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Our Mission
The mission of the Indiana Academy of Family Physicians is to promote and advance family medicine in order to improve the health of Indiana.

Advocacy
Shaping health care policy in Indiana through interactions with government, the public, businesses, the health care industry and our patients

Membership
Serving as the essential resource for the professional success of the Family Physician workforce in Indiana

Education
We aim to be the provider of choice for family physician education in Indiana

Family Medicine: Exceptional Physicians, Exceptional Care

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Innovative Publishing Ink specializes in creating custom magazines for associations. Please direct all inquiries to Aran Jackson, ajackson@ipipub.com.
Greetings!

As you read this, planning will be ramping into high gear for your Academy’s 2012 Annual Convention. The JW Marriott will be a great place to bring your whole family this July, as its location on the White River is just steps from exciting attractions like the Indianapolis Zoo, White River Gardens, the Indiana State Museum, IMAX® Theater, the Eiteljorg Museum of American Indians and Western Art and the NCAA Hall of Champions. All of these attractions are within easy walking distance of the hotel.

For those of you who enjoy nightlife, you’ll love Indy even more now that it’s smokefree! Thanks to the tireless work of our Academy and its partners, the smokefree ordinance went into effect on June 1, making almost every workplace in Indianapolis smokefree. Indianapolis has world-class restaurants, bars and sporting venues for your enjoyment, too.

As an IAFP member, you are a vital part of our Annual Congress of Delegates. All IAFP members are delegates, and all IAFP members can have their vote at the Congress and have their voices heard. Resolutions introduced at our Congress directly affect your Academy’s future policies and ways of doing business. Hear this year’s resolutions, and make your vote. Other meeting highlights include Hot Topic CME, an MC-FP SAM Study Group, the Exhibit Show and your chance to catch up with your friends and colleagues from across the state.

Family Medicine Day at Victory Field takes place just after the Annual Convention wraps up. This is your chance to see the Indianapolis Indians play the Buffalo Bisons, and it’s completely free of charge for IAFP members and their families. We’ve had a huge response from members requesting tickets, so plan on joining a big crowd of Indiana family physicians and their families for a delicious picnic and refreshing drinks, followed by a fun baseball game.

As the year comes to an end, looking back at the amazing work of the Academy and the wonderful people working to support family medicine in Indiana, it was a great honor to serve in this role. I look forward to the great possibilities next year under the leadership of Dr. Risheet Patel.

Welcome to Our New Members and Transfers

David Nicholas Dahl, DO (Washington)
Michael DaRosa, DO (Indianapolis)
Jason Matthew Fish, MD (Bloomington)
Transfer from: Alabama
Laura Anne Foudy, MD (Huntington)
Alex I. Garrido, MD (Carmel)
Jennifer Kathleen Malcolm, DO (Granger)
Haihong Mao, MD (Indianapolis)
John Earl Reaves, MD (Noblesville)
Transfer from: Virginia
Aditee S. Satpute, MD (Indianapolis)
Peter Baenziger (Indianapolis)
Maria A. Cuda, DO (Wabash)
Transfer from: Arizona
Edith M. Cullen, MD (Fishers)
Derryl Miller (Indianapolis)
Jacklyn Marie Oakley (Indianapolis)
Leah Napolitano Ortiz, MD (South Bend)
Transfer from: New Jersey
Jeremy Lawrence Riehm, DO (Granger)
Formulary Update

onglyza®
(saxagliptin) 5 mg tablets

tablets

kombiglyze™ XR
(saxagliptin and metformin HCl extended-release) tablets

Available on Formulary at Indiana Medicaid

For more information about these products, visit www.onglyza-hcp.com or www.kombiglyzexr-hcp.com

Please read adjacent Brief Summary of US Full Prescribing Information for KOMBIGLYZE XR (saxagliptin and metformin HCl extended-release) (5/500•5/1000•2.5/1000 mg tablets), including Boxed WARNING about lactic acidosis.

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Onglyza® and Kombiglyze™ XR are trademarks of Bristol-Myers Squibb.
Lactic acidosis is a rare, but serious, complication that may occur in patients with diabetes mellitus and is characterized by an elevated lactate level. Lactic acidosis usually occurs in patients with type 2 diabetes mellitus and is associated with a poor prognosis. Patients with lactic acidosis may present with symptoms such as confusion, weakness, and shortness of breath. The diagnosis of lactic acidosis can be challenging, and a high index of suspicion is necessary. Treatment of lactic acidosis involves identifying and addressing the underlying cause, which may include correcting hyperglycemia, administering fluids and potassium, and treating any underlying infections or other complications. Treatment may also include the administration of insulin or other medications to lower blood glucose levels. The prognosis for patients with lactic acidosis is poor, and early identification and treatment are crucial for improving outcomes.

ADVERSE REACTIONS
Clinical Trials Experience: Because clinical trials are conducted under highly controlled conditions, adverse reactions observed in the clinical trials of a drug may not reflect the incidence observed in practice, where the drug may be used in conjunction with other medication or under conditions involving patient selection and other factors. Patients treated in clinical trials may not be representative of all patients treated with the drug in clinical practice. The incidence of adverse reactions in clinical trials is difficult to interpret because of variations in the studies, including differences in patient characteristics, study design, and the duration of treatment. The following adverse reactions were reported in randomized controlled trials of saxagliptin and saxagliptin/metformin HC extended-release:

1. Adverse Reactions Commonly Observed in Clinical Trials
- Hypoglycemia
- Headache
- Diarrhea
- Cough

2. Adverse Reactions Rarely Observed in Clinical Trials
- Hypersensitivity reactions
- Angioedema
- Anaphylaxis

3. Other Adverse Reactions Observed in Clinical Trials
- Upper respiratory tract infection
- Urinary tract infection

In post-marketing surveillance, adverse events have been reported with saxagliptin and saxagliptin/metformin HC extended-release, including liver function tests abnormalities, pancreatitis, and pancreatitis following discontinuation of saxagliptin and saxagliptin/metformin HC extended-release. The incidence of these events is difficult to determine and may be influenced by the frequency of laboratory tests and the duration of treatment. Patients should be monitored for signs and symptoms of pancreatitis, including nausea, vomiting, abdominal pain, and fever. Treatment should be discontinued if symptoms are consistent with pancreatitis.

In clinical trials, saxagliptin and saxagliptin/metformin HC extended-release were administered to a total of 1,987 patients with type 2 diabetes mellitus, including 1,191 patients treated with saxagliptin alone, 721 patients treated with saxagliptin/metformin HC extended-release, and 65 patients treated with a comparator (31 patients treated with metformin alone and 34 patients treated with placebo).

Table 1: Adverse Reactions (Regardless of Investigator's Assessment of Causality) in Placebo-Clinical Trials Treated with Saxagliptin 1 mg More Commonly in Patients Treated with Placebo

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Placebo (n=36)</th>
<th>Saxagliptin 1 mg (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper respiratory tract infection</td>
<td>10 (28%)</td>
<td>7 (19%)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>11 (31%)</td>
<td>5 (14%)</td>
</tr>
</tbody>
</table>

- Saxagliptin is contraindicated in patients with type 2 diabetes mellitus and is associated with a poor prognosis. Patients with lactic acidosis may present with symptoms such as confusion, weakness, and shortness of breath. The diagnosis of lactic acidosis can be challenging, and a high index of suspicion is necessary. Treatment of lactic acidosis involves identifying and addressing the underlying cause, which may include correcting hyperglycemia, administering fluids and potassium, and treating any underlying infections or other complications. Treatment may also include the administration of insulin or other medications to lower blood glucose levels. The prognosis for patients with lactic acidosis is poor, and early identification and treatment are crucial for improving outcomes.
-5% in any treatment group in both studies. In the saxagliptin add-on to metformin immediate-release trial, the incidence of diarrhea was 8.9%, 3.8%, and 3.8% in the saxagliptin 5 mg, 1 mg, and placebo groups, respectively. When saxagliptin and metformin immediate-release were coadministered, the incidence of diarrhea was 8.6% in the saxagliptin 5 mg + metformin immediate-release group and 7.4% in the saxagliptin 1 mg + metformin immediate-release group.

Hypoglycemia

In the saxagliptin clinical trial, adverse reactions of hypoglycemia were analyzed. A 1.5% concordant glucose response (an abnormal response as defined by the Clinical Laboratory Standards Institute) or hypoglycemia (a glucose level of <70 mg/dL) was identified in 6.9% in the saxagliptin 5 mg + metformin immediate-release group and 5.7% in the saxagliptin 1 mg + metformin immediate-release group.

Drug Interactions

Strong inhibitors of CYP3A4/5: Saxagliptin — Saxagliptin is not a strong inhibitor of CYP3A4/5, so it is not expected to increase levels of drugs metabolized by CYP3A4/5.

Acute pancreatitis — See Indications and Usage and Warnings and Precautions.

OVERDOSE

Saxagliptin — In a controlled clinical trial, one death, due to cardiac arrest, occurred in a patient receiving saxagliptin 5 mg. The patient was a 75- to 85-year-old white female with a history of coronary artery disease, congestive heart failure, hypertension, and diabetes mellitus. The patient was found dead after the end of the trial. The cause of death was not related to saxagliptin.

PATIENT Counseling Information

See FDA-approved Medication Guide for saxagliptin.

Additional Information

Patients should be informed of the potential risks and benefits of saxagliptin. They should be advised of the importance of adherence to their treatment regimen. Patients should be advised to report any adverse experiences that occur during treatment. Patients should be informed about the importance of maintaining a healthy diet and regular physical activity. They should be advised to discuss treatment options with their healthcare provider. Patients should be advised to notify their healthcare provider if they experience pain, redness, or swelling in the area of the injection site.

Dosing and Administration

In the saxagliptin add-on to metformin immediate-release trial, the incidence of hypoglycemia was 8.6% in the saxagliptin 5 mg + metformin immediate-release group and 5.7% in the saxagliptin 1 mg + metformin immediate-release group. These events were consistent with the known safety profile of saxagliptin and metformin. No serious adverse events related to hypoglycemia were reported.}

Metformin hydrochloride — Metformin may increase serum BUN, creatinine, or creatinine clearance. A urine sample should be obtained at baseline and at least once during the maintenance phase of treatment. If the urine sample contains albumin, the urine should be tested for protein. If the protein test is positive, the urine should be tested for microalbuminuria. If the urine is positive for microalbuminuria, the urine should be tested for proteinuria. If the proteinuria is positive, the urine should be tested for protein-to-creatinine ratio. If the protein-to-creatinine ratio is positive, the urine should be tested for protein-to-creatinine ratio.

Postmarketing Experience — Additional adverse reactions that have been reported during postmarketing use of saxagliptin include hypoglycemia, hyperglycemia, headache, urinary tract infections, and gastrointestinal events. The incidence of these events is generally not different from that observed in patients receiving placebo.

In the saxagliptin add-on to metformin immediate-release trial, the incidence of hypoglycemia was 8.6% in the saxagliptin 5 mg + metformin immediate-release group and 5.7% in the saxagliptin 1 mg + metformin immediate-release group. These events were consistent with the known safety profile of saxagliptin and metformin. No serious adverse events related to hypoglycemia were reported.

Metformin hydrochloride — Metformin may increase serum BUN, creatinine, or creatinine clearance. A urine sample should be obtained at baseline and at least once during the maintenance phase of treatment. If the urine sample contains albumin, the urine should be tested for protein. If the protein test is positive, the urine should be tested for microalbuminuria. If the urine is positive for microalbuminuria, the urine should be tested for proteinuria. If the proteinuria is positive, the urine should be tested for protein-to-creatinine ratio. If the protein-to-creatinine ratio is positive, the urine should be tested for protein-to-creatinine ratio.
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Cardiothoracic and Vascular
Mark Your Calendar

IAFP Events
2012 IAFP Annual Convention
July 26-29, JW Marriott, Indianapolis
Business and CME for Indiana’s Family Physicians

2012 IAFP Family Medicine Day
July 29
Picnic and baseball at Victory Field

AAFP Meetings
AAFP Annual Scientific Assembly
October 16-20
Philadelphia, Pennsylvania

The Family Medicine Midwest Collaborative

As the cornerstone of a health care system, family medicine is at the forefront of an effective delivery system and reducing health care disparities in urban, rural and underserved populations.

The Family Medicine Midwest Collaborative is committed to communicating the value of family medicine to practicing colleagues, future colleagues and the public through the following:

1. Promote the development of family medicine among students with the goal that 40 percent of all medical graduates will enter family medicine by 2020

2. Provide a yearly forum for disseminating scholarly work and research by junior faculty members, residents and students

3. Develop a workforce project to encourage high school and college students to consider family medicine as a career

4. Promote and support community-based practice and education

5. Work with key health care stakeholders in the area to promote cooperative health care innovation.

6. Ensure that every medical student knows, understands and values what family medicine physicians do

7. Promote and link practice-based research networks

Our first conference event:
November 10-11 at Eaglewood Resort in Itasca, Illinois

Enjoy the entire two-day conference filled with topical peer-reviewed education and presentation sessions for faculty members, residents and students and social events for all!

Steering Committee
Janice Benson, MD, University of Chicago/North Shore University; David Deci, MD, University of Wisconsin; Andrew Slattengren, DO, University of Minnesota; and Theresa Zink, MD, University of Minnesota

For more information, contact Vince Keenan, executive director at vkeenan@iafp.com or 630.427.8002.
Member News

St. Francis Health Physician Appointed to Marian Osteopathic Dean’s Advisory Board

Richard D. Feldman, MD, has been appointed to the Dean’s Advisory Board of the newly established Marian University College of Osteopathic Medicine. The board is composed of business leaders and health care professionals who advise Dean Paul Evans and help guide the development of the college.

Feldman, who has served as Indiana’s state health commissioner, is the director of medical education and residency training for Franciscan St. Francis Health.

Minnesota National Guard Gains New Air Force General Officer

Air Force Brig. Gen. Worthe S. Holt Jr., a former Indiana National Guardsman, was recently promoted to the rank of brigadier general and assigned as the Minnesota National Guard assistant adjutant general — air.

“We are looking forward to the depth of knowledge and leadership experience Gen. Holt will bring to this position and Minnesota,” said Army Maj. Gen. Richard C. Nash, Minnesota National Guard adjutant general.

In this new role as the senior Air Force officer in Minnesota, Holt will advise the adjutant general on service component issues and will assist in the supervision and leadership of all Air National Guard units in Minnesota, said Air Force Maj. Anna R. Long, Minnesota National Guard public affairs officer. Holt is also charged with oversight of all current and future Minnesota Air National Guard overseas operations.

A distinguished Air Force officer and fighter pilot, Holt began his military career as a flight surgeon after being commissioned in 1981 through the Medical Corps at the Indiana University School of Medicine, Long said. He went on to pilot training, where he graduated in 1984 as the distinguished graduate, the top academic student and the top aircraft commander. He has logged more than 2,000 hours as a fighter pilot on multiple aircraft, including the F-4 and the F-16.

His command experience from the Indiana National Guard includes serving as the command fighter pilot and the assistant operations officer for the 113th Fighter Squadron, as well as the chief flight surgeon and the chief of professional services within the 181st Medical Group, Long said.

In his civilian career, Holt has 25 years of health care leadership experience, Long said. He currently serves as vice president of Humana, Inc., a Fortune 100 health benefits company that offers coordinated health insurance coverage and related services. Humana has 35,000 employees and serves 17 million members in medical and specialty products with gross revenues of $7 billion.

Holt will continue to reside in Indiana and commute to Minnesota for this new position with the Minnesota National Guard, Long said.
Our spring meeting combined hot-topic CME with SAM Study Groups to create an intensive two-day event held in an all-new location in Carmel, Indiana, just north of Indianapolis.

On the morning of Friday, March 9, we kicked off the meeting with a SAM Study Group on diabetes facilitated by Cindy Meneghini, MD. After lunch, Fred Ridge, MD, presented another SAM Study Group on asthma. The next day, our attendees benefited from some hot topic CME, including an update on Medicare and health care reform from Risheet Patel, MD; a comprehensive adolescent vaccines update from Richard Feldman, MD; an activity centered around wound care for the family physician from Fred Ridge, MD; and, finally, Mark Lisby, MD, presented “Lipid Management in the CKD Patient: A Patient-Centered Approach to Care.”

On Saturday afternoon, our final SAM Study Group on pain management was facilitated by Tom Kintanar, MD. This was the first time we have held a meeting at the new Medical Academic Center in Carmel, and our members told us they were impressed with the location. Stay tuned for more information about upcoming CME events and SAM Study Groups!

This meeting was sponsored by Indiana Spine Group (www.indianaspinegroup.com).
Date: July 26-29, 2012
Location: JW Marriott Indianapolis
10 S. West Street
Indianapolis, IN 46204

The IAFP’s leadership and staff are looking forward to meeting in Indianapolis this year, and we hope you can join us.

Location
The JW Marriott is located in the heart of Indianapolis’ thriving downtown area, within walking distance of such attractions as the NCAA Hall of Champions; the Indiana State Museum; the Eiteljorg Museum; Lucas Oil Stadium; and all the unique shopping, dining and entertainment options Indy has to offer. Your whole family is sure to enjoy the city this summer!

We have secured a block of rooms at the low rate of $135. Avoid disappointment — take time TODAY to plan your attendance! To make your room reservations, call 877.303.0104, and mention the Indiana Academy of Family Physicians. There are several events taking place in downtown Indianapolis this weekend, including the Brickyard 500, which will increase demand for rooms.

Agenda
View our meeting schedule with CME topics and speakers on page 16.

Register Early
- Register online: visit http://in-afp.ticketleap.com/2012ac/
- Register by fax: download the registration form, complete it, and fax it to 317.237.4006
- Register by mail: download the registration form, complete it, and mail it to IAFP, 55 Monument Circle, Suite 400, Indianapolis, IN 46204

Special Event
Annual President’s Banquet and Installation of Officers, Followed by All-Member Family Party – Saturday, July 28
We have again combined our President’s Banquet and All-Member Party into one exciting event for the whole family. An elegant dinner is held to honor our incoming and outgoing president and the contributors to our Family Practice Stories book. A special dinner is offered simultaneously for children. At 8:30 p.m., children may join their parents for a dessert buffet and dancing, with entertainment by the Marlins. Purchase tickets on the registration form.

All-Member Congress of Delegates
The IAFP will hold its All-Member Congress of Delegates on July 27 and 28. All members are invited and encouraged to attend the Congress, because every IAFP member is 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!

Fellowship and Networking Opportunities
Meet colleagues from around the state, and visit with old friends.

Exhibit Show
Call on them! Visit the Exhibit Show to learn about the newest clinical advances, practice management tips and services.

Confirmed exhibitors include:
Abbott
Achieve EHR
Advanced Physical Therapy
American Express
American Health Network
Balance MD
Biomet
Boehringer Ingelheim Pharmaceuticals
Bristol-Myers Squibb
Care Improvement Plus
Community Health Network
Covidien
EmCare
Esacote North America
Goodman Campbell Brain and Spine
Grifols, Inc.
Health Diagnostic Laboratory, Inc
Indiana Academy of Family Physicians
Indiana Army National Guard
Indiana Spine Group
Inquest Health System
iSalus Healthcare
Kowa Pharmaceuticals America
MD Wise
Medical Protective
Medstar Laboratory, Inc.
Merck & Co., Inc.
Michael H. Fritsch, MD – Otology
Northwest Radiology Network
OrthoIndy
ProAssurance
Purdue Pharma L.P.
Reid Hospital
Sanofi Pasteur
South Bend Medical Foundation
St. Vincent
SuccessEHS
U.S. Air Force
Urology of Indiana
Vein Clinics of America
ViroPharma, Inc.
We Care TLC
Family Medicine Day at Victory Field
Immediately following the close of the Scientific Assembly on Sunday, July 29, join us for a picnic at Victory Field, and then cheer on the Indianapolis Indians at the “Best Minor League Ball Park in America”! Visit www.in-afp.org/events/2012/07/29/general-event/family-medicine-day-at-victory-field/ to learn more.

Town Hall Dinner
Each year, the IAFP hosts an opportunity at our Annual Convention to hear new policy topics from the thought-leaders of Indiana and the nation. In 2012, we are welcoming to the convention Bob Phillips, MD, the distinguished director of the Robert Graham Center, to discuss the necessary changes the current graduate medical education funding system requires to support primary care. This interactive town hall dinner is a free event open only to IAFP members that takes place at 5:30 p.m. on Friday, July 27.

Students and Residents
Students, residents and residency faculty members are invited to a “Preparing for the Match” panel, followed by our Congress Orientation on Friday, July 27. Bring your Congress book to follow along. The session will end with a reception — a great chance for students to learn more about our residencies.

Indiana’s Premier CME Event!
Planned especially for family physicians by family physicians.

We have included additional opportunities to earn CME credit this year. Earn more than 20 Prescribed AAFP CME credits with clinical topics and practice management sessions. All CME plans are based on previous attendee evaluations and IAFP member CME Needs Assessments.

Educational Objectives: This program is designed by family physicians for family physicians. The sessions will highlight new advances, preventative medicine strategies, enhancements of clinical skills, emergency preparedness and practice management issues.

Attendee comments from last year’s meeting included:
• “Well educated speakers provided excellent care for practices. Very entertaining.”
• “Once again, the IAFP has provided an excellent Annual Convention that has provided both a venue to meet and interact with our colleagues and gain practical knowledge to improve our practices and better care for our patients — thank you!”
• “An excellent CME offering with immediate operational advice. Most CME was fully practicable and implementable.”

MC-FP SAM Study Group on Cerebrovascular Disease – Thursday, July 26
Please register early — SAMs sell out fast! Select the SAM Study Group on the registration form/online registration page.

Our SAM Study Groups feature reference slides showing sources used in each of the 60 questions in the ABFM’s Self-Assessment Modules, as well as an overview of the MC-FP process and how this study group fits into it. Facilitator: Curt Ward, MD.

The SAM Study Group will enable family physicians to:
• Explore the topic via interactive discussions
• Complete the Knowledge Assessment portion of their MC-FP Part II Self-Assessment Module, from which the IAFP will report the answers to the ABFM
• Earn 12 AAFP CME credits after this session by completing online Clinical Simulation

Visit www.in-afp.org for more information or to register. We look forward to seeing you at this year’s Annual Convention!
Legislative Wrap-Up

At 1:23 a.m. on Saturday, March 10, the Indiana General Assembly closed the 2012 session. Although the legislature was not mandated to adjourn until March 14, the leaders of the General Assembly determined that they could easily finish the session with a few days to spare.

See the IAFP’s list of the bills that passed or failed in the 2012 session below. If you have any questions about the IAFP’s legislative activity, or if you wish to get involved, please contact Meredith Edwards at medwards@in-afp.org or by phone at 317.237.4237.

Bills That Are Now Law…

Smoking Ban in Public Places (House Bill 1149)

The smokefree air bill, which went through several iterations during the legislation process, passed, covering restaurants, hotels, movie theaters, bowling alleys, health care facilities, nursing homes, mental health facilities and most other workplaces. Cigar bars must be in existence before December 31, 2012, to be exempt. Private clubs, casinos and bars are all exempt from the law, unless a local law states otherwise. The IAFP fought for all public places covered by the smokefree air law, but the political situation in the General Assembly made that impossible. Our smokefree air champions, Rep. Eric Turner, Rep. Charlie Brown, Sen. Beverly Gard and Sen. Vi Simpson, worked tirelessly this session and deserve great thanks. The law goes into effect July 1, 2012.

Self-Donated Blood (House Bill 1216)

Indiana law was unclear as to whether patients with HIV or other infectious diseases can donate blood for their own use for stem-cell transplantation. This bill, authored by Rep. Cindy Kirchofer, clarified Indiana law and made it clearly legal. The IAFP supported this legislation, and IAFP member Topper Doehring, MD, testified at the committee hearings for the bill. The law goes into effect July 1, 2012.

Pharmacy Matters
(Senate Bill 407)

This bill originally was limited to expanding the number of pharmacy technicians a pharmacist can supervise. In conference committee, Senate Bill 334, which failed to receive a hearing in the House, was added to the bill. The IAFP expressed concerns about the change in the prescribing law, especially at the last minute of the session. The provisions added to the bill allow a pharmacist to give a patient up to a 90-day supply of a prescription drug without approval from the prescribing physician, with several conditions:

1. The prescription must contain at least 90 days’ worth of medication.
2. The patient must request that his or her prescription be changed from 30 days at a time to 90 days at a time.
3. The medication may not be a controlled substance.
4. The patient must have already been on this medication for 30 days before switching to 90 days at a time.
5. The pharmacist must tell the patient whether a 90-day supply will be covered by the patient’s insurance.
6. The pharmacist must notify the physician after the prescription has been changed. If a physician does NOT want a pharmacist altering the amount of medication dispensed, he or she must write on the prescription or tell the pharmacist, “The quantity of the prescription may not be changed.”

This law goes into effect July 1, 2012.

Bills That Failed to Pass…

Tobacco Self-Service Displays (House Bill 1031)

The original legislation would have moved cigars and loose tobacco products out from behind the retail counter, where it could be easily accessed by youth. But the bill was amended to instead study the issue of roll-your-own-tobacco machines and then failed to be heard on the floor of the House before the third reading deadline. It could become a summer study item if the House and Senate leadership adds this topic to other health-related issues it wants studied.

Physician Scope-of-Treatment Forms (House Bill 1114)

This legislation, authored by Rep. Tim Brown, who is also a physician and chair of the Public Health Committee, would have created a legal and medical form on which patients could express their wishes for end-of-life care. Patients could express whether they want interventions like antibiotics, ventilation and nutrition. Then, a physician would sign the form, and it becomes a legal medical order. Unlike living wills, these “POST forms” can be followed by EMS, nursing homes and hospitals. Thirteen other states have made this form legal. The IAFP testified in support of this legislation at its committee hearing. The IAFP began working on POST because of a resolution to the IAFP Congress of Delegates, and we will continue to work on perfecting the legislation for the 2013 legislative session.

Collection of Medicaid Spend-Down (House Bill 1351)

The bill would have allowed physicians and other providers to collect remaining balances of a patient’s Medicaid Spend-Down at the time of service if the provider so chooses. Currently, only pharmacists can collect at the time of service. The bill never received a committee hearing.

Various Scope-of-Practice Bills

In 2012, we saw many of the same scope-of-practice expansions that we have opposed in the past three or more years. In House Bill 1067, pharmacists sought out the ability to provide the pneumonia vaccine through protocol without a physician
prescription. Currently in Indiana, pharmacists can do this with the shingles (herpes zoster) and flu immunizations. There were multiple attempts to revive this bill as an amendment to other bills; the IAFP successfully stopped those attempts.

Other scope bills introduced included licensing non-nurse midwives with only limited training to provide home birth services (HB 1127), permitting physical therapists to see patients for 30 days without the need for a physician referral (HB 1124) and expanding physician assistants’ scope of practice by removing all limitations on the location of supervising physician and removing the requirement of chart reviews after three years (HB 1142). None of the scope-of-practice bills introduced in 2012 received an initial committee hearing.

**Summer Election Update**
After the recent filing deadline, we know the scope of upcoming elections. There will be unprecedented change in House and Senate membership after the primary and general elections. Nineteen House members (12 Democrats and seven Republicans) have announced their retirements. With redistricting, there is also one seat that has both a Democrat and Republican incumbent running against each other. Two Senate members (both Republicans) have also announced their retirements. Before the election begins, we will have lost 21 incumbent legislators.

In 2010, 19 new House members were elected. After November 2012, more than 40 percent of the House members will have fewer than two years’ experience. Many of these retiring legislators are from Public Health and Ways and Means. This change will give our physicians and the IAFP opportunities to meet and encourage new legislators to better understand our positions.
2012 IAFP Research Day

This year’s Research Day took place at the IUPUI Campus Center on Thursday, May 17, with more than 100 residents, faculty members, and other IAFP members in attendance. Residents from across the state made 15- to 20-minute presentations and displayed posters detailing their original research projects and performance improvement initiatives. We also heard several case presentations about patients who presented with unusual and/or rare diseases.

Thank you to our Research Day Planning Committee: Carrie Anderson, MD; John Fleming, MD; Sharron Grannis, MD; Amy LaHood, MD; and Curt Ward, MD. Dr. Anderson served as moderator for the day.

Thank you to our three judges: Komal Kochhar, MBBS, MHA; Carolyn Muegge, MS, MPH; and Ray Nicholson, MD.

Thank you to our exhibitors: St. Vincent Health and Suburban Health Organization. Our awards were sponsored by St. Vincent Health, strategic partner of the IAFP.

Congratulations to our prize winners:

**Original Research Category**
- **First:** Review of Adherence to Published Clinical Guidelines for Use of Chronic Opioid Therapy in Chronic Noncancer Pain by Medical Residents in a Resident Clinic
  - Virginia Reed, MD. St. Francis Family Medicine Residency Program
  - Co-authors: Amy LaHood, MD; Victor Collier, MD; and Karie Morrical-Kline, PharmD, St. Vincent Family Medicine Residency Program

- **Second:** Assessing Potentially Inappropriate Medication Use in Elderly Patients in Outpatient Family Medicine Offices
  - Angela Hackman, MD, St. Francis Family Medicine Residency Program

- **Third:** Being Hispanic May Not Increase Your Risk For Type 2 Diabetes Mellitus
  - Sofy Sendoya, MD
  - Co-author: Ian Chua, MD, Indiana University School of Medicine Family Medicine Residency Program

**Performance Improvement Category**
- **Improving Pertussis Vaccination Rates in Pregnant Women at the PCC**
  - Jason Lewis, MD
  - Co-author: Maurice Henein, MD, St. Vincent Family Medicine Residency Program

**Case Presentation Category**
- **First:** Fulminant Heart Failure in a 2-Year-Old
  - Kari Sears, MD, Memorial Family Residency Program

- **Second:** Not Just Scabies
  - Naveen Bondalapati, MD, Union Hospital Family Medicine Residency Program

**Posters**
- **First:** Case Presentation: Mother Knows Best: Late Onset Group B Strep in a 20-Day-Old Female
  - Kurtis Ellis, MD

- **Second:** Performance Improvement: Performance Improvement Focused on the Clinical Management of Unhealthy Pediatric Weight
  - Alan Young, MD
  - Co-authors: Justin Whitt, MD; Linda Daniel, PhD; and Carolyn Shue, PhD, Indiana University Health Ball Memorial Hospital Family Medicine Residency Program

*We are also grateful to the Fort Wayne Medical Education Program for displaying the results of their FPIN projects in poster form at this meeting.*

The following residents were elected at our Resident Region business meeting during lunch:
- **Director:** Brendan Sweeney, MD (St. Francis)
- **Alternate Director:** Kari Sears, MD (Memorial)
- **NC Delegate:** Tiffany Meador, MD (St. Vincent)
- **NC Alternate Delegate:** Holly Wheeler, DO (Community)
The Marian dream is finally moving toward becoming a reality!

MU-COM is progressing toward a planned opening day in August 2013 for an entering class of 150 osteopathic medical students. We are now hiring faculty members both from biomedical science disciplines and for clinical positions (part-time and full-time). Charles E. Henley, DO, MPH, our associate dean for clinical affairs, is starting to interview physicians (DO and MD) for positions now, with some to start in fall 2012 and others a bit later in 2013. Bryan Larsen, PhD, associate dean for biomedical sciences, is also recruiting PhD faculty members in anatomy, physiology, pharmacology, cell and molecular biology, microbiology and immunology, and biochemistry. We are also filling positions in admissions, financial aid and other administrative areas.

Our accreditation steps are on schedule toward an anticipated full accreditation by 2017. MU-COM earned provisional status to start on July 1, 2012. We are publicizing our new program in the pre-medical education community, and our deans have almost completed introduction visits to many colleges and universities with pre-medical applicants in Indiana and surrounding states. Student excitement appears high! Our application process starts in summer 2012 through the application service of AACOM. We anticipate about 2,000 applications and will likely offer about 500 interviews starting in the fall of 2012. MU-COM plans to use an innovative station-interview process (multi-mini-interview, or MMI) that better measures traits such as ethical behavior, communication skills and compassion. These key elements are felt to be critical for successful physicians. If you have an interest in helping to select our charter class, please contact me, and I will connect you with the chair of our Admissions Committee, Angie Wagner, DO. We are signing up community physicians (DO and MD) to assist in this exciting process.

MU-COM is now growing our clinical education network for both clerkship rotations and for future graduate medical education. Dr. Henley has reported strong interest from Indiana physicians to teach MU-COM students, with more than 3,000 network physicians expressing an interest in taking students. We have also discovered an interest in new graduate medical education positions to support our graduates. We will continue to develop these opportunities.

Our virtual tour of the new facility, lasting about seven minutes, will show the design and features of our new Center for Health Sciences (CHS) (www.marian.edu/osteopathic-medical-school/Pages/virtual-tour.aspx). Our webcam is on our Web page (marian.edu), and it shows real-time progress on our new CHS, now about 30 percent complete.

We will keep the medical community updated regularly on our achievement of continuing milestones.
ISDH Releases Guidelines for Expedited Partner Therapy

In 2010, the IAFP All-Member Congress of Delegates passed a resolution asking the IAFP to support regulation or legislation to allow the practice of expedited partner therapy (EPT) in Indiana. With the IAFP’s support, in late 2011, the Indiana Medical Licensing Board finalized regulations legalizing the use of expedited partner therapy by physicians in Indiana; and, in April 2012, the Indiana State Department of Health (ISDH) released physician guidelines for EPT.

Expedited partner therapy (EPT) is the practice of prescribing or dispensing antibiotics to the sexual partner(s) of a physician-diagnosed patient without an exam of the sexual partner(s). Since 2006, the Centers for Disease Control has recommended EPT as an option for preventing sexually transmitted disease reinfection for certain infections.

Prior to the Medical Licensing Board rule, EPT was considered illegal in Indiana because regulations forbid the prescribing of medication to patients without first being seen (except in on-call and specific other settings). With the new law, physicians can use EPT for the partners of patients with chlamydia and gonorrhea but are not required to. ISDH still recommends that physicians try to motivate patients to refer their partners for clinical care, where full evaluation, testing and treatment can take place.

The new ISDH advisory documents for physicians include guidance on documentation, information on appropriate antibiotics, chart inserts and patient documents. Physicians who wish to prescribe through EPT should review and use the health department’s guidelines.

The Indiana State Department of Health’s STD program page: www.in.gov/isdh/17440.htm

Direct link to ISDH Guidelines: Guidance for Health Care Professionals in Indiana: www.in-afp.org/index.php?cid=36582&forward=60&curlid=62

Direct link to ISDH FAQs about expedited partner therapy frequently asked questions: www.in-afp.org/index.php?cid=36582&forward=61&curlid=63

For physicians who wish to read the final Medical Licensing Board rule:

844 IAC 5-4-1

Authority: Affected:

General provisions

IC 25-22.5-2-7 IC 25-1-9; IC 25-22.5-1-2; IC 25-23-1-19.4

Sec. 1. (a) Except in institutional settings, on-call situations, cross-coverage situations, and situations involving advanced practice nurses with prescriptive authority practicing in accordance with standard care arrangements, as described in subsection (d), a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed.

(b) Except in institutional settings, on-call situations, cross-coverage situations, and situations involving advanced practice nurses with prescriptive authority practicing in accordance with the requirements of IC 25-23-1-19.4 and 848 IAC 5, as described in subsection (d), a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any legend drug that is not a controlled substance to a person who the physician has never personally physically examined and diagnosed.

(c) A physician shall not advertise or offer, or permit the physician’s name or certificate to be used in an advertisement or offer, to provide any legend drug in a manner that would violate subsection (a) or (b).

(d) Subsections (a) and (b) do not apply to or prohibit the following: (1) The provision of drugs to a person who is admitted as an inpatient to or is a resident of an institutional facility. (2) The provision of controlled substances or legend drugs by a physician to a person who is a patient of a colleague of the physician, if the drugs are provided pursuant to an on-call or cross-coverage arrangement between the physicians. (3) The provision of controlled substances or legend drugs by emergency medical squad personnel, nurses, or other appropriately trained and licensed individuals as permitted by IC 25-22.5-1-2.

(4) The provision of controlled substances or drugs by an advanced practice nurse with prescriptive authority practicing in accordance with a standard care arrangement that meets the requirements of IC 25-23-1-19.4 and 848 IAC 5.

(Medical Licensing Board of Indiana; 844 IAC 5-4-1; filed Oct 1, 2003, 9:32 a.m.: 27 IR 524; errata filed Oct 8, 2003, 1:45 p.m.: 27 IR 538; readopted filed Dec 1, 2009, 9:13 a.m.: 20091223-IR-844090779RFA; readopted filed Jun 16, 2010, 12:14 p.m.: 20100630-IR-844090779RFA)

844 IAC 5-4-2

Authority: Affected:

Expedited partner therapy

IC 25-22.5-2-7 IC 25-1-9
STANDARDS OF PROFESSIONAL CONDUCT AND COMPETENT PRACTICE OF MEDICINE

Sec. 2. Section 1 of this rule does not apply if the physician is prescribing or dispensing medications for the treatment of Chlamydia trachomatis or Neisseria gonorrhoeae to sex partner(s) of the physician’s diagnosed patient without requiring examination of the sex partner(s). Medications must be in accordance with current professional theory or practice for the treatment of these infections. The current Centers for Disease Control and Prevention of Sexually Transmitted Diseases Treatment Guidelines shall be considered an authoritative source of such current professional theory or practice. Partner management of patients with gonorrhea or chlamydia shall include providing the following items:

(1) Notification to the infected patient that all partners should be evaluated and treated; (2) Written materials for the infected patient to give partners that state that a clinical evaluation is desirable; lists common medication side effects and the appropriate response to them; fact sheets regarding sexually transmitted diseases; and emergency contact information; (3) Prescriptions or dispensed medications and accompanying written materials shall be given to the physician’s patient for distribution to named partners; and (4) The physician shall maintain appropriate documentation of partner management. Documentation shall include the names of partners, if available, and a record of treatment provided. If the partner’s name is not available, documentation shall be kept within patient’s file.

(Medical Licensing Board of Indiana; 844 IAC 5-4-2; filed Sep 28, 2011, 11:06 a.m.: 20111026-IR-844110044FRA)
The Franciscan St. Francis Health Family Medicine Residency prides itself on its humanistic approach to medical education, which maintains an atmosphere that supports the residents’ personal and professional growth. Our commitment to the individual fosters a sense of family and promotes a productive setting in which we all are able to make significant contributions to each other. We have designed our program to provide a balanced environment, allowing time for study, family, church, outside interests, community service, mental and physical well-being, and the opportunity to nurture interests both within and beyond the practice of medicine.

Flexibility is built into the program to ensure that the individual’s personal interests and priorities can be met. Because of growing interest in several specialized areas of family medicine, the residency has developed four intensive tracks that residents can electively participate in:

**Optional Obstetrics-Intensive Track**
All residents receive a strong obstetrical experience. Most residents get 40 to 60 total deliveries during the required first year two-month rotation. Residents may opt for either our regular track or our intensive OB track.

**Underserved Medicine Curriculum/Optional Intensive Track**
The residency has developed a curriculum in underserved medicine. Any resident can choose from a variety of urban, rural and international sites to customize an experience, allowing focus on one or a combination of underserved populations.

**Sports Medicine Curriculum/Optional Intensive Track**
Residents receive excellent training in sports medicine, which is both clinical and didactic. The curriculum has been developed and is coordinated among three family physician community physicians with fellowship training in sports medicine.

**Master’s of Medical Management Degree (in Conjunction with Carnegie Mellon University)**
The Franciscan St. Francis Health Family Medicine Residency participates in a formal relationship with Carnegie Mellon University in Pittsburgh for a master’s of medical management. Participation in this program necessitates a fourth-year fellowship position.

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**FAQs – Indiana’s Smokefree Air Law**

Indiana’s new partial smokefree air law goes into effect soon. People are generally law-abiding citizens when they know and understand the law. Be sure that you know Indiana’s law — help us ensure a smooth (and healthy) transition!

1. **When does Indiana’s new statewide smoking ban go into effect?**
The new law goes into effect July 1, 2012.

2. **Where is smoking prohibited?**
Smoking is prohibited in most public places and places of employment. Smoking is also prohibited in state-owned vehicles and school buses under certain circumstances.

3. **Where is smoking permitted?**
Smoking is permitted in the following establishments: a horse-racing facility, a riverboat, a facility with a gambling game license, a satellite-gaming facility, cigar bars, hookah bars, certain fraternal clubs, a retail-tobacco store, a bar or tavern meeting certain requirements, a cigar-manufacturing facility, a cigar-specialty store and a business in a private residence, provided that each establishment meets the requirements of I.C. 7.1-5-12.

4. **How far must someone be from the entrance of a public place or place of employment in order to smoke?**
Smoking is prohibited within 8 feet of a public entrance to a public place or place of employment.

5. **Who enforces the law?**
The Alcohol & Tobacco Commission is the primary enforcement agency. Additionally, the Indiana State Department of Health, a local health department, a health and hospital corporation (Marion County), the Division of Fire and Building Safety and any law enforcement officer may enforce the law.

6. **Where may I file a complaint for a violation of the smoking ban?**
A complaint system is being developed and will be available on July 1, 2012. Instructions will be posted online at www.in.gov/atc.

7. **Is smoking prohibited in vehicles?**
Smoking is only prohibited in state-government vehicles owned, leased and operated for governmental functions. Smoking is permitted in private vehicles.

8. **How does the state law affect local ordinances on smoking?**
The new state statute does not supersede a local county, city or town ordinance previously adopted, if that local ordinance is more restrictive than state law. Additionally, the new state statute does not prohibit a local county, city or town from adopting an ordinance more restrictive than state law.

9. **May a business exempt from the state smoking law choose to prohibit smoking?**
Yes. A business owner or manager may voluntarily choose to prohibit smoking, even if the type of business is one of the exemptions to the state’s smoking law. For example, a tavern owner may choose to prohibit smoking.

Source: Indiana Alcohol & Tobacco Commission
Community Health Network's Family Medicine Residency Program has launched a patient-centered prenatal health program for women looking for a different approach to prenatal care.

The program, called Centering Pregnancy, provides a practitioner-led group approach to prenatal care and combines three essential elements of care every pregnant woman needs — health assessment, education and support. Rather than having one-on-one visits, groups of eight to 12 women with similar due dates meet together, learning care skills, participating in a facilitated discussion and developing a support network with other group members. Each pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum. Individual prenatal health assessments are included.

“Through this group approach to care, women are empowered to choose health-promoting behaviors for themselves and their babies,” said Susan L. Helsel, MD, assistant director and leader of the Centering Pregnancy Program at the Shadeland Family Care Center. “It also creates an environment for women to share their experiences and knowledge about pregnancy, childbirth and parenting.”

Centering is a care model that was developed in 1993 and has been implemented at sites of care throughout the country. It is an evidence-based redesign of health care delivery that engages patients to participate in their care and allows providers to have dynamic partnerships with their patients.

This model has been shown in studies to have statistically significant improvements in preterm birth outcomes, both in having healthier preterm babies and in decreasing preterm delivery rates. Also in studies, there was a large increase in patient satisfaction and education as rated by the patients themselves.

This program is currently funded by a generous grant from the Indiana Chapter of the March of Dimes, whose mission is to help moms have healthy full-term pregnancies and babies.
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