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

IAFP Ten-State Conference Report

PG. 8

Call for Nominations for Officers

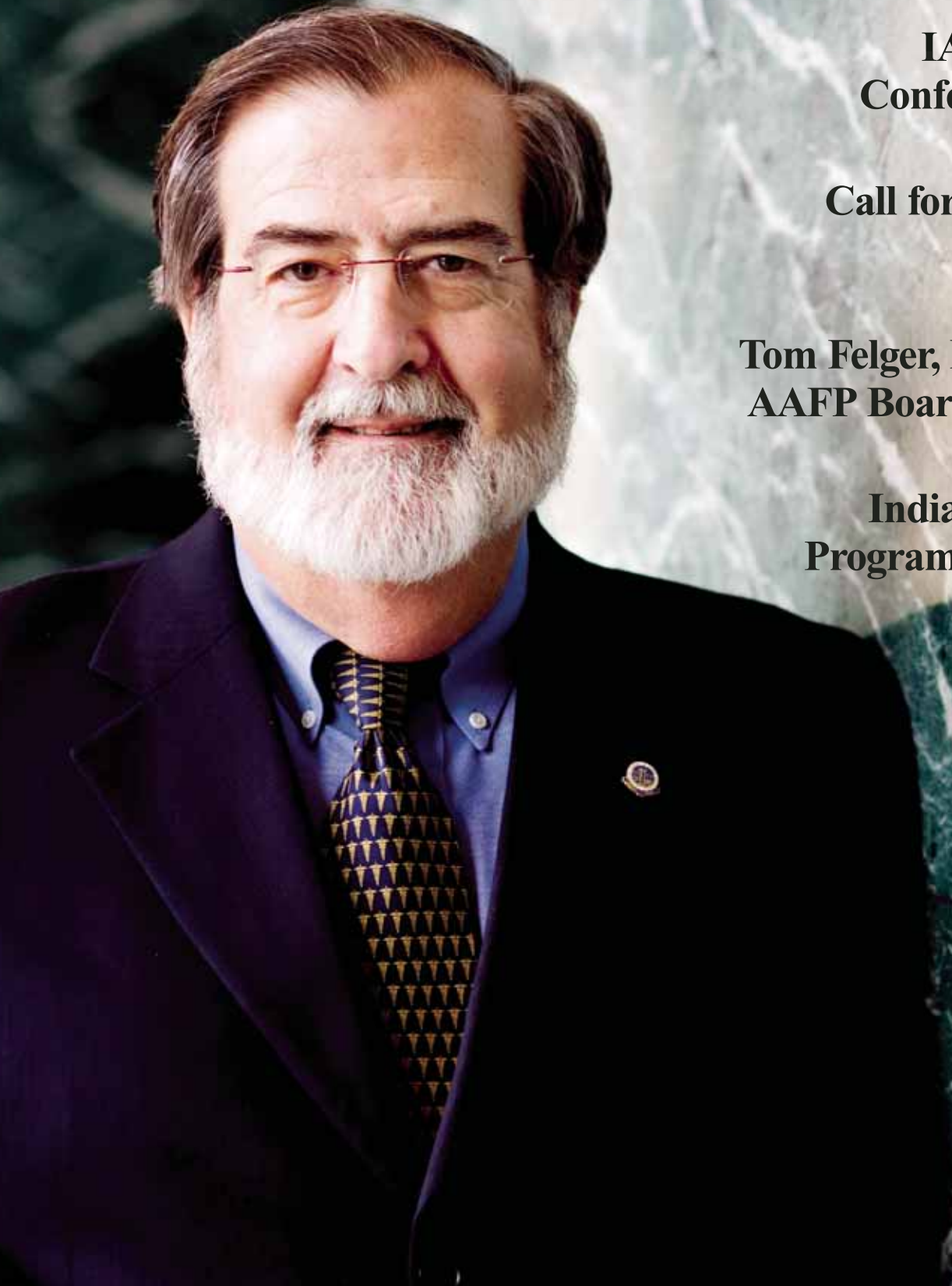
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Tom Felger, MD, Runs for AAFP Board of Directors

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Indiana Residency Programs Highlighted

PG. 20



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FRONTLINE PHYSICIAN

Volume 9 • Issue 1

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

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- 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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FrontLine Physician is published by Innovative Publishing Ink.
10629 Henning Way, Suite 8 • Louisville, Kentucky 40241
502.423.7272
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AT ST. VINCENT CARMEL



Larry Allen, MD

Family Medicine Across the States

As president, I recently had the privilege to represent Indiana at the regional Ten-State Conference, held this year in Connecticut. This annual conference brings the leaders from both Midwest and Eastern states to share best ideas and current challenges in the promotion and practice of family medicine. One of the most valued aspects to this conference for me was to be able to compare notes with our colleagues from other states on the day-to-day rewards and challenges of being a family physician.

I was especially intrigued with my discussions with the Connecticut docs, this year's hosts. The environment in that state is markedly different than the Hoosier state, and in one sense, it should make us thankful for many things we often take for granted. First of all, there are the malpractice rates. They did not do OB as I do, and they had a "claims made" versus an "occurrence" policy (they would need tail coverage if they moved), and their rates were still two to three times higher than mine. For a state of similar population, they had only 400 active members in their academy, and we have around 1,600. Accordingly, the specialist-to-primary-care ratio is much higher. There was only one family doctor in the state who did OB, and she obtained her privileges when no one was looking. Since then, the hospital changed its bylaws to prevent any future breaches (no pun intended). Hospital privileges are obtainable but in general are more limiting. Because the culture has been so inundated with specialty and medical center care, family medicine is not as well understood by the general population, which means they may have a bigger challenge than we have to educate their patients and communities about the character and merits of family medicine.

Having realized some of the differences, I was even more impressed by the consistency in the nature and rewards of family medicine across the states. Some of these heightened challenges and their minority numbers in Connecticut has in a way led to a heightened pride in, and commitment to, the unique role of family medicine. The differences between what they offer and what is pervasive in the culture is so stark that it is easier to recognize the advantages of our specialty. With one particular colleague, I enjoyed sharing patient stories late into the evening about some of those special patient encounters that highlight the way a family medicine doc can make a difference. The conversation led us to the realization of how much trust is at the center of our relationships with our patients. Of course, that trust must be built on our commitment to competence and compassion, but when it is recognized, it is truly appreciated by those whom we serve.

Whether we practice in Indiana or Connecticut or any of the 50 states, we can be encouraged that we do not stand alone. We are all struggling to improve the environment for family medicine. At the academy level, we are all increasing our efforts to advocate the need for payment reform directly to insurers and legislators. Most gratifying, across the states, we are all still called to be committed to our patients first and to hold sacred their trust in us.

Comments and questions are always welcome — llallen@syracusefp.com.



Mark Your Calendar

April 13, 2008

Board of Directors Meeting
Bridgewater Club
Carmel

July 23-27, 2008

IAFP Annual Meeting
Fort Wayne

Indiana Academy Represented at Ten-State Conference

This year's Ten-State Conference was held in Hartford, Connecticut, at the beginning of February. The Indiana chapter has been a member of this group of state chapters for around thirty years, and this year we were represented in Connecticut by Larry Allen, MD, IAFP president; Tom Felger, MD, AAFP Delegate and Board candidate; and Teresa Lovins, MD, IAFP president-elect. IAFP staff member Missy Lewis, MS, CHES, attended also. Sharing of ideas, trends and new projects is always a theme of this conference. Dr. Allen shares his personal thoughts on the Ten-State Conference on page 7 of this issue and included below is a copy of Indiana's recap report that was presented to all attendees of the conference.

Governmental Affairs

The 2007 legislative session in Indiana was one of the most productive in recent memory. The governor's plan for the uninsured (Health Indiana Plan — HIP) was passed by significant margins following a series of changes. The bill included a 44-cent tobacco-tax increase, with a majority of that revenue allocated for the new health insurance plan. The market-based health plan would make insurance available to low-income Hoosiers, based on a health-savings-account-type plan to which members would

make a small contribution. The plan increased payments by 400 percent, or \$9.2 million annually, for providers serving beneficiaries with complex conditions. The plan places a strong emphasis on prevention and will be available on a first-come, first-served basis for those who are eligible. It is not an entitlement program. \$11 million was appropriated for childhood immunizations.

Other significant legislation included:

- Medicaid funding was increased to 5 percent in the budget.

- A bill prohibiting "most favored nations clauses" frequently used by Wellpoint/Anthem in health care provider reimbursement contracts was passed.
- Indiana Tobacco Prevention and Cessation (ITPC), the state tobacco prevention agency, was funded at \$16.8 million — \$6 million more than last budget, but still only half of the



old minimum level recommended by the CDC and \$62 million short of the revised recommendation.

- The Family Medical Education Board Family Practice Residency Fund line item was funded at \$2,386,803 – an \$80,000 increase from the last budget.
- A law requiring seatbelts for all passengers in trucks was passed after years of discussion.
- Prescriptive authority for physician assistants was passed with much input from the IAFP regarding key definitions.
- Pharmacists were given the authority to administer vaccines. The IAFP and ISMA were successful in significantly restricting the bill to only yearly flu vaccines to be issued by pharmacists.
- A law was passed requiring schools to educate parents on the prevalence of cervical cancer and provide information about the HPV vaccinations for school-age girls.
- Automated external defibrillators are now required in all health clubs.
- A bill passed requiring emergency procedures training for teachers of diabetes management.

2008 is a “short” session for the Indiana General Assembly. At the time of print, the General Assembly had reached the “halfway” point, with those bills that are still alive making it past their house of

origin. More than 275 bills will march on to the second half of the session — most notably, the property tax reform bill. The property tax bill is exceedingly important to Indiana residents after a tumultuous election cycle in which many long-serving mayors were thwarted in surprise upsets. Amidst the short session and political drama, health care issues have taken the back burner in the legislature; however, a few bills of note still remain.

Legislation

A bill allowing “assignment of benefits” will require an insurer to comply with a patient’s request to assign his or her reimbursement benefits to an out-of-network health care provider. The bill requires a provider to notify the patient if the provider is an out-of-network provider, and the patient may be billed for amounts not covered by their insurer. If, after notification, the patient still wants those out-of-network services, then it is the patient’s choice to proceed. After much discussion, the bill passed the House by a margin of 60-38.

Other bills of note will require all cigarettes sold in Indiana to be “fire-safe,” establish standard warning signs to pregnant women where tobacco is sold, limit silent rental networking and require increased oversight of the management care organizations that have contracted with the state to provide Medicaid services.

The IAFP successfully opposed a bill that would have required health care providers to, not later than January 1, 2010, use an electronic health records system for purposes of billing and receipt of claim payment for services rendered by the health provider. The bill as written was vastly broad and overly burdensome to most physicians.

A smokefree air amendment was unexpectedly proposed during the 2007 session, prompting the creation of a new statewide coalition to build support for, pass and implement a comprehensive statewide smokefree air bill. The IAFP continues to play a significant leadership role in this campaign and was offered a “rapid response” grant from the Americans for Nonsmokers’ Rights Foundation to boost the effort. As anticipated, a weak smokefree air bill was introduced and failed to even have a proper hearing. Given recent expansions in gaming — with gaming now the fifth-largest employer in the state — the IAFP and

the statewide coalition remain committed to passing a comprehensive law that includes bars, membership clubs and all gaming facilities in 2009. It is expected that a comprehensive bill will be introduced by our champions next year.

Medicaid Bonuses and Payment

The state’s approved bonuses for approximately 5,000 primary care Medicaid providers were distributed in late December 2007. Another round of bonus payments are expected in March or April of this year. The average bonus payment for each Medicaid provider will be around \$5,600.

In addition to the bonuses, the state enacted a permanent rate increase of 25 percent, or \$32 million annually, for primary care physicians and subspecialists who provide preventative services. The increase has been a long time coming, as Indiana’s primary care physicians have not received an increase in Medicaid payments in more than 14 years. The IAFP and other members of the health care community lobbied hard and worked closely with the administration to implement the changes.

Scope of Practice

Despite struggles to come to agreement on a policy regarding the scopes of practice of nurse practitioners and physician assistants, the IAFP has moved forward and met with the incoming president of the American Academy of Nurse Practitioners and the physician leadership of MinuteClinic to open the lines of communication.

Region Affairs

The IAFP has completed its governance restructuring. The previous 13 geographic districts have been streamlined into eight regional chapters. All but one of the regions have met locally, electing new officers and determining the control of their dues money. IAFP staff has coordinated these meetings on behalf of the local officers, arranging dinner and lecture opportunities with the IAFP’s coding specialist, Joy Newby. The region meetings were well-attended, and we expect attendance to only grow in the coming years. The Foundation has also indicated an interest in supporting a second meeting of each region in an attempt to bring medical students at the regional campuses together with practicing family physicians.

Candidates for National Office

In 2007, Tom Felger, MD, announced his campaign for the 2008 AAFP Board of Directors.



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Ten-State Report continued...

Political Action Committee

The IAFP Political Action Committee raised more than \$5,000 this election cycle and contributed to key health policies and policymakers of the Indiana legislature. In addition, the IAFP PAC raised an extra \$1,500 to contribute to Sen. Pat Miller, chairwoman of the Senate Health and Provider Services Committee and a long-time supporter of the IAFP. She faces a particularly daunting incumbent and the IAFP, along with the rest of the health care community, is supporting her reelection.

Foundation

The IAFP Foundation continued to support Tar Wars® in Indiana, sponsored a first-year student extern over the summer and sent two residents to the Conference on Practice Improvement. IAFP/F also coordinated efforts to send medical students to the National Conference, thanks to the generosity of residency programs in the state. The Foundation continues to collect stories for the *Family Practice Stories Book*, with hopes to have it published within the next year. The Board of Trustees met in November for a very productive planning retreat, using the IAFP Strategic Plan as a guide for setting priorities. The Foundation is committed to increasing support for family medicine students and residents in Indiana and will work toward identifying emerging leaders and connecting students and residents with practicing family physicians in their communities. One of our biggest highlights of the year was receiving the AAFP/F Outstanding Programming Award for our work on the IAFP Historic Family Doctor's Office at the Indiana Medical History Museum.

Students and Residents

We continue to have a recruitment event for IUSM students each year, again hosting a reception with residency exhibits rather than a sit-down dinner. Indiana does not collect dues from student members and pays the AAFP dues for those who apply.

With funding from the IAFP Foundation, the residency programs have collaborated in recent years to facilitate the Student Interest Initiative for those students entering their third year of medical school. Each residency facilitates an introductory workshop for the students in an effort to prepare them for the clinical scenarios ahead. The initiative has attracted students of all inclinations during the last couple of years and has proven to be a great success, with 90 attendees in 2007.

Our annual Residents' Day/Research Forum is still a very popular IAFP event, at which 80 to 100 residents hear 12 to 16 original research presentations and case presentations from their peers. We also elect resident officers at this meeting.

2008 Call for IAFP Nominations for Officers

At least 90 days prior to the IAFP Annual Assembly each year, the Nominating Committee shall announce nominations as required by the Bylaws. These nominations shall be formally presented at the first meeting of the Congress of Delegates, which this year will be July 24 and 25 in Fort Wayne. At the time of the meeting, additional nominations from the floor may be made. The said election of officers shall be the first order of business at the second session of the Congress of Delegates on July 25.

Offices to be filled for 2008-2009 are: president-elect, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two-year term) and one AAFP alternate delegate (two-year term).

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

If you are an active member of the IAFP and are interested in submitting your name as a candidate, you must submit a letter of intent, a glossy black-and-white photo and curriculum vitae.

This information must be received prior to April 25. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.



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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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Asthma Disparities in Indiana

Asthma is a common chronic disease affecting more than half a million Hoosiers. The Indiana State Department of Health Asthma Program recently released a report on asthma in Indiana and found certain populations had a greater burden of asthma.

The Asthma Program report found blacks, children, females and persons with an annual household income of less than \$15,000 per year carried a disproportionate amount of the asthma burden with higher prevalence rates, hospitalizations, emergency-department visits and deaths. Several factors that may contribute to these disparities include genetic differences, poverty, environmental exposures and lack of patient education.

The Asthma Program report, which analyzed data primarily from 2005, found adult men had an asthma prevalence of 6 percent, while adult women had an asthma prevalence of 10.3 percent. Adult women had higher asthma hospitalization and emergency-department (ED) visit rates than men; however, hospitalization and ED rates were higher for males 14 years of age or younger when compared to females of the same age. Females also had higher asthma mortality rates than males.

Though the prevalence of current asthma was not significantly different between blacks and whites, the asthma ED and hospitalization rates for blacks were approximately three times higher than whites. Additionally, the asthma mortality rate for blacks was nearly five times higher.

Children had the highest asthma ED rates and the third-highest asthma hospitalization

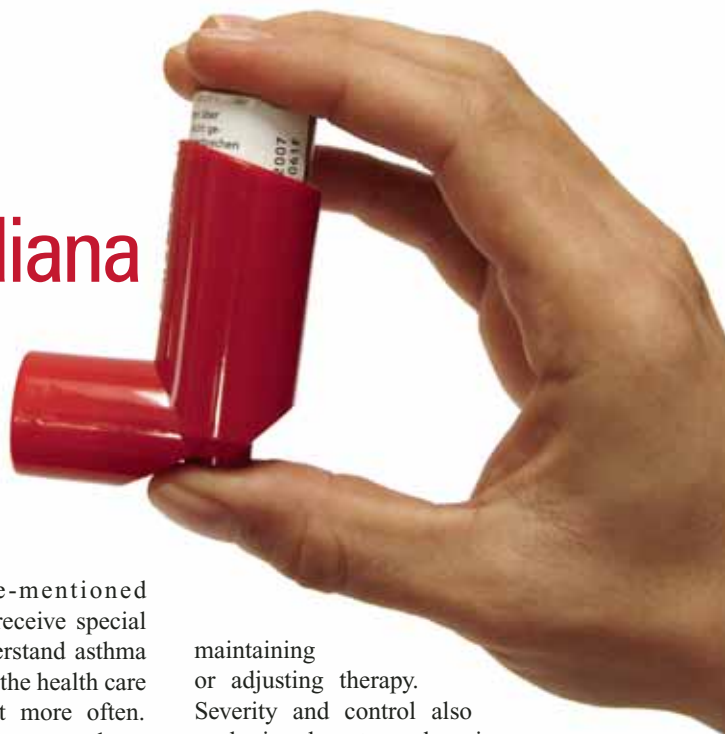
rates when compared to all other age groups. Additionally, asthma prevalence was highest among those with an annual household income of less than \$15,000 per year.

Individuals in the above-mentioned demographic groups should receive special care to help them better understand asthma control, since they tend to use the health care system for asthma treatment more often. This may include extra time to evaluate environmental triggers, assess proper inhaler use during each visit, monitor use of controller and quick-relief medications and determine barriers to asthma control (i.e. cost, low-health literacy, absence of an Asthma Action Plan, etc.).

Most adults and children with asthma should receive an influenza shot every year. Those adults who also smoke should be referred to the Indiana Tobacco Quitline at 800.QUIT.NOW. While these steps are important for all people with asthma, they are critical for populations disproportionately affected.

In August 2007, the National Heart, Lung, and Blood Institute updated their *Guidelines on the Diagnosis and Management of Asthma*, which more clearly defined how to assess asthma severity and control.

Asthma severity measures disease intensity when the patient is not on long-term control therapy, and asthma control measures the extent to which symptoms of disease are minimized and guides decisions on



maintaining or adjusting therapy. Severity and control also each involve two domains: current impairment and future risk.

Additionally, the guidelines have tailored disease assessment and treatment plans to three age groups: 4 years of age and younger, 5 to 11 years of age and 12 years of age and older. These help direct treatment; however, asthma varies widely among patients and does require individualized therapy.

Despite advances in treatment, the guidelines conclude even long-term control medications do not improve the underlying severity of the disease. A copy of the guidelines and a summary can be found at: <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>.

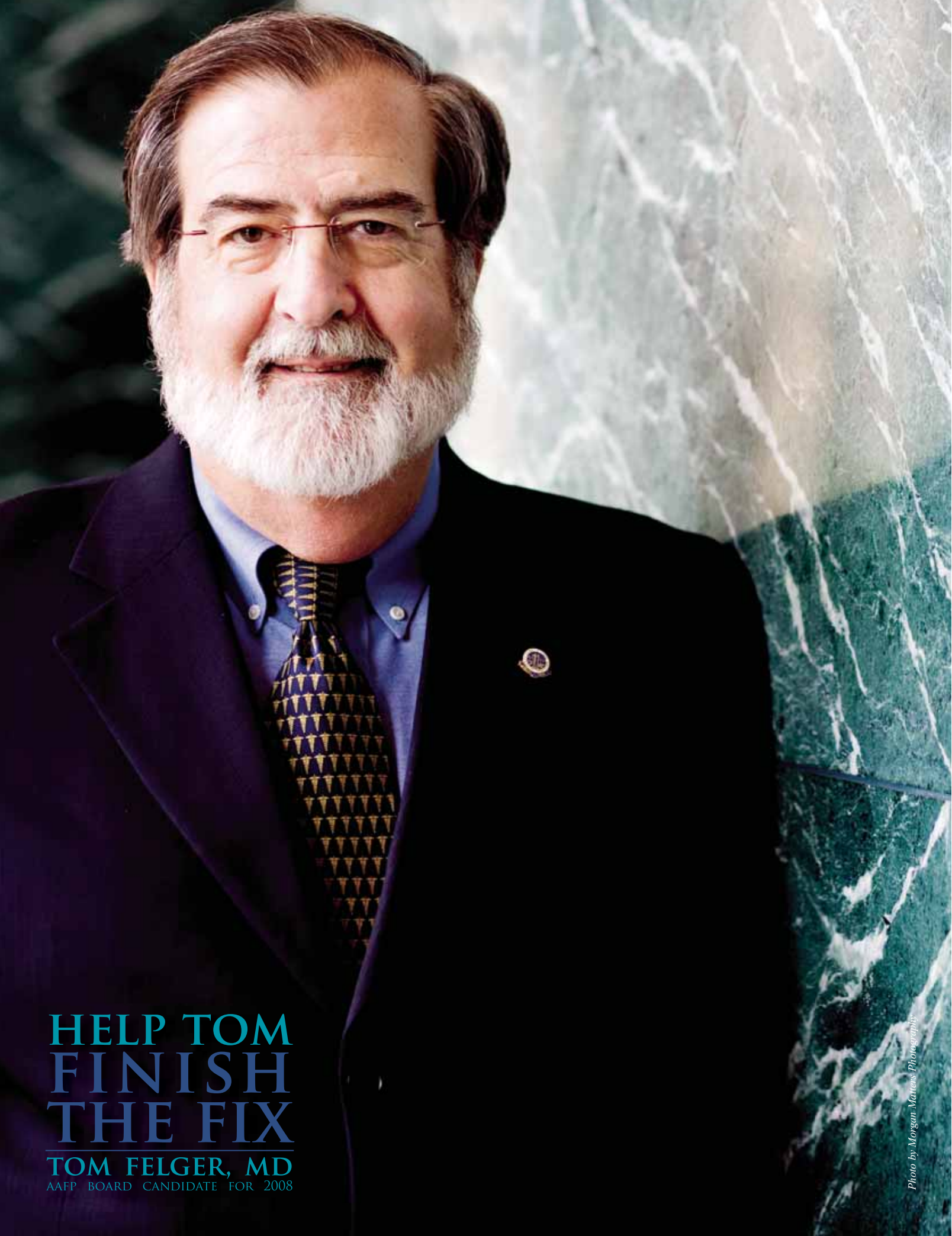
By following the National Heart, Lung, and Blood Institute guidelines, Hoosiers can help reduce asthma disparities and the overall burden of asthma in Indiana. Until more research is completed to determine which factors are contributing to these disparities in Indiana, it is important for individuals with asthma to know the disease can be controlled. All people with asthma deserve to lead active, healthy lives.

For more information on asthma or to access the full report on *The Burden of Asthma in Indiana*, contact the Indiana State Department of Health Asthma Program at 317.233.1325 or www.statehealth.IN.gov/programs/asthma.

	Adult Asthma Prevalence	Hospitalization* per 10,000	ED visits* per 10,000	Mortality* per 1,000,000
Females	10.3%	16.4	43.9	16.4
Males	6.0%	9.4	34.3	8.1
Blacks	9.2%	27.6	94.7	55
Whites	8.2%	10.6	28.3	9.8

Source: *The Burden of Asthma in Indiana*: Second Edition, January 2008

* Hospitalization, ED visits and mortality rates include adults and children.



HELP TOM FINISH THE FIX

TOM FELGER, MD
AAFP BOARD CANDIDATE FOR 2008

IAFP Member Runs for AAFP Board of Directors

Dr. Tom Felger's Platform Includes Repairing the RBRVS System

Those of us in family medicine know that our health system is badly broken and that we cannot afford to pay for it. This is also now known by many of the important players in today's health care system. With many years of surviving private practice, working as an insurance medical director, teaching our residents and a thorough understanding of the RBRVS system, Dr. Tom Felger offers these ideas for fixing the system. Any fix *must* include attention to adequately ***paying*** and thus saving the specialty of family medicine.

To this critical goal, Dr. Felger suggests:

- Continue and finish the recognition AND appropriate payment for medical homes for our citizens.

*I am grateful for the AAFP's leadership in working toward this goal. We are now at a point where important decisions need to be made to create the appropriate process AND **payment** for this valuable service of family physicians.*

- The current, very flawed, RBRVS system needs to be aggressively "fixed" to eliminate the undervalued family medicine services. Even with a medical home payment process, fee-for-service payment is not likely to go away.

With my understanding and experience working with the Medicare and American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process, I can identify and propose fixes for the current system's many flaws that over-reward procedures and undervalue family medicine's thinking and caring services. Simply put, we are underpaid!

Let's Finish the Fix!

A Letter from Dr. Tom Felger

With the help of the Indiana chapter, I am running for the Board of Directors of the American Academy of Family Physicians. My main goal in seeking this position is to use my experience and knowledge to help direct the AAFP leadership in "finishing the fix" of family medicine.

As you well know, our specialty of family medicine is facing a litany of threats to our survival. I'll not list them all now — you know them anyway — but I want to state clearly that I am grateful to our current and recent Academy leadership for their hard work in pursuing a number of new projects and relationships that will benefit all of family medicine if completed correctly. These include direct face-to-face meetings with the major national insurance executives, an ongoing and productive relationship with IBM-level employers and the joint efforts with our primary care specialty friends in the Patient Centered Primary Care Collaborative, www.pcpcc.net.

I believe that if these efforts, and some new ones, are completed successfully, the critical issue to our survival can be attained. Simply put, we have been undervalued in our health care system for far too many years. I also believe that if we are able to obtain our appropriate worth — read that as "better pay" — within the system, our list of problems will solve themselves and our future as a specialty — actually, **the specialty** — will be assured.

Please feel free to contact me for a more personal discussion of my hopes and goals at tom@felger.com or visit www.tomfelger.com.

Tom Felger

Children aren't concerned about osteoporosis.

But their physicians should be.



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

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

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

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

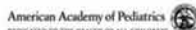
And remind parents that it's never too late for them to take care of their own bone health too. By getting three daily servings of dairy and participating in weight-bearing exercise, adults can help protect their bones while setting a good example for their children.

To learn more, visit nationaldairycouncil.org.

Sponsored by the National Dairy Council and supported by leading health professional organizations.



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Volunteer to Serve on One of Your Academy's Commissions Today!

Dear IAFP Member:

As a valued member, the IAFP wants to provide you with the opportunity to support YOUR Academy. The IAFP cannot operate without the indispensable participation of our members, because we exist to provide the benefits, programs and information YOU need. A great way to make sure your voice is heard is by volunteering for one of our commissions. Take a look at the following list of commission descriptions, and contact us as soon as possible to let us know which one excites you the most. Let us know by phone at 317.237.4237 or e-mail at iafp@in-afp.org. We look forward to working with you soon.

Commission on Education and CME

The commission is responsible for planning the entire official educational program for the annual IAFP Scientific Assembly and the IAFP Family Medicine Update including selecting topics, developing learning objectives and selecting and inviting speakers. The commission also has the authority and oversight for the AAFP-accreditation process for Indiana programs and all IAFP-sponsored and -produced CME, including compliance with rules and regulations set by the AAFP and other CME regulatory bodies. The commission is responsible for exploring future directions and innovative concepts in CME and making recommendations regarding the future of the IAFP CME programming, and the commission will propose policies to the IAFP Board of Directors in matters of continuing medical education for submission to the AAFP.

Commission on Health Care Services

The functions of this commission are to: (1) monitor, analyze and propose policies to influence the social and economic (socioeconomic) health care environment and to determine the impact on family physicians and their patients; (2) serve as a source for gathering, evaluating and disseminating health care socioeconomics

information; (3) develop appropriate responses to assist family physicians in understanding and adapting to a changing practice environment; and (4) recommend IAFP policies and public positions to the Board in the following areas of concern: (a) family physicians' reimbursement and compensation; (b) organization and management of practice; and (c) health care financing and delivery systems. The commission shall also: (1) study and develop recommendations and programs to assist family physicians in pursuing their full scope of practice in health care delivery systems, hospitals and other practice settings; (2) provide members, hospitals and other health care organizations with information and assistance regarding credentialing and privileging reappointment, quality improvement, professional relationships and departmental and other organization issues; and (3) monitor and analyze new and existing quality improvement programs for health care, and provide the family physicians' perspective to professional, private and governmental organizations concerned with such programs.

Commission on Membership and Communications

The functions of this commission shall be: (1) initiating and coordinating membership

services made available through the Academy; (2) administering all awards of the IAFP; and (3) recommending communications activities that support IAFP objectives by: (a) educating the citizens of Indiana about family practice and health issues; (b) promoting family practice objectives in all policy arenas; (c) assisting members in promoting their health care services to their communities; and (d) promoting IAFP as a membership organization of value for family physicians.

Commission on Legislation and Governmental Affairs

The functions of this commission are: (1) to investigate and recommend such actions to the IAFP Board of Directors as may be necessary to assure adequate representation for the family physicians in medical and political groups; (2) to conduct such a campaign of public enlightenment or education as it may deem advisable; (3) to furnish members of the Indiana state legislature and other public officials with pertinent facts and information that they may better maintain high standards of health care; and (4) to recommend to the Board any policies or actions which the Academy may formulate or perform for the general improvement in medical care.

2008 FAMILY MEDICINE UPDATE PRIZE WINNERS

Around 100 family physicians from across Indiana and beyond gathered at the Indianapolis Marriott North in January for the 2008 IAFP Family Medicine Update. Physicians earned more than 25 CME credits and visited exhibitors, while enjoying the comfortable surroundings of the Marriott North.

Several prize drawings were held in conjunction with the Exhibit Show, and the prize winners are listed below:

Philippa Shedd, MD – 19-inch flat-screen TV with DVD player
Philip Ferguson, MD – Kodak Easy Share digital camera with memory chip and plug-in adapter
Joy Bohon, MD – \$50 Speedway gas card
Lucida Keller, MD – \$50 Speedway gas card
Mary Katherine Caron, MD – Gift certificate for one free pair of SAS shoes or handbag

New Codes for Telephone Services

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

Historically, Medicare and commercial insurers have prohibited physicians from billing their beneficiaries and members for telephone services. These payers took the position that physician work resulting from telephone calls was considered an integral part of the pre-work and post-work of other physician services. The fee schedule amount for these services, e.g., a visit, already includes payment for telephone calls.

CPT 2008 includes new codes for telephone services. One code set is reported for physician telephone services, and another code set is used to report telephone E/M services provided by qualified non-physician health care professionals. The American Medical Association (AMA) has not defined who is considered a “qualified non-physician health care professional,” but it does include the staff members to whom you delegate responsibility for obtaining/performing telephone E/M services. The requirements for reporting these codes clearly indicate the service is not an integral part of pre- and/or post-work of another service.

The following requirements must be met to use the new codes:

- These codes should only be reported for established patients
- The call must be initiated by the patient/guardian/parent
- The call does NOT refer to a service performed and reported within the previous seven days
- The call should not be reported if it is related to a completed procedure and the patient is still in the post-operative period
- The call must NOT result in a decision to see the patient within 24 hours or next available urgent visit appointment *
- The call must be documented

* The work involved in any telephone call resulting in a decision to see the patient within 24 hours or next available urgent visit appointment is considered pre-service work for the face-to-face visit. With proper documentation, the pre-service work may be used when selecting the level of care for the visit.

From a risk-management perspective, telephone E/M calls, whether charged or not, should be documented. Unfortunately, in most offices, this is a hit-and-miss process. The physician may remember to document some telephone interactions with patients, but may forget to document others. Non-face-to-face evaluation and management (E/M) services between your staff and patients should also be documented. Again, regardless of whether you decide to charge for telephone E/M services, physicians must have a process to document telephone E/M services.

This process should include how the information is captured. Do you want to dictate these services, use a telephone E/M progress note or message pad, personally document the service in the electronic medical record, etc? Some physicians make calls from locations other than the office or home, e.g., in the car, during a ball game, while making rounds at the hospital, stepping outside a restaurant or theater to make urgent calls, etc. The process should include the expectation of when these E/M services will be documented in the patient’s medical record, e.g., next business day, within two days, etc.

This process should also include who will be responsible for ensuring the paper notes are filed/scanned into the patient’s medical record. If you decide to charge for telephone E/M services,

your process must include the requirement to document the amount of time spent performing the service and how the practice will capture and post charges timely.

The following codes are used to report telephone E/M services provided by a physician:

- | | |
|-------|---|
| 99441 | Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion |
| 99442 | Eleven to 20 minutes of medical discussion |
| 99443 | Twenty-one to 30 minutes of medical discussion |

In addition to deciding whether your practice will charge for physician and non-physician practitioners (e.g., NP, PA, etc.), you need to decide if you will charge for telephone E/M services provided by your office staff. Due to the volume of telephone calls, some practices have one or more “telephone nurses” who obtain information, discuss the patient’s problems with the physician or NPP and call the patient to provide the physician/NPP’s instructions. Regardless of whether the practice has staff members dedicated to telephone calls, telephone E/M services represent significant practice expense.

The following codes are used to report telephone E/M services provided by qualified non-physician health care professionals:

- | | |
|-------|--|
| 98966 | Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days not leading to an assessment and management service or procedure within the next 24 hours or soonest available |
|-------|--|



appointment; five to 10 minutes of medical discussion

98967 Eleven to 20 minutes of medical discussion

98968 Twenty-one to 30 minutes of medical discussion

As previously stated, regardless of whether the practice decides to charge for telephone E/M services provided by qualified non-physician health care professionals, the practice should have a process for ensuring these calls are documented. If charging for these services, the documentation must include the amount of time spent talking with the patient. The process must also address how the charges will be captured so the charges are posted timely.

Since the above codes do not include pre- and post-service work, Medicare considers telephone E/M services non-covered. This means when the requirements are met, as long as physicians are charging non-Medicare patients for telephone E/M services, the Medicare beneficiary may be billed for the service. Since Medicare does not cover this service, practices should not

submit a claim to Medicare unless the patient demands one be filed. Please be sure to include the -GY modifier to these codes if a demand claim is sent to Medicare.

Recognizing member expectations, some commercial insurers have decided to pay for these telephone services. Other commercial insurers consider telephone services non-covered and allow physicians to bill their members for these calls. Newby Consulting, Inc. (NCI) recommends physicians contact their contracted insurers for information regarding coverage.

Since physicians now have codes to report telephone E/M services and physicians are spending more time on these services, and taking into account the practice expense involved in telephone E/M services being performed by staff, NCI recommends physicians give serious consideration to charging their patients for these services. Physicians need to consider how their patients will react to being charged for services previously given gratuitously and determine the amount to charge for these services.

If you decide to charge for telephone E/M services, consider setting a date when the practice will begin charging patients. Then begin to educate your patients that, effective as of the effective date, the practice will “charge for telephone services that do not result in an appointment.” Put a notice on the back of the door in all exam rooms and restroom(s). If possible, put a notice on all patient statements when the practice will begin charging for these services.

As for how to determine an appropriate fee, although not covered by Medicare, these codes have relative value units (RVU) assigned. Practices can use the following information to determine the amount to charge for the different codes.

CPT Code	Total RVU
99441	0.36
99442	0.66
99443	0.98

CPT Code	Total RVU
98966	0.35
98967	0.66
98968	0.98

Reference point: 99213 has 1.68 total RVUs.

Mark Your Calendars Now for the IAFP's

60th Anniversary Annual Scientific Assembly & Congress of Delegates

July 23-27, 2008
Grand Wayne Center/Fort Wayne Hilton
Fort Wayne, Indiana



Please mark your calendars today and plan on joining us this summer for a very special 60th anniversary Annual Meeting, celebrating six decades of outstanding CME programming and providing advocacy, representation and leadership for the specialty of family medicine.

Come to Fort Wayne and have a voice at the All Member Congress of Delegates, earn top-quality CME credits planned by and for family physicians, enjoy our All Member Party and Exhibit Show, and much more!

Check your mail this spring for registration information, and view the latest updates to our schedule at www.in-afp.org, under “Hot Topics.”

For more information, call the IAFP Headquarters at 317.237.4237.

Residency Reports

Ball Memorial Hospital Family

Medicine Residency Program

Ball Memorial's Family Medicine Residency started in 1969 (one of the first programs in the country) and has graduated more than 200 physicians since then. A total of 136 of those physicians now practice in Indiana. Recent news at the residency includes adding Melanie Schreiner, MD, as an associate director in 2007 and having Chris Shue, DO, PGY-3 resident, spend two months in Iraq in 2007 as part of his residency. Dr. Shue, assigned to the 447th Medical Squadron as a family practice physician and flight surgeon, provided acute care and surgical services to the 1,000 Air Force and Army and civilians assigned to Sather Air Base, Iraq. They also ran a biweekly humanitarian clinic for Iraqi civilians.

As a residency program, we pride ourselves in the ability to teach the full range of family medicine. Many of our residents still do OB. With the ability to provide a broad training, our residents are able to perform inpatient, outpatient, OB and advanced procedures (EGD, colonoscopy and C-sections). Privileges have been obtained in the full spectrum of family medicine, both in Indiana and many states across the United States. The "old-time" family doctor lives on in Muncie for residents willing to accept the challenge.

Fort Wayne Medical Education Program

The FWMEP Family Medicine Residency continues to be successful with our advanced obstetric curriculum. During the past four years, nine residents have graduated with a Certificate of Advanced Qualification in obstetrics. All nine have been able to obtain C-section privileges in hospitals in Idaho, Missouri, Utah and Maine. Kristina Kaufmann, DO, one of our chief residents, was selected as one of 20 residents nationwide to receive the AAFP/Bristol-Myers Squibb Award for Excellence in Graduate Medical Education, which was awarded at the annual AAFP meeting in October 2007.

Our residency, which formerly offered only an osteopathic internship, received full accreditation from the American Osteopathic Association as an osteopathic residency, so we are now dual-accredited.

Residents continue to participate in international medicine electives and our curriculum chief, Ryan Johnson, DO, is currently in Tenwek, Kenya, as chief medical officer of a 300-bed hospital that serves a population of 600,000.

Our inpatient medicine director at Parkview Hospital, Dr. Patrick Connerly received the A. Alan Fisher Award for outstanding contributions to family medicine education at the July 2007 IAFP annual meeting.

Indiana University Family Medicine Residency

IUFMR welcomed three new faculty members this year. Dr. J. Brent Sneed assumed the role of assistant director. He is a graduate of our residency program and most recently worked at Raphael Health Center. In 2005, Dr. Sneed received the AAFP Foundation Pfizer

Teacher Development Award. He was one of 15 in the United States to receive this annual award for excellence in teaching. Dr. Jeffrey Henney received his medical degree from the Indiana University School of Medicine and his bachelor's degree at Butler University. He completed his residency at John Peter Smith Hospital in Fort Worth, Texas, and a fellowship in maternity care at Memorial Hospital in South Bend, Indiana. Dr. Tamika Dawson joined our team after her residency at the Indiana University Family Medicine Residency. She has accepted a sports medicine fellowship position with the IU Family Medicine Residency for next year.

Residents and faculty started off the year tackling a ropes course and exercising their team building skills. Ninety percent of our residents were privileged to participate in international rotations in the last year. They were enriched personally and blessed to serve many in the developing worlds. Our family medicine adult and pediatric inpatient service continues to grow in size and services provided Indianapolis family physicians. Three of IUFMR's faculty members are privileged to do C-sections at the second-largest hospital system in the country. The sports medicine and geriatric fellowships continue to recruit our graduates to their program. We are excited to offer an obstetric fellowship in 2009.

Memorial Hospital of South Bend

Family Medicine Residency Program

We are excited that we were able to expand our faculty team this past summer. Dr. Dale Patterson is an excellent teacher who has clinical interests in inpatient medicine, obstetrics and procedures including EGD and colonoscopies.

St. Francis Family Medicine Residency

The St. Francis Family Medicine Residency is now 35 years old and just got notified in January 2008 of another full five-year accreditation. The residency, although continually refining itself, remains much as it always has been in its personality and character. The residency prides itself on continuing its long tradition of academic excellence and providing a humanistic approach to medical education. We value a balanced approach to fostering personal as well as professional growth among our residents and provide a supportive and nurturing atmosphere for education. We continue to enjoy a collegial relationship with our specialty faculty, providing residents with one-on-one teaching with preceptors.

Later in 2008, we look forward to the implementation of our electronic medical record system at the Family Medicine Center. We are fortunate that we have attracted a very bright group of residents. Two-thirds of our current residents are IU graduates, and the remainder come from out-of-state schools. We are also very proud that our residents have scored extremely high on their in-training Board exams in recent years.

Finally, our residency continues to be extremely well-supported by the hospital administration. When the Beech Grove hospital campus is merged with the Indianapolis campus in 2010, the residency will be given a high-profile centrally located location. We will enjoy an

expanded facility conducive to quality education and patient care and will afford both faculty members and residents easy access for inpatient responsibilities.

St. Francis looks forward to a bright future working collaboratively with other Indiana residency programs and the Department of Family Medicine to further primary care in our state.

St. Vincent Family Medicine Residency Program

St. Vincent Family Medicine Residency Program moved to a new facility at 8414 Naab Road on October 23, 2007, located across the street from the main campus. The new 62,000-square-foot Joshua Max Simon Primary Care Center (PCC) serves the primary care needs of central Indiana.

The FM clinic has grown by adding six additional exam rooms (two with two-way monitoring), three subspecialty procedure suites, patient education rooms and ultrasound and treadmill capabilities. The new PCC also supports a radiology suite, a laboratory and a pharmacy.

Two new full-time faculty members joined the program last summer: Joel Kary, MD, a sports medicine specialist, and Elizabeth Roth, MD, a dual-boarded IM/FM physician who covers inpatient care (a former graduate of our IM/FM residency).

A “Community Diabetes & High Blood Pressure Fair” was led by clinical faculty member Amy LaHood, MD, in January. The highly successful event included booths for smoking cessation, podiatry neuropathy checks and diabetes and nutrition screening. The clinic pharmacists provided drug interaction consultations while others entertained children for parents.

FM residents hold bimonthly classes exposing Crispus Attucks HS students to medical training and health care topics, including teen pregnancy, asthma, STDs and current issues, as a mentoring program.

Union Hospital Family Medicine Residency Program

Our 32 years of excellence in post-graduate family medicine education with a commitment to lifelong learning and collaborative care speak for themselves. We are an unopposed program in a moderately large community hospital with plans for completion of a new hospital facility in 2009. Optional accredited rural and international tracks are offered. Our outpatient facilities include the 12,000-square-foot Family Medicine Center (FMC) in Terre Haute and the 9,000-square-foot rural clinic, the Clay City Center for Family Medicine (CCCFM). The OB curriculum includes an optional C-section track and an operative OB fellowship. We have weekly procedure clinics that encompass endoscopy, colposcopy, dermatological procedures and no-scalpel vasectomies. Centricity, a GE product, is our cutting-edge electronic medical record, now in place for 10 years. Each resident is supplied with a PDA, a laptop

computer and access to a variety of Web sites and programs to enhance his or her learning experience. Conferences at the FMC include topics ranging from pediatrics to geriatrics presented by faculty, residents, psychology interns, nutritionists, physicians assistants, family nurse practitioners, medical students and others. The CCCFM staff members and residents participate via our teleconference system, Polycom.

Community Health Network Indianapolis

Clif Knight, MD, former resident, faculty member and program director of the Family Medicine Residency, began his new position as vice president of Medical and Academic Affairs for Community Hospitals East and North on August 1, 2007. He will continue to work closely with the Residency in a teaching/staffing role as well as maintaining a patient panel of his own.

E. Diana Burttea, MD, began her new position as the program director on December 17, 2007. She served as the interim director with Dr. Knight's departure, and prior to that, filled the role of associate director for the Residency.

After serving as practice administrator for eight years, **Rose Popovich** was chosen by Community Health Network Administration for the newly created position of network director of performance improvement. Rose will be working with the Leadership in Action Program to identify processes that impact patient care and physician satisfaction.

Tina Burch, RN, has assumed the role of program administrator for the Residency. She was formerly the clinical director of nursing for the program, which includes family medicine, the maternity care center and the pediatric care center. She will continue to serve as the interim practice manager until that position is filled.

Congratulations to all of these “movers and shakers” for both their past contributions to the success of our Residency, and their continued support in maintaining a thriving program!

Several residents have welcomed new family members in recent weeks or, as we like to think of them, “early recruits”!

- Hannah Rogers – daughter of first-year resident, Jill Rogers and husband Michael
- Rohan Rajanahalli – son of third-year resident, Suma Kharidi, and husband, second-year resident, Praveen Rajanahalli
- Umair Saifullah – daughter of second-year resident, Mona Saifullah and husband, Akber
- Ella Grace Carpenter – daughter of Amy (third-year resident) and Kevin Carpenter
- Felicity Ann Brelage – daughter of Gloria (first-year resident) and Michael Brelage
- Nicholas Shockley – son of Rachel (faculty) and Randy Shockley

Congratulations to all the moms and dads, and welcome future residents!

INDIANA FAMILY MEDICINE RESIDENTS

The IAFP congratulates first year-residents and interns at Indiana's Family Medicine Residency programs.

BALL MEMORIAL HOSPITAL FAMILY RESIDENCY PROGRAM



David Amrhein, MD
Indiana University School
of Medicine



Jennifer Biggerstaff, MD
Indiana University School
of Medicine



Lisa Clay, MD
University of Illinois
College of Medicine



Brad Goates, MD
University of Utah School
of Medicine



Katherine Mullins, MD
Medical College
of Virginia
Virginia Commonwealth
University



Darren Reed, DO
Kirkville College of
Osteopathic Medicine



Jean Roberts, MD
University of Kentucky
College of Medicine



Adrienne Robertson, MD
University of Alabama
School of Medicine

MEMORIAL HOSPITAL OF SOUTH BEND FAMILY MEDICINE RESIDENCY PROGRAM



Kirk Bodach, MD
Indiana University



Travis Casper, MD
Medical University
of Ohio



Anne Harris, MD
Medical College
of Wisconsin



Megan Johnston, MD
University of
North Dakota



Tricia Kurtz, MD
Indiana University



Emily McDevitt, DO
Nova Southeastern
University



Mandy Sorlie, MD
University of
North Dakota



Bethany Wait, DO
Michigan State University

DEACONESS FAMILY MEDICINE



Alex Alvarez, MD



Philip Broshears, MD



Lindsey Ellerbrook, MD



Lee Ann Gee, MD



Nate Oldham, MD



April Toelle, MD

ST. VINCENT FAMILY MEDICINE RESIDENCY PROGRAM



Christopher "Bo" Cuevas,
MD (IM/FM)
St. George's University



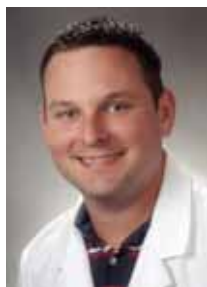
Alina Dean, MD
University of Craiova,
Romania



Jason Everman, DO
Chicago College of
Osteopathic Medicine



Tracey Guildenbecher, MD
Indiana University School
of Medicine



Rodney Guimont, MD
American University
of the Caribbean



Jyoti Gupta, MD
Kasturba Medical College



Andrew Jenkins,
MD (IM/FM)
University of Louisville
School of Medicine



Christine Kelly, MD
Indiana University School
of Medicine



Sunee Snyder,
MD (IM/FM)
Uniformed Services
University of
Health Science



Kristen Stockamp, MD
Loma Linda University
School of Medicine
in California

FORT WAYNE MEDICAL EDUCATION PROGRAM



Rebecca Baker-Palmer, MD
Indiana University School
of Medicine



Aaron Coray, DO
Edward Via Virginia College of
Osteopathic Medicine



George Khalil, MD
University of Texas
Medical School



J. David Kunberger, MD
Ross University School
of Medicine



Mycal Mansfield, MD
Saint George's University
School of Medicine



Henry Mao, MD
Shanghai Railway
Medical University



Matthew McIlff, MD
University of Utah School
of Medicine



Mahnaz Qazi, MD
Allama Iqbal
Medical College



ShaRonda Shaw, DO
Nova Southeastern
University College of
Osteopathic Medicine



Rowena Yu, MD
Cebu Institute
of Medicine

INDIANA UNIVERSITY FAMILY MEDICINE RESIDENCY



Cynthia Ebini, MD, MHA
Ross University School
of Medicine



Saura Fortin, MD
Universidad Nacional
Autonoma de Honduras



Muneeza Khan, MBBS
Karachi Medical and
Dental College, Pakistan



Ban Kinaia, MB, ChB
Al-Mustansiriyah
University, Baghdad, Iraq



Toyosi Morgan, MD,
MPH, MBA
University of Lagos, Nigeria



Angela Myers, MD
Coicgio Mayor de Nuegma
Geñona del Rosaro,
Bogotá, Colombia



Elizabeth Muhiire-Igbanol, MD
Charles University, First
Medical Faculty in Prague



Alisia Munoz, MD
Ross University School
of Medicine



Luis Felipe Romero, MD
Universidad del Valle,
Cali, Colombia



Arturo Salazar, MD
Universidad de
Monterrey, Mexico



Harmmeet Sarao,
MBBS, MPH
Govt. Medical College,
Patiala, India



Amina Syed, MD

Don't Miss Your Next Region Meeting

REGIONAL CHAPTERS OF THE IAFP



IAFP Region Meetings will be underway in April and May, 2008. Joy Newby, coding specialist, will be the featured speaker for the meetings, which are also a great way to take a more active part in your Academy and meet your family physician colleagues.

Region Meetings are held in the evenings on the dates listed below in these cities:

- Thursday, April 17, Southeast (Seymour)
- Wednesday, April 23, East (Richmond)
- Thursday, April 24, Central (Indianapolis)
- Wednesday, April 30, West (Bloomington)
- Tuesday, May 6, West Central (Kokomo)
- Wednesday, May 7, Northwest Region (South Bend)
- Wednesday, May 14, Southwest (Evansville)

**The Northeast Region met in October*

Further details regarding your region's meeting location will be forthcoming.

Don't know your region? Check out the map above. If you have any questions about your region or about an upcoming meeting, please contact Allison Matters at the IAFP Headquarters at 317.237.4237 or by e-mail at amatters@in-afp.org.

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2008 Indiana Legislative Session Report

by Allison Matters, Director of Legislative and District Affairs, and Douglas M. Kinser, JD, Lobbyist

2008 is a “short” session for the Indiana General Assembly. At the time of print (March 14, 2008), the General Assembly had just 24 hours to wrap up the regular session. The bills that are still alive have made it through both houses and are on their way to conference committees. Two hundred seventy-five bills made it to the second half of session — most notably, the property tax reform bill. The property tax bill is exceedingly important to Indiana residents after a tumultuous election cycle where many long-serving mayors were thwarted in surprise upsets.

February 22 was the filing deadline for this year’s legislative candidates to file for election. Many thought the incumbents would be in danger, but interestingly enough, several incumbents chose not to run for re-election. In addition, there has turned out to be little competition in races where incumbents are running for re-election. House Democrats currently have 51 members and only seven have primary opponents. House Republicans currently have 49 members and only 11 have primary opposition. 34 House members have no opposition in the fall. This lack of opposition may have some ultimate affect on property tax reform.

Amidst the short session and political drama, health care issues have taken the back-burner in the Legislature, however, a few bills of note still remain:

Bills Still Alive...

Third-Party Health Service Agreements, Senate Bill 159

The bill says that a contractor may not lease, rent or otherwise grant access to a provider’s health care services under a health care contract. This bill seeks to rid the industry of third-party “aggregators,” who capitalize on selling a physician’s negotiated rate down the line. The bill passed both houses by a large margin and was concurred upon by the original author. The bill was signed by the governor March 13.

Fire-Safe Cigarettes, Senate Bill 28

Establishes reduced ignition propensity standards for cigarettes. At the time of print, this bill had passed both houses and was returned to its house of origin where it was concurred upon by the original author.

Select Joint Commission on Medicaid Oversight, Senate Bill 42

Requires the Select Joint Commission on Medicaid Oversight to determine whether a managed care organization that has contracted with the state to provide Medicaid services has performed the terms of the contract. The bill also extends the expiration of the office of the Secretary and FSSA for two more years. The bill passed both houses, was returned to the Senate and was moved on to the conference committee. At the time of print, the conference committee had met on the bill and a final conference committee report was adopted and returned to the Senate for final action.

Childhood Lead-Poisoning Prevention, Senate Bill 143

This bill was prepared by the interim study committee of the Health Finance Commission. It specifies certain requirements for the division of family resources, child care providers, laboratories, the state department of health, local health departments, residential rental property owners and retail establishments related to childhood lead-poisoning prevention.

It also provides for certain actions by the state department of health for non-compliance with certain provisions and establishes the childhood lead-poisoning prevention fund for outreach and prevention activities. It also establishes a lead-safe housing advisory council to make recommendations related to lead-poisoning prevention. At the time of print, the bill had passed both houses and made its way through conference committee. As of March 14, the bill had yet to pass the Rules Committee to be able to move on for further action.

Dead Bills...

Smoking Ban in Certain Public Places, House Bill 1057

The bill as introduced would have prohibited smoking in: (1) public places; (2) enclosed areas of a place of employment; and (3) certain state vehicles; however, it contained several exemptions, including bars, bowling alleys and casinos. The IAFP worked in conjunction with the Indiana Campaign for Smokefree Air (ICSA) to urge legislators to adopt a comprehensive smokefree air policy free from any exemptions. Rather than being assigned to the committee on Public Health, the bill was assigned to the committee on Public Policy. The ICSA was prepared to provide substantive testimony on the issue; however, the committee snubbed attendees when the chairman cut off the first speaker mid-sentence and adjourned for the year. The ICSA, along with Public Health Chairman Charlie Brown, plan to return to the legislature next year with a comprehensive legislative model for smokefree air.

Warning to Pregnant Women of Tobacco Use, Senate Bill 221

Requires tobacco vending machines and establishments that sell tobacco to post a notice that: (1) states that smoking by pregnant women may result in fetal injury, premature birth and low-birth weight; and (2) provides a phone number for assistance to quit smoking. The bill passed the Senate but died in the House Public Policy Committee as it failed to receive a hearing.

Assignment of Benefits, House Bill 1055

Will require an insurer to comply with a patient’s request to assign his or her reimbursement benefits to an out-of-network health care provider. The bill requires a provider to notify the patient if the provider is an out-of-network provider, and the patient may be billed for amounts not covered by their insurer. If, after notification, the patient still wants those out-of-network services, then it is the patient’s choice to proceed. The bill passed the House by a margin of 60-38; however, efforts to bring it before the Senate were stalled when the insurance and business industries opposed the bill with strong force. The bill is dead this legislative session; however, a resolution requiring further discussion on the issue this summer will likely result.

Electronic Health Records, House Bill 1342

Would have required health care providers to, no later than January 1, 2010, use an electronic health records system for purposes of billing and receipt of claim payment for services rendered by the health provider. This bill was opposed by the IAFP and other members of the health care community, and as a result, the bill died during committee. The bill as written was vastly broad and overly burdensome to most physicians.

Vaccines Containing Mercury, House Bill 1163

Requires that before a person administers a vaccine that contains more than a trace amount of mercury, the person must inform the person who will be vaccinated that there are alternatives to mercury-preserved vaccines. The bill never received a hearing.

Dispensing of Drugs by Pharmacists, Senate Bill 3

Provides that a pharmacist may not be required to dispense or sell a drug or medical device if the drug or medical device would be used to: (1) cause an abortion; or (2) cause the death of a person by means of assisted suicide, euthanasia or mercy killing. The bill made it through the Senate; however, it failed to receive a hearing in the House.


Other Important Happenings

Medicaid Bonuses and Payment

The state's approved bonuses for approximately 5,000 primary care Medicaid providers were distributed in late December 2007. Another round of bonus payments are expected in March or April of this year. The average bonus payment for each Medicaid provider was \$5,600.

In addition to the bonuses, the state enacted a permanent rate increase of 25 percent, or \$32 million annually, for primary care physicians and subspecialists who provide preventive services. The increase has been a long time coming, as primary care physicians have not received an increase in Medicaid payments in more than 14 years. The IAFP and other members of the health care community lobbied hard and worked closely with the administration to implement the changes.

Members of the IAFP Medicaid Advisory Committee (a subcommittee of the IAFP Health and Provider Services Committee) met with Dr. Jeff Wells, MD, Medicaid Director, on February 14 to discuss the bonuses and payment increases as well as other general Medicaid issues. IAFP members conveyed to Dr. Wells that the bonuses and increased payments were appreciated; however, much more is needed to incentivize physicians to participate in the Medicaid program. The IAFP Medicaid Advisory Committee will continue to meet with Dr. Wells on a regular basis to discuss issues facing family physicians.



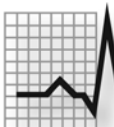
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Definition and History of the Medical Home

The first instance in which the term “medical home” was documented was in a publication of the American Academy of Pediatrics (“AAP”) in 1967. The term appeared in a document published by AAP, and it initially described a centralized location or source for a child’s medical records. The literature provided that children who lacked a medical home and complete health record were at a severe disadvantage in relation to others that had a constant source of care and were likely to have inadequate health supervision. The AAP suggested, “Wherever the child is cared for, the question should be asked, ‘Where is the child’s medical home?’ and any pertinent information should be transmitted to that place.” It was not until 1974 that the medical home concept made it into AAP’s official policy.

Through the years, various groups have adopted and incorporated the concept of the medical home into their own policy. In 1978, the World Health Organization adopted core foundations of the medical home and in the process recognized the importance of primary care in the medical home. Further, in the 1990s, the Institute of Medicine (“IOM”) specifically mentioned the medical home and adopted the concept of primary care fulfilling that void. More recently, the Future of Family Medicine Project has suggested that every American should have a patient-centered medical home (“PCMH”). This suggestion came as the result of a study by the Future of Family Medicine Project in an effort to develop a strategy to change and reinvigorate the discipline of family medicine to meet the needs of patients in an ever-evolving health care environment. The Future of Family Medicine Project calls for every American to have a personal medical home that serves as base at which all individuals will receive “acute, chronic and preventative medical care services.”

National Efforts in Support of the Patient-Centered Medical Home

In addition to simply adopting the concept of the PCMH, various organizations have embraced and implemented action plans to use medical homes to spread access to care and meet the needs of the patient. TransforMED is a national demonstration project focusing on the continuous relationship between an individual and his or her personal physician and the resulting comprehensive and cohesive primary care that is provided. To date, there are 36 sites across the country where physician practices

are facilitated to incorporate continuity of care, quality and safety, team-based care, access to care and increased use of information systems. These sites, which incorporate the medical home concept, have shown increased patient engagement and patient partnership.

Perhaps most notably, four primary care specialty groups joined together in March 2007 to establish the Joint Principles of the Patient-Centered Medical Home. The American Academy of Family Physicians (“AAFP”), the American Academy of Pediatrics (“AAP”), the American College of Physicians (“ACP”) and the American Osteopathic Association (“AOA”), whose combined representation includes more than 333,000 physicians, joined to facilitate a partnership between patients, physicians and the patient’s family. The Joint Principles call for six specific attributes in defining the PCMH and were highlighted in last quarter’s *FrontLine Physician*.

These Joint Principles have been the foundation of a series of collaborative initiatives by various health care industry members: a testament to the current momentum of the movement. The Patient-Centered Primary Care Collaborative (“PCPCC”) is the latest development in advancing the medical home — notably involving groups outside the health care community. The PCPCC is a coalition of employers, consumers, the four primary care organizations mentioned earlier and various other stakeholders. Members of the PCPCC executive committee include such industry leaders as: Aetna, BlueCross BlueShield Association, CVS Caremark, IBM, Merck, Pfizer, UnitedHealthcare and WellPoint, Inc. These groups agree that the patient-centered medical home can be an important step toward rewarding value via a payment system for physicians that invigorates the medical home. The PCPCC notes that compensation under the PCMH model would “incorporate enhanced access and communication, improve coordination of care, rewards for higher value, expand administrative and quality innovations and promote active patient and family involvement.”

The Council of State Governments (“CSG”) adopted the PCPCC’s Joint Principles in a resolution dated November 14, 2007, during its annual State Trends and Leadership Forum. In this resolution, the

CSG also encourages states to implement and fund pilot programs to “demonstrate the quality, safety, value and effectiveness of the patient-centered medical home.” While adoption of a resolution by CSG does not necessarily equate to immediate national policy, the issues that the CSG reviews are often an indication of pressing and timely issues.

Most recently, Congress expressed interest in the issue when it introduced the Medical Homes Act of 2007 in November 2007. The legislation calls for implementation of medical home demonstration projects across the country.

For more information, contact Allison Matters or Missy Lewis at the IAFP Headquarters, 317.237.4237.



THANK YOU!

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

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

FOUNDERS CLUB MEMBERS

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

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Membership Status Totals as of January 31, 2008

Active	1,665
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Total	2,242

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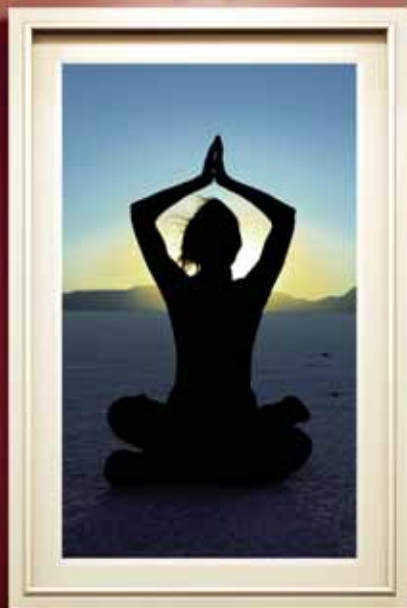
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