting self-service displays and requiring age verification.

Access to Tobacco Manufacturers' Research

FDA authority over tobacco products would give the FDA and the public access to information the tobacco industry has on the health effects of their products, on nicotine and its addictiveness, on marketing to children and other information that would protect public health.

Learning What Is in Tobacco Products

Consumers would have access to information about all of the naturally occurring ingredients in tobacco products, the additives that manufacturers put in the products, and the constituents of tobacco smoke that result from burning the product.

Meaningful Warning Labels

Warning labels would be changed, and the FDA would be able to require manufacturers make further changes to the content and format of warning labels to make them more effective.

Protecting Public Health by Reducing Risks Where Technologically Feasible

The FDA would have the authority to require



manufacturers to reduce or eliminate harmful ingredients and/or smoke constituents where technologically feasible.

Protecting Public Health by Overseeing Reduced Risk Health Claims for New Products

In evaluating reduced-risk claims for new tobacco products, the FDA would calculate whether or not the introduction of such a new tobacco product would reduce harm and protect the public health.

Any Claims Must Be Evaluated for Scientific Accuracy and Their Impact on Public Health

The FDA would have the authority to require tobacco manufacturers to prove any claims they make about the health risks (or alleged benefits) posed by their products (for

example, statements that suggest lower risks of cancer, heart disease, etc.), regarding both their scientific accuracy and their impact on public health.

FDA's Authority Comparable to Other Consumer Products

The FDA's authority to regulate tobacco products would be comparable to its existing authority for drugs, devices and foods.

FDA Would Only Be Able to Regulate Manufacturers, Not Farmers

FDA authority would be limited to tobacco manufacturers and their products. Tobacco farmers would remain under the purview of the Department of Agriculture.

Thanks to Campaign for Tobacco-Free Kids for this valuable information. To learn more, visit <http://www.tobaccofreekids.org/reports/fda/>.

Indiana Tobacco **Quitline** Marks One Year

March 22, 2007, was the first anniversary of the Indiana Tobacco Quitline. During its first year, the Indiana Tobacco Quitline received more than 10,000 incoming calls through 1-800-QUIT NOW.

A total of 4,845 callers registered to receive services. This includes individuals seeking information about quitting for themselves, for their patients or for friends and family members.

Congratulations and thank you to everyone who worked to promote the Quitline throughout the state. Together, we are helping lower tobacco usage rates across Indiana!

Formal evaluation of the program began in October 2006, and results are expected this summer. The End of Program survey is administered seven months after callers register for services. The survey will measure overall satisfaction with the program, quit rates, use of aids while quitting (e.g. cessation medications, advice from a provider) and other service metrics.

The recent 44-cent tax increase took effect on July 1. We can expect nearly 24,000 current smokers to quit as a result. Family physicians

INDIANA TOBACCO QUITLINE

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are encouraged to refer patients who smoke to the Indiana Tobacco Quitline. All Indiana residents are eligible for the one-call service, which can be accessed by calling 1-800-QUIT-NOW. Callers can speak with a quit coach, receive a Quit Kit and receive information about cessation programs in their county. Patients who are pregnant, on Medicaid or uninsured are eligible for the four-call series, during which the quit coach will call the patient back on key dates. Remember to ASK all patients about their tobacco use and ACT to help them quit tobacco!

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Recent IAFP Events

Faculty Development Day and Residents' Day & Research Forum

The IAFP hosted its annual Faculty Development Day on March 7, 2007, and the Academy hosted its Residents' Day & Research Forum on March 8, 2007. Both events took place at the Airport Holiday Inn in Indianapolis.

The theme of this year's Faculty Development Day was **Overcoming Challenges in Residency Education**. Paul Daluga, MD, of Clay City, Indiana, was the program chair and introduced the speakers. First, attendees heard from Mary Dankoski, Ph.D., & John Turner, MD, who spoke about the challenges of clinical teaching. Next, attendees learned about challenges and opportunities with international medical graduates from Joseph Biggs, Ph.D., HSPP. At lunch, a brief update from the IUSM Department of Family Medicine was presented by Chair Doug McKeag, MD. The afternoon session began with a lecture on the ISMA's Impaired Physician Program by Fred Frick, MD, followed by Peter Nalin, MD, speaking on institutional perspectives/best practices for releasing residents. Finally, a panel discussion and group discussion took place on lessons learned from difficult interventions. Serving on the panel and sharing their experiences were Clif Knight, MD, Paul Daluga, MD, Greg Hindahl, MD, and Shaaron Grannis, MD. The day closed with an overview of related legal perspectives from Kevin Speer, JD, IAFP EVP.

More than 100 residents and faculty members attended the **Residents' Day and Research Forum**, moderated by Amy Banter, MD. Attendees heard presentations in the Original Research and Case Presentation categories, and they viewed original research poster presentations.

The IAFP congratulates the following prizewinners:

Case Studies

1. Acute Loss of Vision in a Previously Healthy Adult Female
Rachel Lackey, MD \$200
2. A Case of Strange Behavior
Pamela Somervell, MD \$100
3. Spots that Linger: Benign Dermatoses or Not?
Wes Archer, MD \$50



Wes Archer, MD, Pamela Somervell, MD, and Rachel Lackey, MD

Original Research

1. Management of Bacterial Vaginosis During Pregnancy
Holly Heichelbech, MD \$400
2. (Tied) The Relationship Between Coping Strategies and Physician Burnout
John McCleery, MD, and Dominic Vachon, PhD \$200
2. (Tied) Physician Strategies and Patient Behavior Change
Jared Price, DO, and Dominic Vachon, PhD \$200
3. Cost/Benefit Analysis of Hiring an Onsite Phlebotomist
Walter Cunningham, MD \$100



Walter Cunningham, MD, Jared Price, DO, John McCleery, MD, and Holly Heichelbech, MD



Azita Chehresa, MD

Poster Presentations

Best Poster by a Family Medicine Resident
Family Practice Residency Graduate Survey
Azita Chehresa, MD \$100

Best Poster by a Faculty Member or Practicing Physician
Outcomes of Health Literacy-Based Patient-Centered Diabetes Program
Vipin Jain, MD \$0 - faculty




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American Board of Family Medicine and NCQA Align Physician Measurement Standards

Physicians Can Use NCQA Recognition for Credit Toward Maintenance of Certification, More than 70,000 Diplomates Stand to Benefit

The American Board of Family Medicine (ABFM) and the National Committee for Quality Assurance (NCQA) recently announced an agreement under which ABFM diplomates recognized for quality care through NCQA's popular Physician Recognition Programs will also receive credit towards their Maintenance of Certification for Family Physicians (MC-FP).

Maintenance of Certification for Family Physicians is the means by which the ABFM continually assesses its more than 70,000 Diplomates to ensure they meet the highest standards of accountability and clinical excellence. Under the agreement, ABFM diplomates who successfully complete NCQA's Diabetes Physician Recognition Program or its Heart/Stroke Recognition Program are eligible to receive credit for the completion of a MC-FP Part IV Performance in Practice Module. Diplomates are required to

complete one such module during each stage of the Maintenance of Certification process.

NCQA's Physician Recognition programs identify clinicians who demonstrate consistent delivery of high-quality care for key conditions. Physicians qualify for NCQA recognition by meeting rigorous standards and reviewing the medical records of a sample of patients to ensure they receive care consistent with evidence-based guidelines. Program standards are set by NCQA and its partners, the American Diabetes Association and the American Heart Association/American Stroke Association. More than 5,000 physicians have earned NCQA Recognition to date.

"NCQA Recognition, like certification from the ABFM, is a mark of excellent care," NCQA President Margaret E. O'Kane said. "We're pleased to work with the ABFM to

bring our program standards in alignment — it's a great way to add value to both programs."

"NCQA's Recognition programs and the ABFM's Performance in Practice modules both employ widely accepted guidelines for care based firmly in medical evidence," ABFM President and Chief Executive Officer James C. Puffer, MD, said. "Allowing our diplomates to pursue Recognition and Maintenance of Certification simultaneously reduces measurement burden, so our physicians can spend more time doing what they do best — delivering the best possible care to their patients."

For details regarding MC-FP and PPM requirements, diplomates may visit the ABFM Web site, www.theabfm.org, or call the ABFM Support Center at 877.223.7437. For more information about NCQA's Physician Recognition programs, log on to NCQA's Web site at www.ncqa.org.



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