As the professional liability insurance environment has changed, so have your coverage options. In addition to familiar companies, you are now confronted with an array of non-traditional and start-up insurers who offer surprisingly low rates and other promises to gain new policyholders. But what is the truth about these coverage options?

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*Be careful. These insurers may:*

- Maintain inadequate reserves to pay claims
- Keep reserves in high-risk investments
- Receive no oversight or licensing from regulatory agencies
- Provide limited or sub-standard claims service
- Be unable or unwilling to fulfill their promises

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- Maintains or exceeds reserve levels set by regulators
- Selects only the safest investments for reserves
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For three decades American Physicians has been offering rates that are both competitive and responsible, as well as providing exceptional service and industry-leading value. Our physician focus, impeccable standards and financial stability continue to attract the best practices, year after year.

If you would like more information about insurance options, please contact American Physicians at 1-800-748-0465.

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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.
IMACS OneCall™ is the smartest way to keep doctors and Clarian specialists on the same page. One number puts you in touch with a knowledgeable – and persistent – representative who will track down whatever doctor or service you’re after. To connect to this and other PhysicianLink™ services from Clarian hospitals (Indiana University Hospital, Methodist Hospital, Riley Hospital for Children, Clarian West Medical Center & Clarian North Medical Center), call 800-622-4989 or visit clarian.org/connect.
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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 everyday, 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.

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

...We want Medical Protective to continue to be the company that thinks like a doctor and behaves with the same integrity and individual care as a doctor....

-- from Warren Buffett, April 26, 2006

...We're proud to have Medical Protective as part of the Berkshire family....

-- from Warren Buffett, May 10, 2006

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- Most winning defense
- Smartest solutions
- Committed since 1899

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Strength, Defense, Solutions, Since 1899.
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Defend your reputation and assets.
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The Human Motion Institute team at Clarian Health Partners specializes in bone, joint, spine and muscle care. When your patients need quality, specialized attention for any musculoskeletal problem, the Clarian Human Motion Institute is the logical choice. We can help you return your patients to their normal activities as quickly and safely as possible. Clarian – comprised of Methodist Hospital, Indiana University Hospital, Riley Hospital for Children, Clarian West Medical Center and Clarian North Medical Center – is Indiana’s largest, most comprehensive health system and is one of the busiest hospital systems in the nation. To request free patient information brochures for your office waiting area or to refer a patient, call Clarian IMACS at (800) 622-4989.
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!
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
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. Pisan, 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
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.-4:45 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.

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.
**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!”

---

**IAAFP 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**

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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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at St. Vincent Carmel
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](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.

<table>
<thead>
<tr>
<th>SPECIALTY</th>
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<tr>
<td>General Internal Medicine</td>
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<tr>
<td>Pediatrics</td>
<td>YES</td>
</tr>
<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

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): ________________
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)

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

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

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

**OB/GYN Procedures List**

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

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

<table>
<thead>
<tr>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practice</td>
</tr>
<tr>
<td>Two-person Partnership</td>
</tr>
<tr>
<td>Small Group Family Medicine Practice Group (2-4 partners)</td>
</tr>
<tr>
<td>Large Group Family Medicine Practice (5 or more partners)</td>
</tr>
<tr>
<td>Multispecialty Group</td>
</tr>
<tr>
<td>Other: ______________________________</td>
</tr>
</tbody>
</table>

27. Who is the majority owner of your practice?

<table>
<thead>
<tr>
<th>MAJORITY OWNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Medical Group Practice (single or multi-specialty)</td>
</tr>
<tr>
<td>Hospital or Health System</td>
</tr>
<tr>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>Federal, State or Local Government</td>
</tr>
<tr>
<td>Community Board, etc.</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physicians</td>
</tr>
<tr>
<td>Specialty Physicians</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
</tr>
<tr>
<td>Physician Assistants</td>
</tr>
<tr>
<td>Nursing Staff (RN and LPN)</td>
</tr>
<tr>
<td>Medical Assistants</td>
</tr>
<tr>
<td>Allied Health Staff (lab, X-ray, EKG tech, therapists)</td>
</tr>
<tr>
<td>Administrative Staff</td>
</tr>
<tr>
<td>Psychologists</td>
</tr>
<tr>
<td>Social Workers</td>
</tr>
<tr>
<td>Nutritionists</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

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%):

<table>
<thead>
<tr>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>_______%</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>_______%</td>
</tr>
</tbody>
</table>
32. What percent of your patient population are in each age category (total should equal 100%):

<table>
<thead>
<tr>
<th>Age Category</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>______%</td>
</tr>
<tr>
<td>1-5 years</td>
<td>______%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>______%</td>
</tr>
<tr>
<td>11-15 years</td>
<td>______%</td>
</tr>
<tr>
<td>16-20 years</td>
<td>______%</td>
</tr>
<tr>
<td>21-30 years</td>
<td>______%</td>
</tr>
<tr>
<td>31-44 years</td>
<td>______%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>______%</td>
</tr>
<tr>
<td>65-74 years</td>
<td>______%</td>
</tr>
<tr>
<td>75 years and older</td>
<td>______%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>______%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>______%</td>
</tr>
<tr>
<td>Black</td>
<td>______%</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>______%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>______%</td>
</tr>
<tr>
<td>Other: _________________________________</td>
<td>______%</td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Category</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay/lesbian/bisexual/transgender</td>
<td>______%</td>
</tr>
<tr>
<td>Migrant workers</td>
<td>______%</td>
</tr>
<tr>
<td>Immigrants/refugees</td>
<td>______%</td>
</tr>
<tr>
<td>Homeless</td>
<td>______%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>______%</td>
</tr>
<tr>
<td>Other: _________________________________</td>
<td>______%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private health insurance</td>
<td>______%</td>
</tr>
<tr>
<td>Medicare</td>
<td>______%</td>
</tr>
<tr>
<td>Medicaid/other government assistance</td>
<td>______%</td>
</tr>
<tr>
<td>Self-pay</td>
<td>______%</td>
</tr>
<tr>
<td>Other: _________________________________</td>
<td>______%</td>
</tr>
</tbody>
</table>
37. Where do the majority of your patients go for routine lab work?  

<table>
<thead>
<tr>
<th>SITE FOR LABS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab located within the office (Go to 37a.)</td>
</tr>
<tr>
<td>Lab located outside the office but within the same building</td>
</tr>
<tr>
<td>Lab located away from the building where your practice is located</td>
</tr>
<tr>
<td>Specimen is drawn onsite and couriered to outside lab</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>COMPLEXITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIA Waived</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>No lab in practice</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>SITE FOR X-RAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray equipment located within the practice</td>
</tr>
<tr>
<td>X-ray facility located outside the practice but within the same building</td>
</tr>
<tr>
<td>X-ray facility located away from the building where your practice is located</td>
</tr>
</tbody>
</table>

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
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: __________________________________________________________________

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WE ACCEPT MOST HEALTH INSURANCE PLANS.
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 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 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/perform, 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.

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**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 superbills, 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](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.
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 reimburse-ment, 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 Doepers, 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 substantially 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.
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

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.

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.

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.

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.

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.

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.

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 byGranting 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/.
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 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!
Recent IAFP Events

Faculty Development Day and Residents’ Day & Research Forum


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 McKea, 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

**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 Cunnington, MD
   $100

**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
CareNow

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and Internal Medicine Physicians

Sign on Bonus & Relocation Allowance

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• Paid time off – 3 weeks the first year
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• No hospital admissions
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• With 18 locations and growing, CareNow has centers where you want to live and work. No matter your preference – urban, suburban or rural – we have a center to fit your life.

For more information, call 972-906-8160.
E-mail or fax CV to cindyk@carenow.com • Fax: 972-745-0323
THANK YOU!

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

“…to enhance the health care delivered to the people of Indiana by developing and providing research, education and charitable resources for the promotion and support of the specialty of family practice in Indiana.”

FOUNDER'S CLUB MEMBERS
Founder’s Club members have committed to giving $2,500 to the IAFP Foundation during a five-year period. Members noted with a check mark (✓) have completed their commitment. The Board would also like to acknowledge that most of these individuals continue to give after completing their commitment.

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

PLANNED GIVING CONTRIBUTORS
Ralph E. Barnett, MD
Deeda Ferree
Raymond W. Nicholson, MD

2007 CONTRIBUTORS

Gold Level ($1,000+)
Campaign for Tobacco-Free Kids

Silver Level ($100-$999)

Ball Memorial Hospital Family Medicine Residency
Ken Elek, MD

Al Haley, MD, in memory of A. Alan Fischer, MD
Ilya Schwartzman, MD

James & Joyce Kinsey
Cathy Bryant, MD
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.