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Indianapolis  
Medical Society  
1848

Volume XCVIII • Number 3  
November 2011 • Indianapolis, Indiana

# Bulletin

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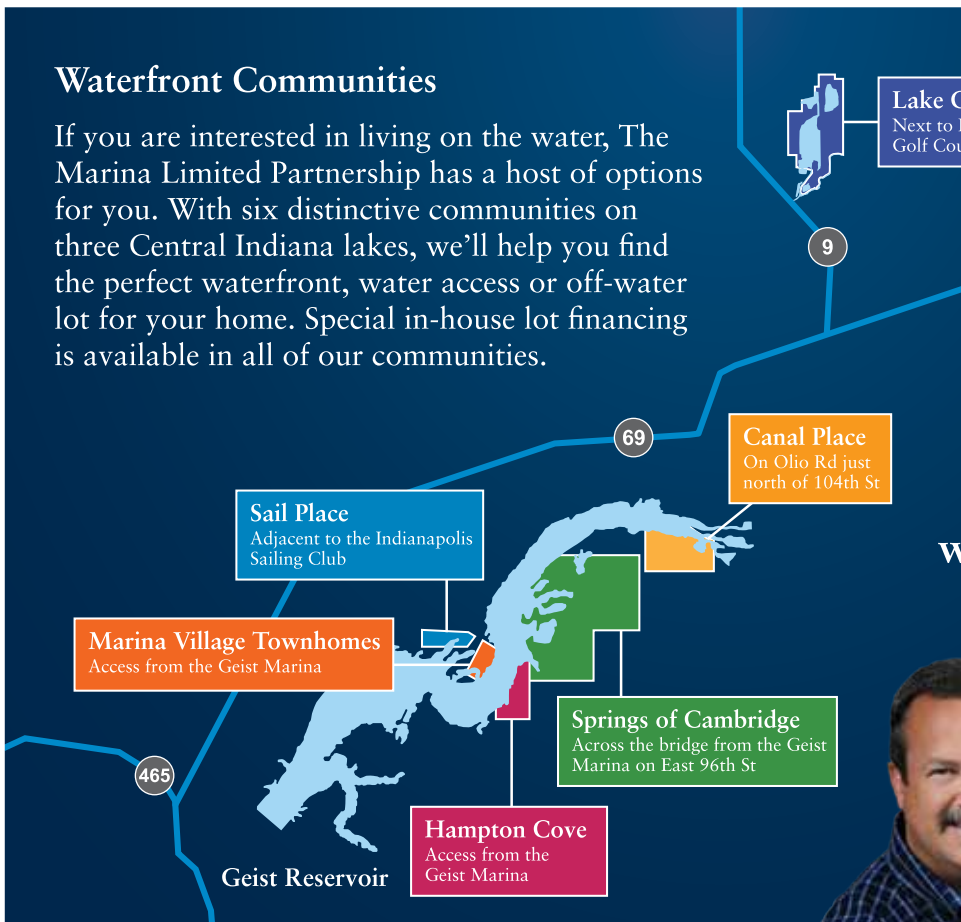
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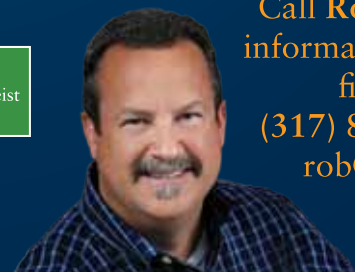
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Vol. XCVIII • Number 3  
November 2011 • Indianapolis

# Bulletin

Official monthly publication of the  
Indianapolis Medical Society  
631 E. New York St.  
Indianapolis, Indiana 46202-3706  
Phone: (317) 639-3406  
Fax: (317) 262-5609  
Web Page: <http://www.imsonline.org>  
E-mail: [ims@imsonline.org](mailto:ims@imsonline.org)

Indianapolis Medical Society President  
Richard H. Rhodes, MD

President-Elect  
Bruce M. Goens, MD

Direct copy for publication and inquiries regarding advertising to:

Executive Vice President and  
Editor, *The IMS Bulletin*  
Beverly Hurt

Associate Editor, *The IMS Bulletin*  
Marcia K. Hadley

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We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin*. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, [bhurt@imsonline.org](mailto:bhurt@imsonline.org).

*The Bulletin* is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

Remember the *Indianapolis Medical Society Foundation* when planning your will. (Contribution form included in this issue.) Unless otherwise specified, your contribution will be directed toward medical scholarships.

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## about our cover



On our cover: Enjoy the harvest of our bounty ... Happy Thanksgiving!

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## Grand Opening Celebration

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**Date:** November 19, 2011 | Saturday

**Time:** 2:00 p.m. – 5:00 p.m.

**Place:** 13225 N. Meridian Street | Carmel, IN 46032  
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SACRUM



## *Medication Reconciliation: More Than Just a List*

Martin is a middle aged overweight male with a history of hypertension, hypercholesterolemia, CAD and type II diabetes. A couple of months ago, Martin stopped taking his blood pressure pills which included Atenolol, because he didn't feel any better on them than off them and didn't like feeling tired all the time. Following an episode of shortness of breath resulting in a brief hospitalization, Martin is about to be discharged from his community hospital with a new diagnosis of heart failure. During the hospitalization, his Metformin was held due to contrast dye exposure. Upon discharge, the nurse reviewed his medication discharge instructions. These included directions to continue the medications prescribed in the hospital along with a new prescription for Carvedilol. Since the Metformin was held, this was unintentionally omitted from his new home medication list. Martin didn't give his medication list much thought and had his new prescription filled at a pharmacy that was not his usual pharmacy. Upon his follow-up visit to his primary care physician two weeks after discharge it is discovered his blood sugar is elevated and that he is exhibiting bradycardia resulting from failure to re-start his Metformin and duplication of his Atenolol and Carvedilol.

Martin's story contains real elements from past patient encounters. We each have our own story of patients who had medication "misadventures" due to gaps in communication. Despite the recurrence of medication duplications, omissions, and incorrect dosages, it is still noted that one of the basic tasks of gathering, reconciling, and communicating a list of medications continues to have gaps resulting in potential patient harm. In fact, numerous case reports have been published demonstrating a high incidence of adverse events occur during transitions of care. In a recently published study, more than 40% of medication errors are believed to result from inadequate reconciliation during admission, transfer, and discharge; 20% of these result in harm to the patient. In addition, variances between the medications patients were taking prior to admission and their admission orders ranged from 30% to 70% in two literature reviews. While great strides have been made to expand the dialogue around the importance of improving the medication reconciliation process, much work remains.

Medication reconciliation is not, by any means, a new term. Doctors, nurses, and pharmacists in all settings have been familiar with the process of taking medication histories for decades. Most health care professionals would unanimously agree that the significance of medication reconciliation from a patient safety standpoint and from an accreditation standpoint is not a topic of debate. Nevertheless, Nickerson and colleagues in 2005 found that of the medication history discrepancies they identified, 83% had the potential for harm. Through the efforts of groups such as the Institute of Safe Medication Practices (ISMP) and the Institute of Health Care Improvement (IHI), the medication reconciliation process has been edited and refined in order to prevent these harmful medication errors.

Furthermore, Vira and colleagues reported that a successful medication reconciliation process can prevent the potential for harm in 75% of cases. Now, with the reinforcement of a National Patient Safety Goal by The Joint Commission, hospital and ambulatory settings are working to find the medication reconciliation process that works for them.

While there were a myriad of people involved in recording Martin's medication histories, and evaluating his "list of medications" it is easy to forget that the person central to the reconciliation process is Martin himself. Although Martin's contribution to providing accurate and concise medication information may be compromised by literacy level, lack of knowledge, or just a general belief that his doctors know best, he or a family member are key liaisons to bridge the communication gap between his healthcare providers. In fact, it is often the patient, caregiver, or family member that can mention a medication change prompting a healthcare professional to search further for the correct information. Medication reconciliation is also a great opportunity to educate, coach, and motivate the patient. Some interventions with Martin include emphasizing the importance of keeping an up-to-date medication list and educating him that compliance with medications may prevent more costly hospital readmissions. This would also be the time to review indications for medications, side effects, drug interactions and appropriate life-style changes to enhance his overall health. In addition, just looking at a list of medications doesn't translate to determining exactly how a patient actually takes (or doesn't take) their medication.

Complete and accurate medication reconciliation is a team effort. No single health care provider is the sole owner of this process. Developing a practitioner role summary can be helpful in enhancing the collection, assessment and communication of medication information for our patients. While nursing has historically played a central role in hospital and clinical settings to provide education to patients and obtain medication histories, they are not the owner. Nurses are the healthcare providers most often responsible for administering medications and providing instructions to patients upon discharge from healthcare facilities. Pharmacists can provide a confirmation of patient adherence with a medication regimen. A quick call to a patients' community pharmacy can determine timely refill practices. Furthermore, pharmacists are aware that the term "medication" for many patients extends beyond prescription medications to over-the-counter medications, herbals, vitamins, nutritional supplements and vaccines. The myriad of drug names and common confusion of brand/generic names can lead to duplication of therapy. Physicians are ultimately responsible for the "reconciliation" or final review of determining which medications should be continued, modified or discontinued based on their patient assessment. Healthcare accreditation organizations such as The Joint Commission have challenged orders such as "Continue meds as from home" or "Discharge  
*Continued on page 30.*

# Past President's Perspective



## *Dense Boobs & Dogged Determination*

*Paula A Hall, MD*

It is late in the day and I have been seeing the regular routine of patients. I am sure I am not alone when I admit that I sort of have a “patter” that I give the patient. Perhaps not quite like the carnival hawker trying to get paying customers into the tent, but it is a sales pitch. I can assure you that ambivalence does not get a lot of asymptomatic patients to sign up for screening colonoscopies. While I am pitching the idea of a day of fasting, a sleepless night of very urgent diarrhea, followed by a garden hose with a small camera being inserted in their hind end, I also take a complete history. Since I spent years at IUMC teaching the History and Physical course to eager and innocent sophomore medical students, I have stayed true to my admonishment “You should always take the same complete history; so, you will never have to wonder when the nurses are calling you, in the middle of the night, about a patient, if you asked whether the patient has, for instance, new onset of chest pain.” So, part of my history asks the female patients whether they have had their mammogram. When I get an equivocal answer or a no, I stop and give them a spiel on why we women need to get mammograms. I think I am reasonably convincing and usually the patients cave and agree to let us facilitate the appointment.

Well, I had a really recalcitrant patient in the office the other day. She arrived on my doorstep because for the last two years she had noticed a significant change in her bowel habit. Now I would be remiss, if, I did not mention that she told me her family doctor had been trying to get her to see me for several years. Regardless, I am busy taking my history, and lo and behold, in addition to not having a screening colonoscopy when recommended, she has been refusing mammograms as well. Did I mention that my history had also uncovered that her sister had breast cancer? So, I explain, if we crammed six other women in my tiny exam room that one of us in our lifetime will, unfortunately, become familiar with the nuances of lumpectomies versus mastectomies not to mention radiation and chemo. Still, my patient stubbornly stands her ground and rejects outright even the possibility of getting a mammogram. This, of course, stimulates my competitive nature, as well as, my maternal instincts and like a mother with teenagers, I dig in and commit for the long haul. I ask, “Why, with your sister having had breast cancer would you take such a chance?” After a little give and take, I determined that the reason this high risk woman was refusing a mammogram was because she found them painful. Now, I am with her on that evaluation of the procedure. I have been told that I have “dense breasts.” Some might see this as an asset or at the very least not an issue, but believe me when it comes to mammograms **dense is not good!** It means they

are going to “pancake your boobs” even more than usual to get a sufficient exam. So, I explain that the machines are better, and it doesn’t require as much squeezing, but she still refuses to even consider the possibility of getting a mammogram.

As an aside, I will say that by now most patients and particularly my children would have acquiesced and at least pretended that they were going to follow my sage advice. But this was one tough nut to crack. So, I switched tactics and suggested that she consider an ultrasound. “Oh No” she tells me she could not possibly have one of those because “Medicare won’t pay for it.” I quickly explained, she could get an ultrasound; she would just have to pay for it out of her own pocket. Well, you would have thought I was asking her to cut off her right arm. She had no intention of paying for it out of pocket. She was just not going to get one. We went back and forth a little more and my parting salvo was if she thought paying for an ultrasound was expensive, she should consider her 20% portion that Medicare will not cover if she does get breast cancer.

So I have finally arrived at the point of this article. I am not writing to tell you about my dense boobs or my dogged determination; rather, my frustration with a system that is broken. As the politicians continue to play games with healthcare, I ask the question, “Why can’t we fix some simple things that are obviously wrong with healthcare?” I don’t deny that this lady has the right to refuse to get a mammogram. But why, if she does get breast cancer, does the taxpayer have to pay for her more expensive care because she did not want to catch the disease in its early stage when it is cheaper to treat? We are talking serious money here! Shouldn’t we hold patients accountable for their choices? If she does not want a mammogram, so be it. But shouldn’t we as taxpayers ask her to accept the financial responsibility for making this choice? Have her sign a contract with Medicare that she will assume all costs of care related to breast cancer, if she were to be so unlucky as to contract it. At some point, patients are going to have to accept more responsibility for their poor decisions. Employers are starting to get the message and they are discounting the insurance premiums for patients who are making healthy choices. Shouldn’t we, as the people paying the bill for Medicare, start asking those people enjoying the benefits of the program to quit doing stupid things that cost all of us lots more money? I know we live in America and I do believe in choice. But I think that patients knowingly making bad choices should not expect the taxpayer to continue to pay for their folly. Hello Washington? Are you listening? This could save us good money and maybe even encourage people to get healthier.

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# Bulletin Board

After receiving a new kidney, a local woman paired with her transplant physician to write a book aimed at helping others with or at risk for chronic kidney disease (CKD). The book, "Kidney Steps," written by Vicki Hulett and her daughter and donor, Jennifer Waybright, and edited by Indiana University Health transplant nephrologist **Tim E. Taber, MD**, aims to help patients like Hulett avoid chronic kidney disease or slow its progression by reducing diabetes risk and high blood pressure, two leading causes of CKD.

Dr. Taber is the medical director for IU Health's kidney transplant program, the state's largest program of its kind.

**Jared R. Brosch, MD**, neurology resident at IU, authored the paper "American Childhood Football as a Possible Risk Factor for Cerebral Infarction," published in the *Journal of Child Neurology*, October 2011.

**Edward J. Kowlowitz, MD**, owner and medical director of the Center for Pain Management in Indianapolis, recently challenged a regional Medicare reimbursement policy and, surprisingly, won. Dr. Kowlowitz spoke with the *IBJ* (the article appearing as a Q & A on September 26, 2011) about the experience, as well how his three-physician practice is growing even while many physician practices are selling to hospitals.

**Bridget M. Sanders, MD**, a member of St. Francis Medical Group, has been elected to membership into the Indiana chapter of the Alpha Omega Alpha Honor Medical Society.

A colorectal cancer surgeon with Kendrick Colon and Rectal Center, Dr. Sanders will be inducted into the group at a ceremony and banquet at the Indiana University Purdue University Indianapolis next spring. She was nominated by members of the Indiana chapter.

Dr. Sanders joined the Kendrick practice in 2005. She specializes in the treatment of pelvic floor disorders, as well as laparoscopic colon and rectal surgery. She treats patients at Franciscan St. Francis Health hospitals in Indianapolis, Beech Grove and Mooresville.

Certified by the American Board of Surgery and the American Board of Colon and Rectal Surgery, she is a Fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

Dr. Sanders earned her medical degree at the IU School of Medicine where she later completed a surgical residency. Following the residency, she completed a colon and rectal surgery fellowship at Cleveland Clinic before joining Kendrick.

Franciscan St. Francis Health presented an arthritis and hip and knee replacement seminar at Wednesday, October 26, at the Primo West, 2353 E. Perry Road, Plainfield.

**Robert A. Malinzak, MD**, explained the latest procedures in joint replacement and arthritis treatments. He is a board-certified orthopedic surgeon specializing in adult reconstructive surgery and joint replacement.

Dr. Malinzak is a surgeon with Joint Replacement Surgeons, a practice group affiliated with the Center for Hip & Knee Surgery at Franciscan St. Francis Health—Mooresville.

**Jeffrey A. Greenberg, MD**, Indiana Hand to Shoulder Center, was involved in multiple presentations over the summer including:



Jared R. Brosch, MD



Jeffrey A. Greenberg, MD



Tod C. Huntley, MD



Edward J. Kowlowitz, MD



Robert A. Malinzak, MD



Bridget M. Sanders, MD



Rick C. Sasso, MD



Tim E. Taber, MD

Evolution of the Distal Radio-Ulnar Joint, Treatment of Distal Biceps Rupture, Treatment of Distal Radio-Ulnar Joint Arthritis and Salvage of Failed Treatments at the Montana Hand Society Meeting, Billings, Montana, June 9-12, 2011.

Chairman, Precourse 9: A Practical Approach to Ulnar Sided Wrist Pain, "Subcondylar Osteotomy for Ulnar Impaction" - presentation, American Society for Surgery of the Hand, 66th Annual Meeting, September 8, 2011

Treatment of Distal Radius Fractures, American Society for Surgery of the Hand, 66th Annual Meeting, Stryker Orthopedics Presentation, September 7, 2011

Distal Metaphyseal Ulnar Shortening Osteotomy Paper presented at paper session American Society for Surgery of the Hand, 66th Annual Meeting, September 10, 2011

**Rick C. Sasso, MD**, Indiana Spine Group, was the first author in a book chapter published in the recently released textbook, *Advanced Reconstruction: Spine*. Dr. Sasso's invited chapter is "Cervical Arthroplasty." The book is published by the American Academy of Orthopedic Surgeons in conjunction with the North American Spine Society.

Dr. Sasso was also the visiting professor at the Mayo Clinic in Rochester, Minnesota. Dr. Sasso gave grand rounds to the neurosurgery and orthopedic surgery residents on September 12, 2011. His invited lecture was "Cervical radiculopathy – surgical options including the role of arthroplasty: FDA IDE status."

**Tod C. Huntley, MD**, Center for Ear nose Throat & Allergy PC (CENTA), was interviewed for treatment advice for obstructive sleep apnea for the article "Sleepless in Nevada" in the September/October issue of the *Saturday Evening Post*.

## Take Your Best Shot

### The 2012 IMS Bulletin Cover Contest

Beginning with the New Year, the IMS wants your photographs for use on the covers of the IMS Bulletin, on the web and in other publications.

Take Your Best Shot contest will be judged by professional photographers from the Indianapolis area.

Prizes and a gallery show will be given at the end of 2012!

To enter send your digital photos (300 dpi, color, 8 x 10") to [ims@imsonline.org](mailto:ims@imsonline.org)

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8051 S. Emerson Ave., #450  
46237-8633  
Ofc – 859-3259\*  
Fax – 859-3265  
Plastic Surgery, 2008  
Indiana University, 2001



Kelly, Timothy Joseph, MD  
(Reactivation)  
Fairbanks Hospital  
8102 Clearvista Pkwy.  
46256-4698  
Ofc – 572-9319

Internal Medicine, 1982  
Addiction Medicine  
Indiana University, 1979

Knauss, Nicolas C., DO  
Resident – St. Vincent Hospital  
Internal Medicine  
Chicago College of Osteopathic  
Medicine, 2011



Linton, David P., DO  
Advanced OB/GYN of Indiana  
10122 E. 10th St., #230  
46229-2601  
Ofc – 355-9220\*  
Fax – 355-9230

Web – [www.advancedobgynindy.com](http://www.advancedobgynindy.com)  
Obstetrics & Gynecology  
Texas College of Osteopathic  
Medicine, 2004

Watson, Christopher N., MD  
Resident – I.U. School of Medicine  
Radiation Oncology  
Indiana University, 2007



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Aaron Cohen-Gadol, MD  
Jeffrey Crecelius, MD  
Henry Feuer, MD  
Daniel Fulkerson, MD  
Randy Gehring, MD  
Peter Gianaris, MD  
Eric Horn, MD, PhD  
Steven James, MD  
Saad Khairi, MD  
Thomas Leipzig, MD  
Shannon McCanna, MD  
James Miller, MD  
Jean-Pierre Mobasser, MD  
Paul Nelson, MD  
Troy Payner, MD  
Eric Potts, MD  
Michael Pritz, MD, PhD  
Richard B. Rodgers, MD  
Carl Sartorius, MD  
Mitesh Shah, MD, FACS  
Scott Shapiro, MD, FACS  
W. James Thoman, MD  
Michael Turner, MD  
Thomas Witt, MD  
Robert Worth MD, PhD  
Ronald Young, MD

## Pediatric Neurosurgeons

Laurie Ackerman, MD  
Joel Boaz, MD  
Daniel Fulkerson, MD  
Jodi Smith, PhD, MD  
Michael Turner, MD  
Ronald Young, MD

## Interventional Neuroradiology

Andrew DeNardo, MD  
John Scott, MD

## Physical Medicine and Rehabilitation

Amy Leland, MD  
Nancy Lipson, MD

## Interventional Pain Management

Christopher Doran, MD  
Anthony Sabatino, MD, FIPP  
Jose Vitto, MD  
Derron Wilson, MD

## Neuropsychology

Donald Layton, PhD

# 2011 Inaugural

— Photography by Debbie Winchester



Dr. Jeffrey J. Kellams, IMS Immediate Past President, presided over the “formal” installation of Dr. Richard H. Rhodes as the 2011-12 IMS President. This basic IMS Inaugural occurred on Tuesday, October 4th, in conjunction with the regularly-scheduled IMS Board of Directors’ Meeting.

The Otis R. Bowen Community Service Award was presented to Dr. Margaret J. Blythe, for her efforts in establishing a network of adolescent clinics with the Indianapolis community, as well as numerous other activities associated with identifying barriers and providing access to care for underserved teens and their families. Dr. Blythe was nominated by Dr. Theresa Rohr-Kirchgraber.



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William H. Dick, MD

## Speaker: Dr. William H. Dick – Aspirin: The First Wonder Drug



Ancient Ur

This story dates back to 5,000 B.C. when willow bark was mentioned on a tablet in present day Iraq. Willow was noted for its ability to reduce pain. The substance that the Sumerians recovered from the willow bark and tree was salicylic acid. Later the Egyptians, Greeks and Romans all knew about the substance. The name “aspirin” did not appear until late in the nineteenth century when Bayer scientists named it for “A” – acetyl chloride; “spir” – plant species *Spirea ulmaria*; and “in” – a popular ending name for medications at that time. In 1854, a British Museum archeologist, J.E. Taylor, found the ancient city of Ur in southern Mesopotamia. The above-mentioned clay tablet was found in the ruins of Ur.

Edwin Smith was the first American to live in Egypt, settling in Luxor (Thebes) in 1862. His landlord sold to Smith some old papyrus rolls, which had been found by grave robbers. The texts were produced in 1354 B.C. and were copies of an earlier work which was a thousand years older.



Edwin Smith Papyrus

One papyrus is the Edwin Smith Surgical Papyrus, which now resides at the New York Historical Society. The other papyrus is the Ebers Papyrus. It was given to Leiden University by Georg Ebers, a German professor of Egyptology in Germany.

The first papyrus described 48 surgical cases, including trauma, along with their diagnoses and treatments. The second papyrus is 110 pages long, making it the longest Egyptian medical papyrus ever recovered. It dealt with internal medicine, diagnosis of pregnancy, contraception, eye conditions, heart disease, depression and dementia.

In England, Rev. Edward Stone worked on willow bark and made some observations. He noted that a substance from the tree helped reduce the fever from victims of the ague (malaria). His local Lord, George, Earl of Macclesfield submitted Stone's work to the Royal Society of London in 1863. Other people added to the research: Raffaele Pirea (1838) in Italy and Johann Pagenstecher in Switzerland, both produced salicylic acid. In 1853, Charles Gerhardt of Strasbourg discovered the basic structure of aspirin – a six-carbon benzene ring with a hydroxyl group (OH) and a carboxyl group (COOH).

Working on coal-tar products, Friedlieb Ferdinand Runge of Germany and William Henry Purkin of England, were the first to experiment on organic dyes in the 1850's. Purkin

went on to become the father of the new Organic Chemistry industry. Friedrich Bayer and Johann Friedrich Weskott merged companies in 1863 and produced various dyes. In the 1880's Bayer hired Carl Duisberg who took the company to a higher level.



Bayer Aspirin Powder

Duisberg, working for Bayer, later hired Heinrich Dreser, Felix Hofmann and Arthur Eichengrun – the trio responsible for producing acetylsalicylic acid (ASA) in 1899. The brand name was aspirin.

Aspirin aided in the treatment of fevers, arthritis, headaches, tonsillitis, toothaches, the common cold and in 1918-19, muscles aches and fever from influenza. Due to the WW I conflict, Bayer lost all of its U.S. patents. Miles Labs in Elkhart, IN produced Alka-Seltzer to great success. Due to TV advertising, painkillers increased in number and sales in the 1950's. Acetaminophen (Tylenol) was released in 1955. Ibuprofen was discovered in 1962 and was marketed in 1974 as Motrin by Upjohn. In 1984, Advil and Nuprin, entered the market.

In 1950, Dr. Lawrence Craven of Glendale, CA published his observations on the cardiac effect of ASA. He noted that his male patients who took aspirin had fewer heart attacks. Though his work lacked scientific proof, he was later vindicated when in 1985, the U.S. Secretary of Health advised cardiac patients to take ASA to prevent second heart attacks.



Bayer Aspirin Tablets

Ibuprofen has 20 times the anti-inflammatory effect of aspirin, 16 times the analgesic effect and 10-20 times the antipyretic power. In 1971, John Vane and Priscilla Parker in England published in *Nature* their findings of ASA's mode of action: it blocked prostaglandins. Vane won the Nobel Prize in 1982 for his discovery of prostacyclin.

Aspirin had lost its competitive edge to acetaminophen, ibuprofen and the other non-steroidal medications. It survived, however, due to its use as a preventative against coronary thrombosis and stroke. Later the anti-tumor effect was seen, especially in colon cancer. Uses were also found in prevention of dementia, the rate of pre-eclampsia and in other cancers, including breast, lung, prostate and esophageal types.

Bayer AG recovered its rights to the “Bayer” name in the U.S. in 1994. It bought Cutter Labs in 1974 and Miles Labs in 1978. Drugs such as Adalat, a cardiovascular medication and Cipro, a superb antibiotic with many uses, had been released. In 1999, Bayer celebrated the 100<sup>th</sup> anniversary of aspirin. Today, it has over 100,000 worldwide employees. Bayer began as a coal-tar company and went on to market one of the most amazing compounds in history: aspirin.

IMS



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## *Sell your practice? To an insurance company? Why not!*

We all understand the traditional ways to sell your practice:

- Hospital sale
- Company buy-out
- Partnership buy-in buy-out

These are the normal analytics for a sale. Now I'm talking about selling your practice to an insurance company...a carrier!

All of us have been reading about the buying of practices (all practices not just primary care) by United Healthcare, Anthem Blue Cross Blue Shield, Cigna, etc. United's Optum health-services unit includes 2,300 physicians in a range of specialties. Optum Chief Executive Larry Renfro said his company "shares Monarch HealthCare's commitment to bringing patients, physicians, hospitals and health care payers closer together in the mission to increase the quality and affordability of care." They are pursuing these buy-outs aggressively. I have interviewed and met with all the above and let's look at some of the advantages of a sale to an insurance carrier:

1) They truly get an appraisal and look at fair market value. Carriers don't guess...they hire the best appraisers and get fair market value.

2) They have money. They have cash. There is no stock play, no (typically) deferred compensation payment over a decade of time. Cash at closing. No headaches. Long-term strategies. Cash!

3) After closing they leave the practice generally alone. They don't try to change the world. They know what made you successful and want to keep it that way.

4) They employ the seller typically for three to five years and under a blend of productivity and equal distribution. You are guaranteed payment as opposed to traditional buy-outs where it is truly *eat what you kill or nothing*.

5) Most carriers, insurance companies know how to run a business and make a profit. The old adage applies...business is business. If you want a friend ... buy a dog.

What are the down sides of selling to an insurance company or carrier:

1) Future anti-trust issues. Could the government put a stop to these acquisitions? Do we pay taxes? Sure they can.

2) Will this shut down hospitals or worse will the carriers start buying hospitals and totally control health care? Possibly.

3) Will they use this as a bridge to change tax structure reducing our ability to use the proceeds as capital gains treatment? Maybe.

4) Will they close panel your practice so you are only seeing the insurance company's employees or select patients? Highly probable.

5) Will this be a means to an end where finally the insurance companies own and control all? Likely.

Let's evaluate your real worry about any of the above five points:

Why do you care? You care because of one commodity...the patient. However, in the real world the patient could possibly be better taken care of financially and medical care wise by the insurance carriers. Aren't we moving towards "big brother" controlling all anyway?

I think in today's market and with the economy in the tank, we need to look at non-traditional ways to buy-out physician practices and instead of just locking the door and transfer records, a viable way in which we can sell our practices for real fair market value and go to retirement with something.

I receive phone calls every day from physicians who are now ready to sell (at age 70) and have had no planning for succession so their volume is in decline, they have no ideas of value but want out in three months. This does not compute... it can't compute. They might as well lock the door. You need to plan and control your own destiny.

I would personally recommend selling to an insurance carrier. They have cash. They sign employment agreements that are reasonable. They have market. Let them have the total market but make sure you do the following:

1) Get your own appraisal. Determine your fair market value.

2) Prepare for retirement five years in advance.

3) You be the aggressor. Contact the carriers yourself.

4) Know what you want. From A-Z determine it from employment agreement to closing sale.

5) Engage the right people to make it happen (attorney, accountant, and consultant).

In today's real health care world a physician needs to be aware of all traditional and non-traditional ways to sell their practices. We still have the tried and true old method of a young doctor coming into a practice for a couple of years as an employee then buying into the practice and eventually buying you out of the practice the traditional way. Now we have the insurance carriers buying practices and controlling health care the non-traditional way.

I believe in this nuance in the market. It is worth seeing if it works and not just looking through rose colored glasses.

Realize these people have money, the market, intelligence and most important, the business savvy to make it work. What do you feel? Are you selling out to your enemy...the pirates of health care ... Okay, a pirate's life for me!

*Michael D. Brown, CHBC, President  
Health Care Economics  
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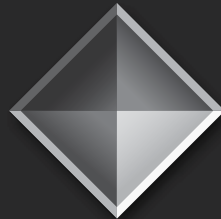
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# CME & Conferences

## Community Health Network

### Community Hospital East

First  
Wednesday Critical Care Conference  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Second  
Wednesday Medical Grand Rounds  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Third  
Wednesday Neuro Grand Rounds  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.  
Months of January, March, May, July, September, November

### Community Hospital South

Fourth  
Thursday Medical Grand Rounds  
Conf. Rooms A & B, 7:30 - 8:30 a.m.

### Community Hospital North

First  
Wednesday Pediatric Grand Rounds  
Multi Services Rooms 1, 2 and 3  
7250 Clearvista Dr. 7:30 - 8:30 a.m.

First  
Friday North Forum  
Reilly Board Room; 12:00 - 1:00 p.m.

### Community Heart & Vascular/ Indiana Heart Hospital

First  
Wednesday Disease Management Conference:  
rotates CHF & EP Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

Third  
Wednesday Ken Stanley CV Conference  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

Fourth  
Wednesday Imaging Conference:  
rotates Cath & Echo Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

## Cancer Conferences 2011

### Community Hospital East:

First  
Tuesday East General Cancer Conference  
Medical Staff Conf. Room, 12:00 to 1:00 p.m.

Second  
Wednesday East Chest Cancer Conference  
Cancer Registry Conf. Room, LL 22,  
7:00 to 8:00 a.m.

### Community Hospital North

First & Third  
Tuesday North Multidisciplinary Breast Conference  
8040 Clearvista Parkway, Suite 500, 7:00 - 8:00 a.m.

Third  
Wednesday North General Cancer Conference  
Reilly Board Room, 12:00 to 1:00 p.m.

Fourth  
Wednesday North Chest Cancer Conference  
Reilly Board Room, 7:00 to 8:00 a.m.

### Community Hospital South

Second  
Monday South Chest Conference (site specific-lung)  
Education Center Rooms 5&6, 7:00 - 8:00 a.m.

First  
Wednesday South Multidisciplinary  
Breast Cancer Conference  
Community Breast Care Center South,  
533 E. County Line Rd., Ste. 101, 8:00 - 9:00 a.m.

Third  
Wednesday South General Cancer Conference  
President's Board Room, 12:00 to 1:00 p.m.

### North Cancer Pavilion

Third  
Wednesday Melanoma Cancer Conference  
CHN Cancer Pavilion Conf. Rm., 7:30 to 8:30 a.m.

For more information, contact Valerie Brown, (317) 355-5381.

## Indiana University School of Medicine/ Indiana University Health

### IU – Methodist – Riley

Nov. 9 Improving COPD Management  
in the Primary Care Setting in Indiana  
Terre Haute, Indiana

### 2012

May 4 15th Annual IU Gastroenterology/Hepatology Update  
University Place Conference Center, Indianapolis

July 20 Review and Interpretation of the 2012 ASCO Meeting  
University Place Conference Center, Indianapolis

Course dates and locations are subject to change. For more information, please visit <http://cme.medicine.iu.edu> or call 317-274-0104.

The Indiana University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

We have more than 100 recurring meetings available. For a listing or more information, please visit <http://cme.medicine.iu.edu> or call 317-274-0104.

## St. Vincent Hospital and Health Care Center Inc.

Nov. 11 & 12 Back Talk: A Comprehensive Review and  
Practical Approach to Spinal Diagnosis and  
Treatment, 11.75 Credits  
Renaissance Hotel, Carmel  
Call (317) 228-7000 for more information

## JWM Neurology

Saturday, March 10, 2012

“Neurology Connection 2012” Seminar for Physicians

This half-day course covers 9 topics relative to neurologic conditions and sleep disorders. For more information contact JWM Neurology at 317-308-2828 ext., 1604.

## Academy of Medicine of Cincinnati

30th Annual Winter Conference  
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## CME & Events

### Indiana Spine Group

**Back Talk: A Comprehensive Review and Practical Approach to Spinal Diagnosis and Treatment**

**November 11 – 12, 2011**

Renaissance Hotel, Medical Academic Center, Carmel, Indiana

Indiana Spine Group is hosting their fifth annual spine symposium. This symposium is for primary care physicians and health care practitioners, and will provide the latest information for the diagnosis and treatment of your patients with spinal problems and abnormalities. New this year are clinical workshops on Saturday. Visit <http://indianspinegroup.com/backtalk/2011/backtalk.html>

To receive conference announcements and a brochure, please send your email and mailing address to [info@indianspinegroup.com](mailto:info@indianspinegroup.com) or call (317) 228-7000.

This activity has been approved for AMA PRA Category 1 Credit. This activity has been reviewed and is acceptable for up to 11.75 Prescribed credits by the American Academy of Family Physicians.

#### Grand Opening – Carmel Facility

Please join Indiana Spine Group, as they celebrate the grand opening of Indiana Spine Group's new Carmel facility. This celebration will include tours, health information, food and giveaways.

**November 19, 2011, Saturday, 2:00 p.m. – 5:00 p.m.**

13225 N. Meridian Street, Carmel, Indiana

New Carmel facility includes:

- Patient diagnostics and treatment,
- Physical therapy,
- Imaging Center,
- North Meridian Surgery Center,
- Medical Academic Center,
- Café, and more.

For more information, call (317) 228-7000 or send an email inquiry to [info@indianspinegroup.com](mailto:info@indianspinegroup.com).

### Indianapolis Medical Society

#### November

- 6 ISMA Board of Trustees, 9:00 AM, state headquarters
- 6 IMS Advisory Breakfast, 7:30 AM ...prior to ISMA BOT
- 12-15 AMA Interim, New Orleans, LA
- 15 Executive Committee, Society, 6:00 PM, Sandwiches

#### December

- 6 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
- 14 Senior/Inactive Luncheon Meeting, Noon, Society, Guest speaker: Jeff Rasley, J.D., I.U. School of Law, Columbia, Theological Seminar, Master of Divinity "Philanthro-Trekking the Nepal Himalayas"
- 20 Executive Committee Dinner, with Spouses/Guests

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  - Congenital disorders
  - Spinal cord stimulation
  - Workers' compensation

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When acute disorders require more aggressive approaches, or when recovery is extended and threatens to become chronic, The Spine Institute stands as a partner to physicians in providing specialized spine evaluations, surgical opinions and rehabilitation. Continuity of care is the goal of our practice and patients are returned to referring physicians with timely reports and full documentation.

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# Project Health



Carrie Jackson Logsdon, Director

## Project Health Has a Time-Saver for You!

If you have uninsured Marion County patients who are reluctant to take the tests you order, fill their prescriptions, go see another specialist or consent for surgery – **PROJECT HEALTH CAN HELP**. Project Health now includes more than 1,000 physicians, as well as, Community Hospitals, IU Health (IU and Methodist), and St. Vincent Hospitals, the Indiana Heart Hospital, the St. Vincent Heart Center, St. Vincent Women’s Hospital, Mid-America Clinical Labs, Ameripath, and IU Health Laboratories that have donated their services. Successful procedures have included everything from simple cataract removals to open heart surgery, brain surgery, and cancer surgery followed by chemotherapy and radiation. More than \$18.5 million in care has been donated.

Project Health can provide this to YOUR uninsured patients too! Simply fax a referral sheet, which you can find on the website, [www.imsonline.org](http://www.imsonline.org) and click on Project Health. Scroll down to below the Donate Now button, and you download the referral form. Project Health takes those patients who aren’t eligible for any other healthcare program – those people who are truly the working poor. Project Health patients must earn more than \$21,770 or more a year, be non-pregnant adults, and live in Marion County. When in doubt, just fax a referral form, and Project Health staff will assist them. The case managers also assess for other social service needs. If the patient does not speak English, Project Health provides interpreters.

Project Health does all of the eligibility screening, requiring tax forms or pay-check stubs, a copy of their driver’s license or a bill sent to them to establish residency. Patients must sign a pledge form in which they agree to have a family doctor or clinic that they use for most problems, not to use the Emergency Department for primary care, and show up for appointments on time. They are dropped

from Project Health, if they violate these rules. In fact, the ED utilization rate dropped from 74% in the first year to less than 1% all subsequent years. Last year, **only one patient** improperly used the ED. Most are so sick by the time they find Project Health that they don’t dare break

the rules. Project Health staff always calls to make the first appointment. After that, care is between the doctor and the patient with regard to how many follow-ups are needed. The only thing your staff is asked to do is send in a claim form showing the amount your services were with a “0” balance.

Sam Hazlett, MD, Community Heart and Vascular Physicians, first realized how important Project Health could be when in 2004 he referred seven patients to Project Health and three of them underwent open heart procedures.

Alfredo Lopez, MD at Alivio Clinic says:

*“I began working with Project Health in 2004 when I discovered they could offer specialty care, labs, diagnostic tests, and even chemo and radiation. Before this, there was absolutely no source for these services. My staff had to spend precious hours calling all around town to find a specialist willing to treat my patients. I greatly appreciate the fact that if I order a test the patient will get it, and I can immediately reach a proper diagnosis. And if they need surgery, Project Health will arrange for it. Project Health has become invaluable resource to our clinic.”*

Thank you to all the providers who have donated their services. Having this massive team in place really simplifies things and allows staff to get patients in “same day” if necessary. Fax referral forms to 262-5609. And please call 262-5625 or email [carrie@imsonline.org](mailto:carrie@imsonline.org) with questions or suggestions.

Date: \_\_\_\_\_

**Patient Referral to Project Health**

New Patient       Existing PH Patient

Patients can be referred by any existing doctor or clinic, or an emergency room doctor or social worker. They must be 18 years old or older and a Marion County resident.

---

Patient First Name (please print) \_\_\_\_\_ Last name \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_

Patient SS# \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

---

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Best time of day to contact patient:    \_\_\_ Anytime    \_\_\_ Mornings    \_\_\_ Afternoons    \_\_\_ Evenings

WHAT LANGUAGE DOES THE PATIENT SPEAK?    \_\_\_ ENGLISH    \_\_\_ SPANISH    OTHER \_\_\_\_\_

DOES THE PATIENT NEED AN INTERPRETER?    \_\_\_ YES    \_\_\_ NO

CURRENT PRIMARY CARE DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

**CLINICAL REASON FOR REFERRAL** \_\_\_\_\_

DOES PATIENT NEED TO SEE A SPECIALIST?    \_\_\_ YES    \_\_\_ NO    DIAGNOSIS CODE: \_\_\_\_\_

**IF YES, WHAT KIND OF SPECIALIST ?** \_\_\_\_\_

- Please fax all pertinent labs and reports if they are available to Project Health along with this request.
- If the patient needs a surgical procedure please call the Project Health case manager at 262-5626 or 262-5657 .
- If the patient needs a complicated diagnostic procedure that is not done in your office, also call the case manager who will advise you where to send the patient.

---

SENT BY NAME: \_\_\_\_\_ PHONE NUMBER & EXTENSION \_\_\_\_\_

\_\_\_ Primary Care Doctor    \_\_\_ Nurse    \_\_\_ Specialty Doctor    \_\_\_ Other

\_\_\_ ER Doctor    \_\_\_ Social Worker    \_\_\_ ECCO

REFERRED BY: \_\_\_\_\_

Physician/Nurse or Social Worker Name (print) \_\_\_\_\_ Practice/Clinic or Hospital Name \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_ E-mail \_\_\_\_\_

**FAX THIS FORM TO PROJECT HEALTH AT 262-5609**  
**QUESTIONS? – Call 262-5626 or 262-5627 for a Project Health Case Manager**





**Seated Left to Right**

Morgan Tharp II, M.D.  
Keith Logie, M.D.  
Andrew Greenspan, M.D.  
M.S. Murali, M.D.

**1<sup>st</sup> Row Standing**

Hillary Wu, M.D., Ph.D.  
Madelaine Sgroi, D.O.  
Melody Sands, APRN-BC  
Danielle Doyle, M.D.  
G. Irene Minor, M.D.  
Tracy Price, M.D.  
Elsayed Aly, M.D.

**Back Row**


Paul DesRosiers, M.D.  
Sead Beganovic, M.D., Ph.D.  
Harold Longe, M.D.  
Thomas Whittaker, M.D.  
Bryce Lord, D.O.  
Jennifer Morgan, M.D.

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Friends agreement is subject to member satisfaction reviews. Circle of Friends will require ongoing review and maintenance to assure members that the vendor and IMS should maintain the relationship. A signed Contract/Application Agreement and Participation Agreement are necessary for participation after all approvals have been met. See the Benefits Information below for a complete listing and details of the current year's events. Participation in IMS Circle of Friends has many advantages, including numerous opportunities to spend time with IMS Member physicians. You can choose from three levels of participation for IMS Circle of Friends. Each level entitles you to listings in the monthly IMS Bulletin, the annual Pictorial Roster, website listing and advertorial. Other events may be included, as IMS will use every opportunity to share this valuable resource with our members.

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# In Memoriam



Roscoe Louis Curry, MD  
1921- 2011

Dr. R. Louis Curry, 90, general practitioner, Indianapolis, died peacefully Saturday October 1, 2011. He was born April 19, 1921 in Greentown,

Indiana.

Dr. Curry graduated from Greentown High School in 1938. He attended Ball State Teachers College and received his Mathematics degree in 1942.

Dr. Curry joined the U.S. Army Air Corps in 1942 and served as a Captain until 1945. In 1953, he received his medical degree from The Hahnemann Medical College. He interned at Methodist Hospital, Indianapolis. He practiced for over 50 years on the eastside of Indianapolis and he was one of the original physicians of Community Hospital East.

A longtime member of the Indianapolis Medical Society, Dr. Curry served as an Alternate Delegate from 1977-1980 for the IMS.

## In Summary

**Alcohol: A double-edged sword for heart and health, from the *Harvard Heart Letter***

A study showing that moderate, prudent drinking protects the heart and arteries raises a big question: What should we do with this information? In what sounds like a contradictory conclusion, the researchers say their findings “lend further support for limits on alcohol consumption.” That makes sense, reports the *October 2011 Harvard Heart Letter*, when you consider the complexity of alcohol’s effects on heart disease, stroke, and other aspects of health.

In the study, which included more than two million men and women followed for an average of 11 years, moderate alcohol use (compared to no alcohol use)

- reduced the risk of a new diagnosis of coronary artery disease by 29%
- reduced the risk of dying from any cardiovascular disease by 25%
- reduced the risk of dying from a heart attack or coronary artery disease by 25%
- reduced the risk of dying from any cause by 13%.
- reduced the risk of having an ischemic (clot-caused) stroke by 8%
- increased the risk of dying from a stroke by 6%
- increased the risk of having a hemorrhagic (bleeding) stroke by 14%.

The amount of alcohol consumed influenced the effect. For coronary artery disease and death from it, any amount of alcohol—from just under one-half drink per day on up—reduced heart disease risk by about 25%. But this was offset by stroke risk: at four drinks per day, the risk of having a stroke was 62% higher than it was with no alcohol use, and the risk of dying from a stroke was 44% higher. The lowest risk for any cause of death was at one drink per day.

While a drink a day may be good for the heart, many people drink much more than that. Excessive drinking is a major cause of preventable deaths in the United States and contributes to liver disease, a variety of cancers, and other health problems. Too much alcohol can dissolve the best of intentions and the closest relationships. The National Institute on Alcohol Abuse and Alcoholism estimates that 4 in 10 people who drink alcohol are heavy drinkers or at risk of becoming one.

If alcohol affected only the coronary arteries, a drink a day might be good medicine. But it affects almost every body part, and the amount consumed determines the ultimate outcome. That means careful consideration is needed for this two-sided beverage.

Read the full-length article: “More to the story than alcohol = heart protection” at [http://www.health.harvard.edu/newsletters/Harvard\\_Heart\\_Letter/2011/October/more-to-the-story-than-alcohol-heart-protection?utm\\_source=heart&utm\\_medium=pressrelease&utm\\_campaign=heart1011](http://www.health.harvard.edu/newsletters/Harvard_Heart_Letter/2011/October/more-to-the-story-than-alcohol-heart-protection?utm_source=heart&utm_medium=pressrelease&utm_campaign=heart1011)

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## ICD-10CM – Musculoskeletal System – Ankle Sprain

Today we look at the female 26 year old patient who presents to her physician's office with "ankle sprain." No other information is offered about the injury or how it happened.

In ICD-9CM we code this statement as:

- 845.00 sprains and strains of ankle, unspecified site

This code comes from ICD-9CM Chapter 17 Injury and Poisoning (800-999). The beginning of ICD-9CM Chapter 17 instructs us to "use additional code for retained foreign body, if applicable" and also to "use E code(s) to identify the cause and intent of the injury or poisoning (E800-E999)." Our documented statement does not give us an indication of retained foreign body or how the ankle was sprained.

In ICD-10CM you will find that injuries are grouped by the body part rather than by categories of injury. The documented statement of "ankle sprain" leads us to Chapter 19 Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88) ICD-10CM code S93.4- Sprain of ankle. Instructions provided ask us to code any associated open wound, and to also use a secondary diagnosis code from Chapter 20 External causes of Morbidity (V00-Y99) to indicate the cause of injury. If this is the initial encounter a place of occurrence code is used after other external cause codes.

### ICD-10CM: S93.4- Sprain of ankle

**This block instructs us to use a fifth, sixth, and seventh digit:**

- S93.4- Sprain of ankle
- S93.401- Sprain of unspecified ligament of right ankle
- S93.402- Sprain of unspecified ligament of left ankle
- S93.409- Sprain of unspecified ligament of unspecified ankle
- Required 7<sup>th</sup> digit to identify the encounter:
  - A – Initial
  - D – Subsequent
  - S – Sequela

Coding professionals may be tempted to code as unspecified when the physician's documentation does not give us the

specifics needed to select a more specific code but I would caution against this. It is true that in our case of the "ankle sprain" that there is an unspecified code to choose from in ICD-10CM (S93.409\_). This is an action that you may regret in a few years when you review your severity and risk scores assigned to you by government and third party payer plans. Your coded files will not have the specificity needed to justify higher levels and better reimbursement.

Our documented statement of "ankle sprain" will require a written inquiry to the physician for additional information:

- Which ankle, right or left?
- Is this the initial, subsequent or sequela encounter?
- How did this injury happen?
- Where did this injury happen?

The following week we receive the inquiry back from the physician with the information that is needed to select an ICD-10CM code for the encounter. The physician indicates that this is the first encounter for this right ankle sprain leading us to code ICD-10CM as **S93.401A**. The physician also tells us that the patient slipped in the driveway on the ice while going to the mailbox. This is coded in ICD-10CM as **W00.0xxA** *fall on same level due to ice and snow, initial encounter*. The seventh character "A" indicates that this is the initial encounter. You may notice that code **W00.0xxA** describes how the injury happened and that this code includes two "xx" placeholders. We will discuss the role of placeholders in a future article.

---

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# President's Page ...

(continued from page 8)

on current meds” to encourage physicians to take a more active role in minimizing errors at time of transfers between healthcare visits or levels of care. The communication between the patient, nurse, pharmacist and physician needs to be closely integrated for optimal outcomes.

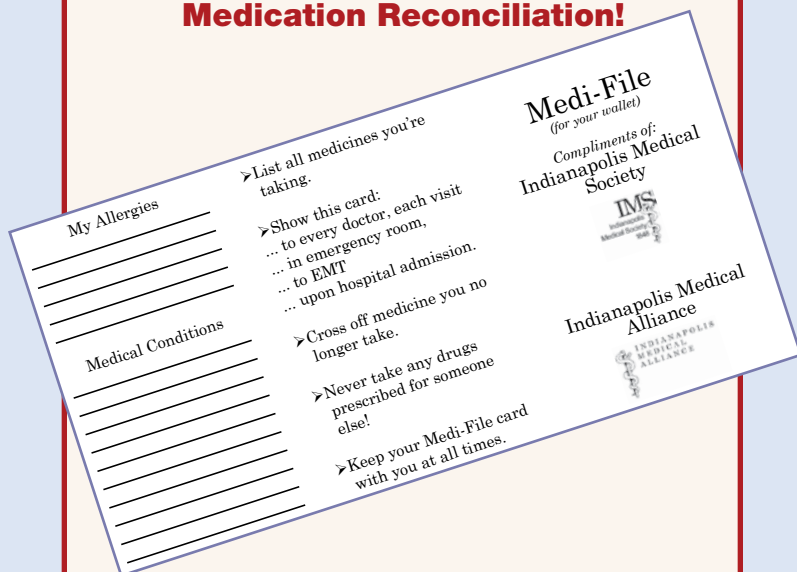
The most challenging aspect of medication reconciliation is transitioning accurate information across institution borders: from primary care practitioner to emergency medicine clinic to hospital to community pharmacy. The lack of a single patient medical record system that crosses the continuum of care, hospital and insurance company medication formularies, lack of singular best practice and patient ambivalence are all reasons adding to the complexity of communicating key medication information. Although there are numerous case reports of successful methods of medication reconciliation systems *within* a singular healthcare facility, there are few reports on how this information is communicated to the next provider in a concise, accurate and timely manner. With the current pressure for health care providers and facilities to convert all medical records to an electronic process the opportunity for better collaboration and communication may be around the corner. Although finding the medication reconciliation process that works may seem challenging, it is not unattainable. The list is just the beginning. The end results from how we use the list.

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