

FRONTLINE

P H Y S I C I A N

A Publication of the Indiana Academy of Family Physicians • Summer 2008



60th Annual Scientific Assembly

Celebrate the IAFP's Diamond Anniversary

PG 11

Interview with Tom Felger, MD

IAFP's Candidate for AAFP Board of Directors

PG 18

We Are All Marcus Welby, MD

PG 26

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FRONTLINE

PHYSICIAN

Volume 9 • Issue 2

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

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

- To provide responsible advocacy for and education of patients and the public in all health-related matters;
- To preserve and promote quality cost-effective health care;
- To promote the science and art of family medicine and to ensure an optimal supply of well-trained family physicians;
- To promote and maintain high standards among physicians who practice family medicine;
- To preserve the right of family physicians to engage in medical and surgical procedures for which they are qualified by training and experience;
- To provide advocacy, representation and leadership for the specialty of family medicine;
- To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.



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OF FAMILY
PHYSICIANS**

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

Innovative Publishing Ink specializes in creating custom magazines for associations.
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—from Warren Buffett's Letter to Shareholders, February 28, 2006

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—from Warren Buffett, April 26, 2006

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—from Warren Buffett, May 30, 2006

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Larry Allen, MD

Focus on the Patient-Centered Medical Home

This is my fourth and final article for *FrontLine* while serving as your president, and reflecting on the past year brings to me a feeling of gratitude for the opportunity to serve and pride in the specialty we have all chosen to uphold. I have had a chance to meet and discuss our profession with many leaders across the state and country and found it easy to find common ground around the value family medicine brings to our health care system.

However, I have also found it a bit overwhelming to try to keep up with and understand the significance of all the changes and potential changes in medicine and the delivery of health care services. In fact, if you are like me, we must be careful not to develop a case of functional ADD in trying to keep up with it all and still serve our patients. By the time we skim over news from the AAFP, the AMA, *Family Practice News*, *Medical Economics*, the national newswires, information from the TransforMed project, the Future of Family Medicine report and the relatively new Patient-Centered Primary Care Collaborative, we might feel an input overload and feel a little disoriented as to where the answers are and even what the questions are. (At the same time, we must deal with the daily demands of being family docs to our communities.) I would like to very briefly summarize some of my impressions from this chair and hopefully provide some helpful stimulation to help us all focus.

One of the marketing items I was given recently was a license plate cover with the slogan "EVERYONE DESERVES A FAMILY PHYSICIAN." I think this summarizes the common value that is driving much of the changes and reform efforts we are seeing. The

value of family medicine is acknowledged, but the access appears endangered. (Most of the endangerment revolves around the payment system, as Tom Felger is highlighting in his campaign for AAFP Board member this year.) There are lots of different groups and individuals championing and piloting various ideas to help family medicine thrive in our evolving national health care system. They range from the more individual approaches of cash only models and concierge practices, to implementing the principles of the TransforMed project, to the more collaborative models of P4P plans, Medicare's PQRI and becoming accredited as a defined **patient-centered medical home** in order to increase revenues from third-party payers. This last model is being developed by the Patient-Centered Primary Care Collaboration (PCPCC), and I would urge everyone to become familiar with the work of this group and follow developments in this area (for info, visit aafp.org and pcpcc.net).

I cannot be certain what the end result of the transformations we are seeing will be or which models will prove successful, but I am encouraged that there is room for us as family docs to be at the table for the discussions. The IAFP leadership is representing you at statewide meetings of insurers and government agencies. It behooves all of us to be aware of the current landscape and to continually improve the medical homes we provide to our patients.

The IAFP is celebrating 60 years at our Annual Meeting in Fort Wayne (July 23-27). Take advantage of this opportunity if you can, and we can continue this discussion.

Mark Your Calendar

July 23-27, 2008

IAFP Annual Meeting
Fort Wayne, Indiana

July 24-25, 2008

IAFP All Member Congress of Delegates
Fort Wayne, Indiana

July 30-August 2, 2008

National Conference of Family
Medicine Residents/Students
Kansas City, Missouri

September 14-17 2008

AAFP Congress of Delegates
San Diego, California

September 17-21, 2008

AAFP Annual
Scientific Assembly
San Diego, California

New IAFP Employees

Meredith Edwards



Meredith will be working as the IAFP's interim director of legislative and region affairs. You may have met her as she traveled the state for IAFP region meetings. While Allison Matters is away this summer, Meredith will be taking over her duties. Primarily, Meredith will be managing the political action committee and coordinating the Congress of Delegates at the 2008 Annual Meeting.

Meredith is a graduate of Purdue University. Although she originally planned to teach upon graduation, she found public policy and the political world far too difficult to give up after an internship with the 2008 Indiana General Assembly. During her time with the General Assembly, she worked for the Ways and Means Committee, where she staffed committee hearings, reviewed and summarized legislation and researched issues coming in the 2009 session.

While work at the Statehouse changed from day to day, she could always count on calls from Hoosiers about their property taxes. Now she enjoys experiencing another side of policy formation here at the IAFP. Outside of work and politics, her interest in ballroom dancing ensures she will be the first one on the dance floor for the Annual Meeting's All Member Party.

Lindsay Grace



In keeping with the leadership role that the Academy plays in supporting tobacco-control throughout the state, the IAFP has contracted with the Marion County Health Department through June 2009 to provide staff support for Smoke Free Indy, the local tobacco control coalition in Marion County.

Lindsay Grace began her work as the Smoke Free Indy campaign coordinator in April. She will be working with community organizations, grassroots advocates and local decision-makers throughout Marion County, with the ultimate goal of eliminating secondhand smoke from ALL workplaces in the county.

Lindsay received her bachelor of science degree in public affairs with her concentration in public policy analysis and political science from Indiana University. In her free time, she enjoys politics, talk radio, reading, food and wine, tailgating, exercising and, most importantly, spending time with her family and friends. Being born in Louisiana, Lindsay also loves college football (Louisiana State University ... GEAUX Tigers!!!), the Indianapolis Colts and any sports team associated with her alma mater.

Membership Update

Keep Us Informed

Please remember to keep all of your contact information up-to-date with IAFP. If you have any changes in your address (home or office), phone number, fax number and/or e-mail address, please call (317.237.4237) or e-mail (iafp@in-afp.org) the IAFP Headquarters with your updated information.

Membership Status Totals as of April 30, 2008

Active	1,661
Supporting (non-FP)	6
Supporting CME (FP)	2
Inactive	15
Life	189
Student	129
Resident	246
Total	2,248

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Together with suggesting regular physical activity, that's a prescription for success.

For more information on the USDA 2005 Dietary Guidelines and the health benefits of dairy foods, visit www.nationaldairycouncil.org.

¹U.S. Department of Agriculture and U.S. Department of Health and Human Services. Dietary Guidelines for Americans 2005. 6th Edition. Washington, D.C.: U.S. Government Printing Office, January 2005. www.healthierus.gov/dietaryguidelines.com



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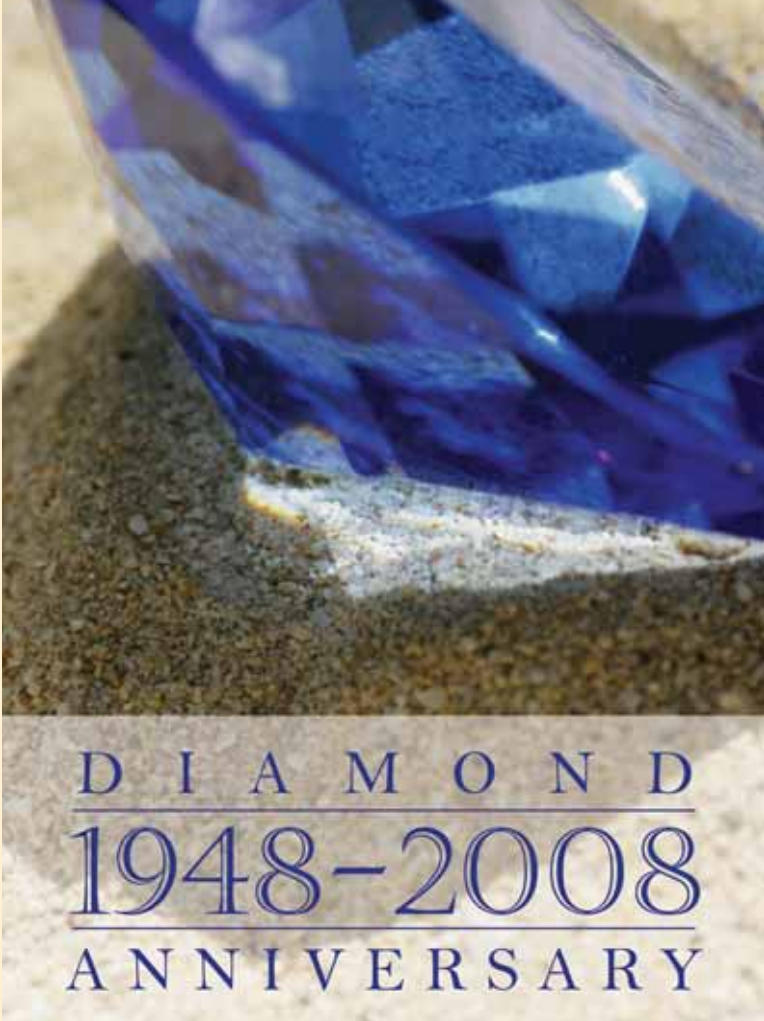
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Please Join Us for the IAFP's 60th Annual Meeting in Fort Wayne, Indiana

Annual Scientific Assembly
July 23-27
Congress of Delegates
July 24 and 25

Join other family physicians in celebrating 60 years of the IAFP and making plans for our future.

Exciting and challenging times are ahead for family medicine. Attend the IAFP's 60th Annual Meeting for a look at our past and an opportunity to envision our future.

MEETING HIGHLIGHTS

Medical Home Town Hall Meeting and Congress Dinner

Thursday, July 24, 5:30 p.m. Open for all IAFP members! The medical home is an initiative to bring better payment to family physicians and better care to patients, learn the principles and have the opportunity to ask questions during the Town Hall Meeting.

All Member Congress of Delegates

The COD, the Academy's policy-making body, will convene at 7 p.m. on Thursday, July 24, and again at 5 p.m. on Friday, July 25. All Active members of the IAFP are called together to consider issues affecting family physicians and Academy policy. Current IAFP leadership and staff members strongly encourage you to participate in this decision-making process. Take advantage of your privilege to voice concerns in reference committee hearings and from the COD floor, and to vote!

Scientific Assembly

Earn more than 25 hours of Prescribed credits in just three days (Thursday, Friday and Saturday). **As a member service, our CME fee is intentionally kept low ... averaging less than \$15 per credit for IAFP members.** All CME is planned by family physicians for family physicians. This year's CME program includes both state and nationally recognized speakers. Topics have been selected after considering IAFP member needs assessment results, creating a program that is tailored to what members want. Most clinical sessions have been approved as Evidence Based CME — earning you double credit.

Exhibit Show

Open Friday 8:30 a.m.-4 p.m. and Saturday 8:30 a.m.-noon. Learn about the most up-to-date products and services in health care. Enter the prize drawing for a chance to win!

Prizes will include tickets to a Colts' pre-season game in the new Lucas Oil Stadium, a Nintendo Wii video game system, a Garmin GPS Navigator and more!

All Member Party

Friday, July 25, 7 p.m. The "Diamond Disco" will be open for a night of great food, dancing, family fun and more! It is planned for families so bring yours! There will be a costume contest so dust off those old bell-bottoms and join us for the festivities.

President's Reception and Annual Banquet

Saturday, July 26, 6:30 p.m. This special and elegant evening will be in celebration of our newly installed officers, the 2008 IAFP award winners and our 60th anniversary!

See complete info on the next pages!



Program Information and De

Indiana's Premier CME Event! Planned especially for family physicians by family physicians. Earn 25 hours of CME in just 2.5 days, with lectures, clinical topics and practice management sessions.

General Information

Register Early

The Fort Wayne Hilton sells out early — 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

We're back in Fort Wayne this year, at the stunning downtown Grand Wayne Center!

Hotel

Attached to the Grand Wayne Center, the Fort Wayne Hilton offers a swimming pool and fitness area and is a short walk away from Fort Wayne's many attractions, including museums, theaters and a botanical conservatory. Room rates for IAFP registrants are \$119. Call 260.420.1100 today to make reservations.

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 18, 2008, to be eligible for a full refund. Cancellation received after July 18 and before July 22 will be subject to a \$50 administrative fee. No-shows are not eligible for a refund.

Special Events

All Member "Diamond Disco" Party – Friday, July 25

This year's All Member Party theme is a "Diamond Disco," celebrating the IAFP's 60th anniversary. Come and join in the fun for all ages! Buffet, dancing, drinks, games and prizes for best costume, best couple and 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 26

Giveaways for all participants. Registration not necessary for this event. Join us inside the Grand Wayne Center lobby at 7 a.m. on Saturday, and we'll walk/run to scenic Headwaters Park. All are welcome!

Celebrate Our 60th Annual President's Banquet, Award Ceremony & Installation of Officers – Saturday, July 26

This elegant evening and dinner is held to honor our outgoing president and the 2008 IAFP Award winners, including the 2008 IAFP Family Physician of the Year. An afterglow party will follow the banquet so that attendees may congratulate the newly installed president. Purchase tickets on the registration form. A special party is offered simultaneously for children so that parents may have a "night out."

Bring the Whole Family

Youth Activities

The IAFP Annual Meeting creates a great opportunity for your children to make new friends that they can reconnect with each year and for you to enjoy valuable family time. Children will enjoy the All Member Party on Friday night and the special kids' party held while the grown-ups are attending the President's Banquet.

Spouse/Guest Activities

Activities for adults at the Fort Wayne Hilton include a pool and newly renovated fitness center. Your spouse will also enjoy the All Member Party and the Annual President's Banquet, as well as 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 the All Member Party and President's Banquet. Purchase tickets on the enclosed registration form.



tailed CME Schedule

You Won't Want to Miss:

- **All Member Congress of Delegates**

The IAFP will hold its All Member Congress of Delegates on July 24 and 25. 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!*

- **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 and services.

- **Free wireless Internet access throughout the conference center and hotel**



Schedule at a Glance

Wednesday, July 23

7:30 p.m.

Board/VIP Reception and Dinner

Thursday, July 24

7 a.m.

Executive Committee

8 a.m.-7:30 p.m.

Registration Open

9 a.m.

Board of Directors

Noon

IAFP Golf Tournament

1-4 p.m.

CME Sessions

5:30 p.m.

Congress of Delegates Dinner &

Family Medicine Town Hall

7 p.m.

First Session of Congress of Delegates

Reference Committees to follow

8:30 p.m.

Afterglow Party for Assembly

Attendees

Friday, July 25

8 a.m.-5 p.m.

Registration Open

8 a.m.-9:15 a.m.

CME Breakfast

8:30 a.m.-4 p.m.

Exhibits Open

9:30 a.m.-4:45 p.m.

CME General Sessions

12:30 p.m.

Physician and Exhibitor Lunch

12:30 p.m.

Student and Resident Lunch

12:30 p.m.

Board of Trustees Meeting

5 p.m.

Second Session of Congress of Delegates

7 p.m.

All Member Party

Saturday, July 26

6:45 a.m.-4 p.m.

Registration Open

7 a.m.

Past Presidents' Breakfast

7 a.m.

Annual Fun Walk/Run

7:45 a.m.

CME Breakfast

9 a.m.-5 p.m.

CME General Sessions

8:30 a.m.-noon

Exhibits Open

Noon

Luncheon – sponsored by the IAFP Foundation

6:30 p.m.

President's Reception

7:15 p.m.

President's Banquet

Sunday, July 27

8 a.m.

Board of Directors Breakfast and Meeting

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.

All arrangements, from selection of CME offerings and 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.



Complete Schedule

Thursday, July 24, 2008

- 8 a.m.-7:30 p.m. Registration open in Convention Center
- 1 p.m. Opening of IAFP 60th Scientific Assembly – Teresa Lovins, MD
- 1:15 p.m. **Asthma Update – Frederick Leickly, MD**
- 2 p.m. **EB CME: Generic Vs. Name Brand Anticonvulsant Drugs – Omar N. Markand, MD**

Learning Objectives:

Upon completion of this activity, the learner will know:

1. What bioequivalence criteria the FDA uses to approve a generic AED
2. The possible effects of drug toxicity on one hand and the occurrence of break through epileptic seizures on substitution of name brand with generic and one generic with another generic brand of the same drug
3. How to make sure that an unintended substitution does not occur

2:45 p.m. **Foot Pain – Matt Parmenter, DPM**

3:15 p.m. **Heart Valve Disease – Mark Gerdisch, MD**

Learning Objectives:

Upon completion of this activity, the learner will:

1. Understand the various pathologies that lead to surgery
2. Recognize the preoperative decision making for valve surgery
3. Identify the impact of valve repair versus valve replacement on long-term outcomes.

- 4 p.m. Break
- 5:30 p.m. Congress of Delegates Dinner and Family Medicine Town Hall – The Medical Home – Principles and Joint Discussion
- 7 p.m. First Session of Congress of Delegates – Reference Committees to follow
- 8:30 p.m. Afterglow Party for Assembly Attendees and Spouse/Guest – Sponsored by North East Region

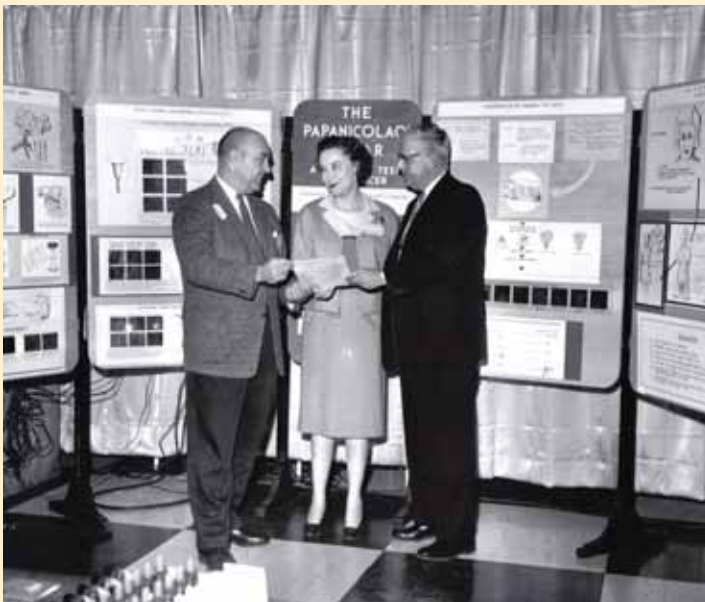
Friday, July 25, 2008

- 7 a.m.-5 p.m. Registration open in Convention Center
- 8 a.m.-9:15 a.m. **Breakfast EB CME: Management of Alzheimer's Disease in a Primary Setting – David Smith, MD**

Learning Objectives:

After participating in this activity, the physician should be better able to apply evidence-based medicine to:

1. Screen patients for the signs and symptoms of all stages of AD using available techniques and tools
2. Categorize patient history into cognition, behavior and function to assess severity of AD
3. Diagnose AD using various diagnostic tests and interviews with patient and caregiver
4. Evaluate overall benefits and risks of pharmacologic therapy for AD
5. Communicate the benefits and importance of persistent therapy at all stages of AD to the patient's caregiver and family



Scenes from the exhibit hall at one of your Academy's early Annual Meetings – honor those who have served and register today for the 60th Diamond Anniversary Annual Meeting.



A scene from the Annual Banquet at an IAFP Annual Meeting almost 60 years ago.

9:30 a.m.

EB CME: The Triangle of Treatment: Taking a Team Approach to Managing Rheumatoid Arthritis – Alvin Wells, MD

Learning Objectives:

Upon completion of this activity, the learner will be able to:

1. Identify three early warning signs of rheumatoid arthritis (RA)
2. Describe the epidemiology and systemic complications of RA and integrate the treatment of co-morbidities into a patient's overall treatment plan
3. Describe the disconnect between controlling signs and symptoms and controlling radiographic progression
4. List two adverse events associated with each disease modifying anti-rheumatic drug (DMARDs)
5. Describe current and evolving treatment options for RA, and be alert to monitoring and side effects related to these therapies

10:45 a.m.

Break to View Exhibits

11:30 p.m.

EB CME: Pediatric and Adolescent Vaccines Update – TBA

Learning Objectives:

Upon completion of this activity, the learner will be able to:

1. Identify risk factors in acquiring HPV infection
2. Identify HPV types and their association with cervical cancer and genital warts

3. Define how the new HPV vaccines work and the differences between products

12:30 p.m.

Physician and Exhibitor Luncheon –
Indiana Profile and Workforce Report – Debbie Allen, MD

Friday Afternoon: Practice Management Series

1:45 p.m.

Some Lessons Learned from the TransforMed Project – Risheet Patel, MD

2:45 p.m.

Break to view exhibits

3:30 p.m.

Risk Issues in Telemedicine – James (Bart) Lyon

4 p.m.

Coding Update – Joy Newby

4:45 p.m.

CME sessions adjourn for the day

5 p.m.

Second Session of Congress of Delegates

7 p.m.

All Member Party “Diamond Disco”



Annual Meetings of yesteryear: the exhibit hall and the registration desk

Saturday, July 26, 2008

6:45 a.m.-4 p.m.

Registration open in Convention Center

7:45-8:45 a.m.

EB CME: I'm So Sleepy: Diagnosis and Treatment of Excessive Daytime Sleepiness in the Primary Care Setting – Tom Kintanar, MD

Learning Objectives:

At the conclusion of this program the learner should be able to:

1. Differentiate between excessive sleepiness and other sleep disorders
2. Recognize the underlying causes of excessive sleepiness to target patients at the greatest risk
3. Recognize the risk factors/symptoms of OSA
4. Select an appropriate therapeutic option to treat excessive sleepiness when necessary

9 a.m.

EB CME: Prevent and Reduce Type 2 Diabetes and the Metabolic Syndrome – Steven Masley, MD

Learning Objectives:

Upon completion of this activity, the learner will be able to:

1. Explain why patients develop abnormal blood sugar “regulation”
2. Share how food and activity choices prevent and reverse this process
3. Clarify how therapy goals for lifestyle changes are different than those used for blood sugar control related to medication use
4. Identify evidence-based supplements that enhance blood sugar control

10 a.m.

Break to view exhibits

10:30 a.m.

Mood Disorders – Jerry Fletcher, MD

11 a.m.

EB CME: Pathways to Smoking Cessation: Genetics, New and Current Therapeutic Options, and Practice Guidelines – TBA

Learning objectives for this activity include improvements in the following domains:

Knowledge

1. Describe advances in the genetics of nicotine dependence
2. Explore and evaluate current medical and lifestyle treatment options for smoking cessation

Skills/Attitudes

1. Incorporate smoking status as a vital sign
2. Interpret and apply updated smoking cessation guidelines

Professional Practice (not evaluated at activity)

1. Reflect on practice and identify strategies to improve cessation rates

12 p.m.

Luncheon – sponsored by the
IAFP Foundation

EB CME: Ten Years Younger – Steven Masley, MD

Learning Objectives:

At the conclusion of this program, the learner should be able to:

1. Identify risk factors for accelerated physiological aging (e.g. the metabolic syndrome, obesity, inactivity, etc.)
2. Share the advantages of offering testing in an outpatient office setting (body composition, strength testing, aerobic fitness testing, cholesterol screening and cognitive testing)
3. Clarify evidence-based dietary regimens that have been shown to enhance these factors (increasing fruit, vegetable, fiber, omega-3 fat, and nutrient intake while lowering refined carbs, saturated fat and hydrogenated fat)
4. Clarify a balanced evidence-based approach to fitness, utilizing aerobic training, flexibility, and re-emphasizing the importance of strength training and maintaining lean muscle mass into the golden years.

1:15 p.m.

EB CME: Managing Menopause with Non-Estrogenic Agents – Barbara Apgar, MD

2 p.m.

New PAP Smear Guidelines – Barbara Apgar, MD

2:45 p.m.

Break

3 p.m.

“Meeting the Challenge” Diagnosis and Management of Parkinson's Disease – Larry Allen, MD

4 p.m.

CME sessions adjourn for the day

6:30 p.m.

President's Reception

7:15 p.m.

President's Banquet – an afterglow party in honor of newly installed President Teresa Lovins, MD, will immediately follow the banquet

For more up-to-date information and learning objectives, visit www.in-afp.org

AAFP Credit Application has been made to the American Academy of Family Physicians (AAFP) for a total of 25 Prescribed credits, including portions of the program 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 25 Category 1 credits toward the AMA Physician Recognition Award. Physicians should only claim credit commensurate with the extent of their participation in the activity.



IAFP MEMBERS Can Save on Vaccines with New IAFP Partnership with Atlantic Health Partners



in recent years to identify how to assist our members with the ever-increasing costs of providing vaccines, along with addressing proper storage, ordering and payment problems.

We are pleased to announce the IAFP has found a strong, new partner in this cause. Atlantic Health Partners can help your member practice save precious dollars and advocate on your behalf with payers and manufacturers.

Atlantic, a physician purchasing program, works directly with Sanofi Pasteur and Merck and has obtained very favorable pricing and purchasing terms for a wide variety of pediatric, adolescent, adult and travel vaccines. Members of the Atlantic program make purchases

The very mention of immunizations can start debate among anyone who works in family medicine.

The IAFP has been working

directly from Sanofi and Merck (as many of you do now) but typically receive better pricing and purchasing terms. In addition, participation is voluntary, and there is no cost to enroll in the Atlantic program.

There are other vaccine purchasing programs, but Atlantic has made a special effort to engage family physicians. The benefits of deeper discounts and advocacy for IAFP members, along with Atlantic's support of IAFP programs, immediately attracted our organization.

IAFP members who participate with Atlantic should experience strong satisfaction with the program, most notably for the savings, ability to make smaller purchases, customer support and easy enrollment.

Jeff Winokur is the primary contact at Atlantic, and we encourage you to call him at 800.741.2044 or e-mail him at jwinokur@atlantichelpthpartners.com for more information about how your practice can benefit from participation.

HELP TOM FINISH THE FIX

TOM FELGER, MD
AAFP BOARD CANDIDATE FOR 2008

A Strong Advocate for Family Medicine

An Interview with Tom Felger, MD



Tom Felger, MD, of Granger, Indiana, is running for the AAFP Board of Directors this year. Dr. Felger is a past president of the IAFP and has been a very active member of the Academy for many years. Chris Barry, *FrontLine Physician's* managing editor, recently conducted an interview with Dr. Felger to find out more about his campaign.

Why are you running for the AAFP Board of Directors?

I have been blessed to be a family physician for my career. I have received many emotional rewards and supported my family well. I feel that I should be willing to give something back by serving on the Board and improving the future for our younger and future family physicians.

What do you feel you will be able to bring to the Board to facilitate its process?

I ran a successful solo practice for many years that included obstetrics and procedures the entire time. I learned how to survive in the business side of practice from the school of hard

knocks. With my procedural interest, I have also sat, and argued, on various credentialing committees to defend family medicine's right to perform a number of procedures based on competence, not a specialty label. I have been fortunate to have represented the AAFP on the AMA Relative Value Update Committee (RUC) for the last nine years. I believe I have acquired a fairly unique knowledge of how the CMS/RBRVS system works and does not work. I hope to be able to use my understanding of the system to develop new ways to "fix" the system and ensure the survival of our specialty.

What do you see as the most important issue facing family medicine today?

To me, this is really straightforward. Family physicians are just not paid enough for their work. This has evolved over many years, but I think it is the core problem that leads to our low student interest level and our colleagues opting out over lifestyle choices, and it increases the burden of repaying student loans. I am concerned that our specialty may not exist in 10 to 20 years if we do not fix the huge disparity between procedural and primary care incomes.

How do you see health care reform occurring for our society?

As all family physicians know, our current health care system is dysfunctional. We have the highest costs per citizen and embarrassingly poor health results among all industrialized countries. Unfortunately, I do not think that our system can be fixed bit by bit by each state. We will need some form of national coordination to see any meaningful improvement. That means Congress will be involved. Whether we call it universal health care or "Health Care for All," the AAFP label, somehow our 47 million uninsured citizens will need to be included in the system. The devil will be paying for and controlling it. What we will ultimately need is some degree of cost control. This will not be popular with anyone, but just spending money as we have for decades has failed us.

I am encouraged that there seems to be a real recognition among public and private health leaders that a health system without a primary care foundation is unlikely to succeed. Our Academy will need to be aggressive in the reform debate to ensure the viability of a

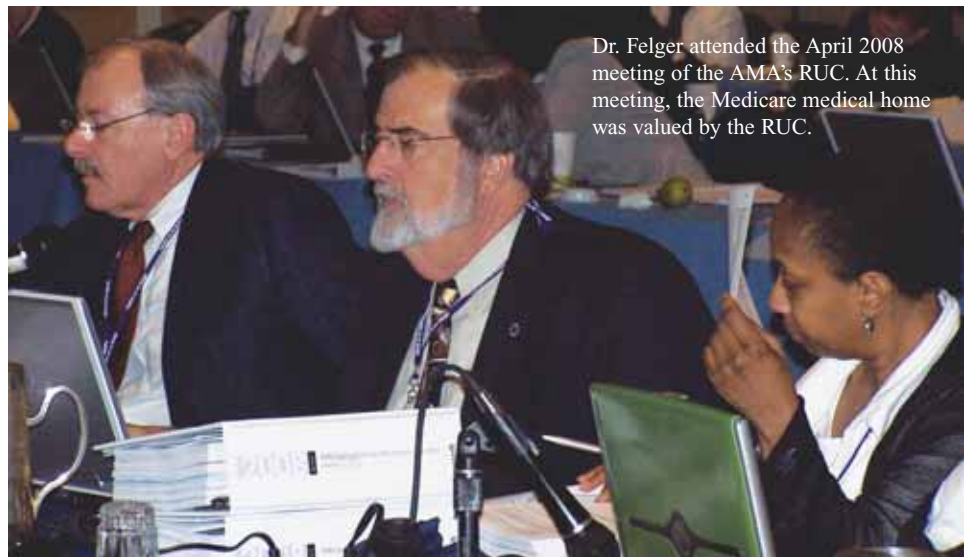
primary care base is assured. A single-party payer will also not be popular, but somehow national spending and profit guidelines will be needed. Between end-of-life expenses and outlandish CEO salaries, these issues will need to be on the table for discussion.

What have you learned from your experience on the RUC?

I have mostly enjoyed my time on the RUC. I started nine years ago helping to review (revise) the practice expense component of our RVUs as published by Medicare. I have substituted and sat on the full RUC for the last six years. I have learned that the congressionally mandated, in 1989, Resource-Based Relative Value System that was intended to equalize the payment differential between procedures and cognitive services has failed badly. There are several reasons for this that I have learned in my time with the RUC.

First, the old Harvard study that was thought at the time to fairly establish the relativity of services was quite flawed. It transferred by a formula most of the old codes with no re-evaluation, so all the old disparities actually continue in the new format.

The next problem is the RUC itself. It is procedurally dominated. Five RUC members, of 23, are cognitive specialties. RUC has a very rigid process to evaluate new and revised codes that seems to see almost all the procedural codes go higher in value, rather than go down. The recent review of the E/M codes was resisted vigorously by the larger surgical societies, and the final increases were less than our request, which was based on our results using the RUC's own system to determine our work values.



Dr. Felger attended the April 2008 meeting of the AMA's RUC. At this meeting, the Medicare medical home was valued by the RUC.

A last reason for the RBRVS failure is the fact that CMS actually welcomes the RUC. Since the RUC exists and is making valuable decisions for the house of medicine, CMS does not have to make unpopular decisions most of the time. In fact, since 1992, CMS has accepted 94 percent of RUC recommendations. Therefore, any RUC errors then become errors that are in the Medicare Physician Fee Schedule and affect both our Medicare and private payments.

Do you think that the medical home will benefit family physicians?

Yes, I am very encouraged by the potential to increase payment to our members through the medical home. Most family physicians are providing these services now — they just aren't getting paid for them. These unfunded services have fallen into the hassle factor for years. There will be some changes needed for most practices, but these are not as many or as burdensome as they first seem. Most of the effort to get NCQA qualification for a medical home will be in

creating the documentation for what is happening now. For example, one of the requirements is 24/7 availability. My associates and I did this routinely for years. It was called "being on call." However, we never wrote up a protocol to document it. Many other measures are in the same category. We are doing the work, we just have not written down a protocol to document it.

The important role for the AAFP will be to push hard for an appropriate valuation of these services from the private insurance companies. Not just a token payment. Valued correctly, the medical home payment will help almost all of our members.

Another positive to family physicians in formally becoming a medical home is that we will all probably serve our patients a little better than we are now. I believe we have done well for decades, but like anything else in life, we can always improve.



Dr. Felger discusses issues pertinent to family medicine with legislators at the Indiana Statehouse.

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Foundation Update

Tar Wars®

Donald Bough, a fifth-grade student from Loogootee, Indiana, created the winning poster in this year's Tar Wars® poster contest. His poster, which featured a penguin and the words "Be cool, don't smoke," has been sent to the AAFP for the national competition. Donald will be tossing out the first pitch at the June 22 Indianapolis Indians game, and he and his parents will be traveling to Washington, D.C., in July for the Tar Wars® National Conference. Congratulations and good luck, Donald!

A special thanks goes out to **Dr. Larry Sutton**, a faithful Tar Wars® volunteer (also from Loogootee) for his long-term dedication to Tar Wars® in his community. Dr. Sutton presented the Tar Wars® lesson at Loogootee Elementary East and other schools in the area.

Smokefree Gaming

Did you know that Indiana is now the third-largest gaming revenue state in the United States, surpassed only by Nevada (Las Vegas) and New Jersey (Atlantic City)? Currently, 16,000 Hoosiers are employed by the gaming industry. This will only continue to increase as the new racinos open and gaming continues to expand. The IAFP Foundation recently received a grant from the Americans for Nonsmokers' Rights Foundation in support of the Indiana Campaign for Smokefree Air (ICSA) educational efforts. Specifically, the coalition has been challenged to reach out to employees of casinos and other gaming facilities, educate these

workers about the impact that their work environment has on their health and train them to share their story as advocates of smokefree air in the workplace.

Here is how you can help. We are looking for gaming employees who suffer from health problems caused or exacerbated by secondhand smoke in the workplace who are willing to share their stories. Without these personal stories, it is unlikely that attention will be paid to the unhealthy work environments of gaming employees, and they likely will be left unprotected when the time comes for Indiana to pass a smokefree workplace law. Gaming and hospitality employees are no less deserving of a healthy work environment than are physicians, bankers, retail clerks or teachers. If you have a patient who works in a smoky environment and is willing to tell his or her story, have him or her contact Missy Lewis (mlewis@in-afp.org).

Family Practice Stories Book

Interviews and story collection are in full swing! Gus Percy and **Andy Campbell, MD**, expect to have a draft of the book completed by the end of the year, but we need your help to meet our goal. If you entered a practice prior to 1960 and would like to share your stories, let us know. Or, if you have a particular mentor, teacher, partner or colleague who has stories to share, we are happy to make the contact on our end — just contact the IAFP Headquarters with his/her name, and we will take it from there. What better way to honor the dedicated family doctors who have come before you!?



Residents' Day/Research Forum Grows More Popular Each Year



On March 6, 2008, almost 150 residents and staff members from Indiana's family medicine residency programs packed into the ballroom at the Marriott North in Indianapolis for the annual IAFP Residents' Day/Research Forum. This event gives family medicine residents from around the state the chance to present their original research, case presentations or poster presentations to their peers and teachers.

Our sincere thanks go out to **Larry Allen, MD**, of Syracuse, Indiana, who was our moderator for the day, and who joined **Debbie Allen, MD**, and **Ray Nicholson, MD**, on the panel of judges that awarded the following prizes at the end of the day.

Case Studies

1. Two Case Reports in Pregnant Patients with Plasminogen Activator Inhibitor-1 (PAI-1) Deficiency, Haihong (Henry) Mao, MD, MS, Resident – Fort Wayne (\$200)
2. SMA Syndrome as a Cause of Recurrent Nausea and Vomiting in an Anorexic Patient, Toyosi Morgan, MBBS, MPH, MBA – IU (\$150)
3. Biliary Atresia – An Atypical Case Presentation, Ryan Deweese, MD – St. Vincent (\$100)
4. Toxic Epidermal Necrolysis (TENS): A Case of a Lethal Skin Condition Masquerading as a Common Ailment, Phumeza Msikinya, MD – IU (\$50)

Original Research

1. Incidence of Hyponatremia in Mini-Marathon Participants, Chris LaFollette, MD – St. Francis (\$300)
2. Weight Gain Ratios in Gestational Diabetes: A Case Control Study, Jennifer Schamerloh, MD – St. Francis (\$200)

Honorable Mention

Colorectal Cancer Screening – Performance Improvement, Kwanza Devlin, MD – St. Joseph (\$50)

Are We Asking the Right Questions in the Existing Review of Systems – AWARE ROS (Pilot Study), Eric Weaver, MD – St. Joseph (\$50)

Poster Presentations

1. Optimal Dosing of Candida Antigen for Treatment of the Common Wart, Sara Bruns, DO – St. Francis (\$100)

Co-Authors: Michelle McCarthy, MD; Carrie Anderson, MD

2. The Impact of the Primary Care Workforce Distribution on Health Outcomes, Azita Chehresa, MD, PhD – IU (\$50)

Co-Authors: C.M. Muegge, MS, MPH; N. Countryman, MD; K. Kochhar, MBBS; J.J. Brokaw, PhD; P. Nalin, MD; A.M. Holloway, MHA; T.W. Zollinger, DrPH

2008 IAFP Faculty Development Day

The 2008 IAFP Faculty Development Day was held at the Marriott North in Indianapolis on March 5. This year's theme was "Molding Our Future: Innovations in Family Medicine Residency Education." With the recent change in the program requirements for family medicine residency education and the P4 Project's emphasis on innovations that facilitate the key goals of the Future of Family Medicine initiative, residency programs are the incubators for change that will lead our specialty forward in the coming decades. Residency programs will also be instrumental in helping to provoke much-needed changes in the health care delivery system in the United States and will no doubt develop models of practice that will be adopted by their graduates. This was the rationale for the program, planned by **Christopher Doebling, MD**, program chair, and featuring keynote speaker **Dr. John Saultz**, chairman, OHSU Department of Family Medicine, who presented "Transforming Family Medicine: Taking a Leap of Faith."

The remainder of the program was split into two sections: Innovations in Curricula and Innovations in Evaluation. In the former section, attendees heard presentations on Cultural awareness programs, international medicine rotations/track and family medicine-based fellowships. In the latter, presentations were heard on the Collaborative OSCE Program, the Learner's Portfolio/Journal and

incorporating the competencies into rotation goals and objectives/evaluations.

The IAFP would like to thank Dr. Doebling for his work in planning the program and serving as our moderator for the day and all of the faculty members and speakers without whose contributions the Faculty Development Day would not be possible. Our speakers included:

Laurie Pylitt, MHPE, PA-C, IU/Methodist – Indianapolis
Bill Rozycki, PhD, IU/Methodist – Indianapolis
Kevin Ericson, MD, St. Joseph's – South Bend
Curt Ward, MD, St. Vincent's – Indianapolis
Javier Sevilla, MD, IU/Methodist – Indianapolis
Kevin Gebke, MD, IU/Methodist, Geriatrics
Anne Knox, MD, St. Vincent's Current Fellow
David Harsha, MD, Program Director, St. Vincent's FMRP
Diana Burtea, MD, and Kathy Zoppi, PhD, Community Hospital
John Saultz, MD – OHSU
Kathy Zoppi, PhD, MPH, Community Hospitals – Indianapolis
Carrie Anderson, MD, and Richard Feldman, MD, St. Francis – Indianapolis
Dale Patterson, MD – Memorial South Bend



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Update to Treatment of Tobacco Dependence Fits with Patient-Centered Medical Home

On Wednesday, May 7, the U.S. Public Health Service released the 2008 Clinical Practice Guideline Update: Treating Tobacco Use and Dependence. It represents nearly two years of work by a 24-member panel and has been informed by the input and review of many tobacco treatment researchers and clinicians. The Guideline Update is designed to provide an evidence-based blueprint for clinicians and health systems to assist patients who smoke to successfully quit tobacco use.

More than 55 organizations have reviewed and endorsed the Guideline Update, including the AAFP. It delivered a clear message to the nation's health care professionals: there has never been a better time for their patients to quit smoking.

"The 2008 update provides an excellent summary of evidence that has been accumulating about effective tobacco dependence treatment," says family physician Carlos Jaén, MD, PhD, vice chair of the guideline update panel. Jaén is chair of the department of family and community medicine at the University of Texas Health Science Center in San Antonio. He's also a member of the AAFP Tobacco Cessation Advisory Committee. The management concepts set forth in the guideline update stand to benefit family physicians and their patients in particular, Jaén says. "At no other time in history have we had such a large number of effective treatments and interventions that can be delivered in the context of the family medicine office." The update makes it clear that tobacco dependence is a chronic disease that often requires repeated interventions and multiple attempts to quit, Jaén says. "We wouldn't think of counseling a diabetic patient for diet and exercise once and then be done with it. The same applies to tobacco dependence."

It shouldn't be just the doctor who intervenes, Jaén adds. "The people who work in our family medicine offices are very motivated to help patients. This guideline update provides tools to help all of us help our patients. It should be a team effort — which fits into the concept of the patient-centered medical home.

"The new guideline also provides a 'blueprint' for clinicians and health care systems, describing how smokers can access effective treatments, how clinicians can provide such treatments quickly and effectively and how health care systems can support both smokers and clinicians in smoking cessation efforts," Jaén continues.

In response to the Guideline, Indiana is taking action. In June, Dr. Judy Monroe, Indiana state health commissioner and family physician, will convene a group of health care provider organizations



to discuss the new guideline and develop recommended strategies Indiana should employ. This will be incorporated into the 2015 Indiana Tobacco Control Strategic Plan.

Individual, group and telephone counseling are all effective, according to the update, and their effectiveness increases with treatment intensity. "I was pleasantly surprised by the strength of evidence for counseling provided by telephone quitlines," Jaén says. "It's a powerful way to augment anything we do in the office." The number of Hoosiers seeking assistance to quit smoking has ramped up in the past year. In April, 1,358 Hoosiers contacted the free Indiana Tobacco Quitline (800.QUIT.NOW) for assistance from trained quit coaches. The Indiana Quitline is available and free to any adult Hoosier who is ready to quit.

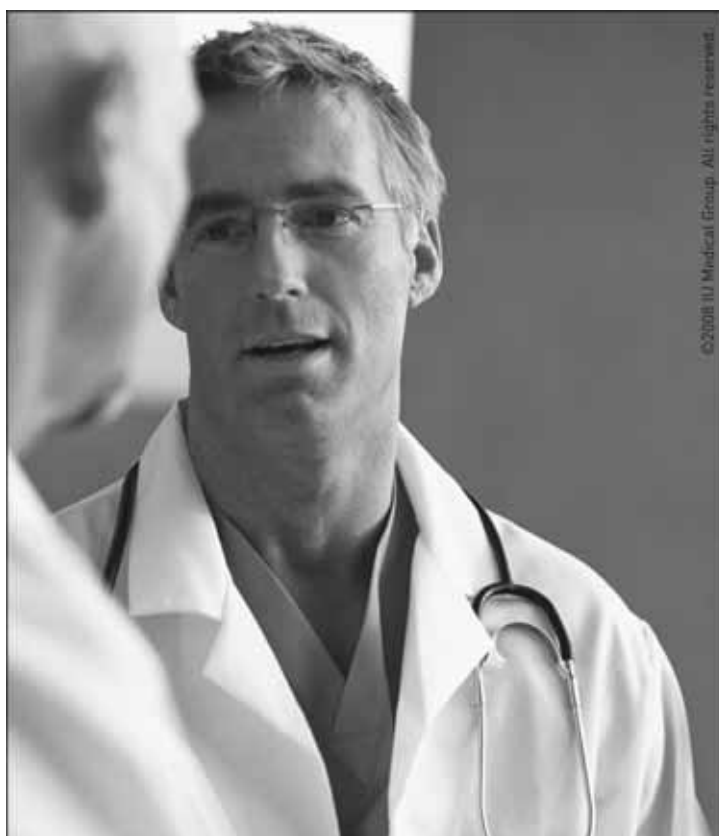
ITPC's network of locally affiliated coalitions also have cessation resources available that reach all of the Indiana's counties to provide help to smokers who are ready to quit. Log on to www.itpc.in.gov to get a full listing of those local resources.

Guidelines Provide Further Direction for Quitting

The PHS guidelines included 10 key recommendations:

- Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
- It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.
- Tobacco dependence treatment is effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in the Guideline.
- Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in the new Guideline.
- Individual, group and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt: 1) practical counseling (problem-solving/skills training) and 2) social support delivered as part of the treatment.
- Numerous effective medications are available for tobacco dependence and clinicians should encourage their use by all patients attempting to quit smoking except when medically contraindicated or with specific populations in which there is insufficient evidence of effectiveness. There are seven first-line medications available that reliably increase long-term smoking abstinence rates.
- Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
- Telephone quitting counseling (800.QUIT.NOW) is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.
- If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivations treatments in the Guideline to be effective in increasing future quit attempts.
- Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans including the counseling and medication identified as effective as covered benefits.

Copies of the Guideline and its companion materials are available at <http://www.surgeongeneral.gov/tobacco>. For more information regarding the free Indiana Tobacco Quitline, call toll-free 800.QUIT.NOW (784.8669). The service is free to anyone 18 years and older and an Indiana resident.



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We Are All Marcus Welby,

*Editor's Note: Several officers and chapter staff members represented Indiana at the AAFP Annual Leadership Forum in Kansas City. It was a motivating and thought-provoking conference. As you know, Indiana's own **Jason Marker, MD**, of Wyatt is the New Physician director on the AAFP BOD. He will be finishing his one-year term in San Diego this fall. As the New Physician member of the AAFP Board, Jason was asked to address the state chapter leaders in attendance. His speech, centered on Marcus Welby and the medical home concept, apparently hit home with several of the attendees and has been circulating between AAFP members via e-mail.*

Congratulations to Jason on a job well done.

I was born in 1971. To some of you here, that makes me an "old guy," and to some of you that makes me a "whipper-snapper." Either way, the year of my birth places me at the beginning of the public's understanding of a

patient-centered medical home. Why is that so important? Well, the AAFP has spent a lot of time working on the medical home concept. We've spent a lot of money, built a lot of relationships and, in general, put a lot of eggs into the basket of the medical home. But for all that, we're still having trouble selling the concept to America, and the reason is that the public has held onto its 37-year-old understanding of the patient-centered medical home.

According to the Nielsen Television Index, the number-one TV series of the 1970/1971 season was *Marcus Welby, MD*, starring Robert Young. This incredibly popular ABC medical drama portrayed Dr. Welby as a kindly general practitioner — comfortable with all illnesses, though not necessarily an expert in them; willing to listen to patients at length, but knowing that sometimes the answer would require research and chart review; understanding that a patient's temperament, fears and family environment

would often be the key to making the diagnosis; and aware that patients and younger colleagues needed his education to ultimately improve the health of the community. In his fictional practice, he dealt with drug addiction, rape, tumors and autism. He followed patients in the hospital even as he turned their care over to specialists. He understood that patients had long-term problems that needed to be understood in the context of their psyche, and he knew he would need the help of his nurse, his assistant and his health department to get the job done. Now tell me that's not a patient-centered medical home.

I searched dozens of Web sites for information about Marcus Welby, and you know what I found? Mostly weblogs of people complaining about their doctors and contrasting them to Marcus Welby. Even in the 1970s, Dr. Welby's loyal bedside manner on TV led many physician organizations to protest against him for making their jobs



harder and potentially increasing rates of malpractice claims. When Robert Young was interviewed by *McCall's* magazine, he once related a conversation he had with a doctor at a convention of family physicians. This physician said to him, "You're getting us all into hot water. Our patients tell us we're not as nice to them as Dr. Welby is to his patients." To this, Robert Young replied, "Maybe you're not."

We in this room have to help the public see that the Marcus Welby they are still looking for is us. We have to help them see that the core values they want, we have to offer. We have spent so much time and effort trying to convince Washington, big business and the insurance companies of the truth of this that we have nearly forgotten to bring along the real stakeholders — our patients. However, and listen closely here, it is NOT the work of the AAFP to bring the public along. It's the AAFP's job to work with Washington and big business and the insurance companies. We in this room have to show our patients and our communities that we are already a patient-centered medical home, that family docs will give them the value they want, that family physicians are the ones who can help them navigate the complex health care landscape, that family medicine will be there for them when the partialists have gone to bed, that the "family" in our name means what it says.

When the public understands this, then they too will put pressure on Washington, big business and the insurance companies, and only then can the AAFP mission of advocating for family medicine be accomplished.

Now ... I need to pause a moment to lay out a challenge for the two main groups that are here this week. If you've got a few grey hairs, and you've heard all this before, and it all seems like so much useless talk from this "whipper-snapper," this next sentence is for you. If you think you are going to wait for the payment system to change to fairly pay you to do what you need to do to be a medical home, you have failed this Academy. For

now, the people who pay you hold the keys, and until they see quantifiable quality, the bank is locked. You have to provide the quality, measure the quality, prove the value and show the numbers. Only then will we have the ability to negotiate from a position of power. And we can't get the power until you can help show the progress.

On the other hand, for those of you still a stone's throw from residency, I would lay out the following statistics. According to a 2007 Association of American Medical Colleges survey, in the next 20 years, one in three U.S. doctors are going to retire, leaving 71 million baby boomers to be cared for. These patients are the richest, the smartest and the healthiest you have ever seen, and they are going to be around for a long time, demanding every single piece of a true medical home. Unfortunately, they are going to have to be taken care of by a group of physicians who value their time more than their money and their personal lives more than their practice. In fact, 71 percent of physicians under 50 say that personal time is a very important factor in a desirable practice, most are willing to risk career advancement for better quality of life, and 32 percent would prefer part-time hours. I'm here to tell you, you cannot work 20 hours a week, never go to the hospital, refuse to work with mid-level providers, abandon Medicare patients, throw away your pager, charge like a lawyer for every single phone call and call yourself a medical home. If you say you want life balance, then the side of the scale where medicine lives has to be spent actively engaging every day with the networks of providers that can pick up the slack when you're not there. You cannot afford to ignore technology, group visits, telemedicine, registry development, e-prescribing, CQI projects and patient advocacy, or your patients will see you as impotent to provide quality longitudinal care for their family, and they will look elsewhere.

Marcus Welby is not a great fictional doctor because he was on the AAFP Board of Directors, or because he was a constituent chapter president, or because he represented

GLBT physicians for his state, or because he golfed with his senator once. He is a great physician because he embodied how people want to be treated, how people want their families to be treated in times of illness. None of us here can live up to the TV challenge of Dr. Welby, but everyone here can do something in their practice to move us closer. Everyone here can remember that we as family doctors already are a medical home — we just have to act like it, we have to show it to our patients, we have to share how we do it with our colleagues, and we have to support our Academy as they market the results of our work to the nation.

He followed patients in the hospital even as he turned their care over to specialists. He understood that patients had long-term problems that needed to be understood in the context of their psyche, and he knew he would need the help of his nurse, his assistant and his health department to get the job done.

Don't let anyone tell you that Marcus Welby is dead. Heavens, he was just born in 1971 like me. Instead, show them that he's alive and well in all of us, he's alive and well in family medicine, and he's alive and well in the patient-centered medical home.

Thank you very much for your time. Have a great conference, and let's get to work making this concept a reality for our patients.

Medicare Revises Advance Beneficiary Notice (ABN)

by Joy Newby, LPN, CPC, PCS, Newby Consulting, Inc.

Just when you thought you understood how and when to complete a Medicare Advance Beneficiary Notice (ABN), CMS revises the form!

Effective March 3, 2008, physicians can use the revised form [CMS-R-131 (03/08)]. The use of the revised form is **mandatory September 1, 2008**. This means physicians must use the revised form when executing ABNs on or after September 1, 2008. The new form is on page 29.

Pertinent changes include:

- Has a new official title, the “Advance Beneficiary Notice of Noncoverage (ABN),” in order to more clearly convey the purpose of the notice
- Replaces both the existing ABN-G and ABN-L
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB)
- Has a **mandatory** field for cost estimates of the items/services at issue
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare
- ABN cannot be translated into any other language. Currently, the revised ABN is only available in English, but will be translated into Spanish in the future. For beneficiaries who speak languages other than English or Spanish, verbal assistance in other languages may be provided to help beneficiaries understand the notice. Physicians should document any translation assistance that they provide in the “Additional Information” section of the notice.

A complete set of instructions is available on the CMS Web site identified above.

- ABNs are not required in emergency or urgent care situations
- ABN must be reproduced on a single page and may be either letter or legal. Other than the physician completed sections, the

notice should be identical to the CMS-R-131 (03/08) posted on the CMS Web site

- Physicians must execute an ABN when they believe Medicare may deny the service as not medically necessary in order to hold a Medicare patient financially responsible for the service(s)
- The ABN must be executed before providing the items or services
- All physician completed sections must be typed or handwritten and should be large enough to allow ease in reading – size. To assist physicians in creating ABN(s), the form is available in rich text format on the CMS Web site
- The ABN must be verbally reviewed with the patient and any questions answered before it is signed by the patient
- Signature should be a cursive signature with printed annotation if needed in order to be understood
- A copy must be given to the patient after the form is signed – physicians must retain the original notice

The form included with this article identifies the 10 blanks for completion of the notice. These blanks are labeled from “A” through “J” on the example enclosed with this article. The information below is summarized. Physicians must refer to the complete set of instructions posted at www.cms.hhs.gov/bni.

A. Mandatory – At a minimum, the practice name address and telephone number must appear to ensure the patient can follow-up with additional questions.

B. Mandatory – Enter the patient’s first and last name. CMS would also like the patient’s middle initial if it is used on the patient’s Medicare card.

C. Optional – Enter an identification number for the patient that helps to link the notice with a related claim when applicable – **DO NOT** use the patient’s Medicare number.

D. Mandatory – In the sentence portion, “If Medicare doesn’t pay for,” include the term that best defines the item/service for which the ABN is being executed, e.g., item(s) or service(s), laboratory test(s), equipment, etc.

In the column identified by section **D**, enter the name/description of all items or services that are subject to the notice. Use easy to understand terms. If technical language must be used, it must be explained verbally to the patient.

E. Mandatory – Explain in easy to understand language why you believe Medicare may deny the service. There must be at least one reason applicable to each item/service. When appropriate, the same reason can apply to multiple items/services.

Possible reasons include, but are not limited to:

- Medicare does not pay for this service for your condition
- Medicare does not pay for this service as often as this (denied as too frequent)
- Medicare does not pay for experimental or research services

F. Mandatory – Enter the estimated cost for each item or service described in the column identified in section **D**.

G. Patient Completed – There are now three different options from which to choose. The patient must select only one of the items. If the ABN includes multiple items and the patient chooses to receive some but not all of the items or services, they must cross out the items they do not want. If this cannot be done clearly, a new ABN must be completed.

H. Optional – Physicians can use this space for additional clarification that will be of use to the patient. Physicians can also use this space to document any translation assistance in executing the ABN.

I. Patient Completed – The patient must sign the notice. The signature indicates that the patient has received and understands the notice.

J. Patient Completed – The patient must enter the date he or she signed the ABN.

***When appropriate, the patient-completed sections may be completed by the patient’s authorized representative.*

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the (D) _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Legislative Update

by Meredith Edwards, Interim Director of Legislative and District Affairs, and Douglas M. Kinser, JD, Lobbyist



IAFP PAC Update

The presidential primaries gave Indiana a thrilling moment in the spotlight, but the political excitement in Indiana is far from being over. For state officials, the summer and fall will be filled with campaigning until the November 4 election. There will be limited activity with interim study committees throughout the summer, although hearings on the budget will begin soon.

Your IAFP Political Action Committee (PAC) has been hard at work identifying state legislators who will support family medicine when elected. The IAFP chooses carefully which legislators will receive campaign donations, requiring all legislators to be approved by the IAFP Board of Directors. This year, we chose legislators from both parties in leadership or members of health-related committees. The legislators the IAFP chose are in the best position to work for the Academy's causes and to influence other legislators to do the same.

The IAFP PAC successfully helped Sen. Connie Lawson (R-Danville) and Sen. Beverly Gard (R-Greenfield) to defeat their primary opponents. The IAFP supported Sen. Lawson because of her position as the majority floor leader and her work within the Health and Provider Services committee. Sen. Gard was chosen because of her work within the Health and Provider Services Committee and her previous work in the health care industry.

The IAFP plans to give to six more campaigns this summer and has already donated to the campaign of Sen. Pat Miller (R-Indianapolis), nurse and chair of the Health and Provider Services Committee. Speaker of the House Pat Bauer (D-South Bend) and House Republican Leader

Brian Bosma (R-Indianapolis) will both receive donations for their re-election campaigns. Sen. Vi Simpson (D-Bloomington), who is a member of the Health and Provider Services Committee, will receive a campaign contribution.

Three members of the House of Representatives Public Health Committee will also be receiving contributions. The IAFP will help fund the re-election campaigns of Chairman Charlie Brown (D-Gary), Vice Chair and nurse Rep. Peggy Welch (D-Bloomington) and emergency room doctor Rep. Dr. Tim Brown (R-Crawfordsville). Other candidates may be added as the races develop and we see how much money is available. All contributions to candidates are approved by IAFP's PAC committee.

The IAFP PAC donations to legislators come only from your donations to the PAC. Our donations to legislators give our staff members time with the legislators during their campaigns and during sessions. At these times, we are able to educate the legislators on family medicine issues that matter to our members. Please consider donating to ensure the IAFP can continue to work for you inside the legislature. All donors who give \$100 or more are invited to the special PAC reception at the 2008 Annual Meeting.

If you are interested in donating to the IAFP PAC, please send contributions to:

Indiana Academy of Family Physicians
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Indianapolis IN, 46204


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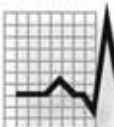


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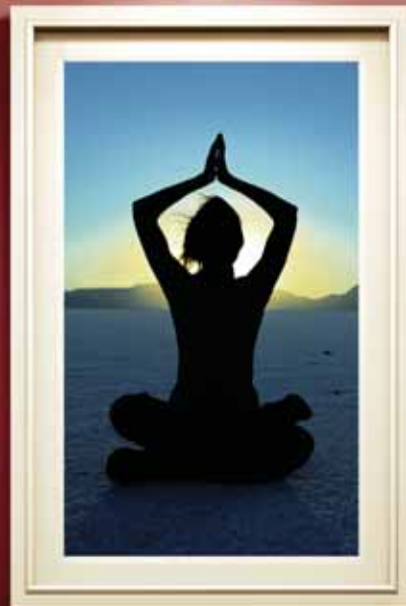
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