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Bulletin



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Recipients of the **Health Care Heroes Awards** will be profiled in a special supplement of *Indianapolis Business Journal* on March 4, 2013. They will receive their awards at a breakfast hosted by *Indianapolis Business Journal*, Comcast Spotlight, Fifth Third Bank and Hall, Render, Killian, Heath and Lyman in March 2013.

To receive a nomination form, visit www.ibj.com; mail your name, company name, address, phone and fax number to *Indianapolis Business Journal*, 41 East Washington Street, Suite 200, Indianapolis, IN 46204; or call Patty Johns at 317-472-5319.

THIS YEAR'S CATEGORIES ARE:

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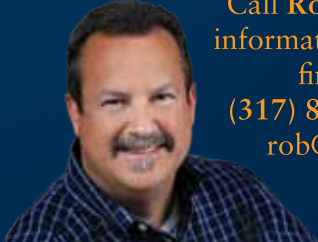
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We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin*. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, bhurt@imsonline.org.

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.

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about our cover



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Information Technology

History

The last three President's Page articles discussed the Affordable Care Act (ACA), Accountable Care Organizations (ACOs) and The Patient Centered Medical Home (TPCMH). While these legislative and organizational activities pertain to the general process of health care delivery, information technology (IT) is an important tool in the delivery of care. The introduction of electronic medical record (EMR) came about over 20 years ago by various entities encouraging the medical community to use computers to use and store medical information. It was presumed this would enhance healthcare by improving quality (better outcomes by reducing costs of duplicated services), safety (smart software to vet drug prescribing) and efficiency (improved access). The original concept intended that medical data stored on computers (EMR) would be linked; creating a **comprehensive electronic health record (EHR)** that could be easily accessed regardless of location of the patient encounter. Also, best practice protocols and drug information would be embedded in the EMR to assist in the treatment of patients.⁽¹⁾

Physician Acceptance

The initial physician response was limited due to cost and time considerations. However, due to financial incentives provided by the federal government there has been increased acceptance. The \$787 billion American Recovery and Reinvestment Act (Stimulus Bill) signed into law in February 2009 included \$19.2 billion to increase the use of electronic health record by hospitals and physicians. \$17 billion was for incentive payments for physicians who participated in Medicare and Medicaid programs. This portion of the bill is called the Health Information Technology for Economic and Clinical Health Act or **HEITECH Act**. The incentives were to be issued to current users and new adopters of certified EMR systems to be used in a "**meaningful way**". There is a formula for these incentives (\$45,000 per physician for Medicare over 5 years to \$65,000 for Medicaid over 6 years) with penalties of reduced reimbursement for physicians who do not properly use EMR by 2015. The EMR must have certain features and functions that meet the criteria for **meaningful use**.⁽²⁾ Recent CMS data shows that more than 2,700 eligible hospitals and 73,000 eligible providers have attested to stage I meaningful use requirements.⁽³⁾ For various reasons (decision support tools, performance measures, cost reduction, data collection/analysis and patient safety) other entities (state governments, insurance companies and medical institutions) also promoted the adoption of EMR.

In addition to the financial considerations, the efficiency and usability of EMR are important physician issues. The AMA has expressed concern that EMR reduces physician efficiency.⁽⁴⁾ For example data entry in some EMRs are labor intensive making a physician less efficient and important information may be difficult to locate in some EMR systems due to the interface design. The U.S. National Institute of Standards

and Technology of the Department of Commerce studied EMR usability in 2011 and found a number of concerns reported by health care workers.⁽⁵⁾ Despite cost, usability and efficiency concerns, a survey of 13,575 physicians by the Physician Foundation this year (2012) shows that 69.5% have adopted EMR.⁽⁶⁾ To what degree these are fully functioning systems that include ordering meds and tests, reviewing results and clinic notes is uncertain.

Financial and Quality Outcomes

Observers note that using EMR does not automatically improve quality if the practice pattern of the doctor does not change. Now that many physicians have adopted EMR, experts agree that the next step is to help doctors better utilize it in order to enhance patient care. A large study of 50,000 patient records published in *Archives of Internal Medicine* in 2007 comparing 2500 physician offices using EMR vs. pen and paper showed no statistical difference in the quality of care on 14 of 17 guideline-based measures.⁽⁷⁾ However, another *Annals of Internal Medicine* issue of May 16, 2006 presented a review of 257 studies that found many physicians using EMR increased their adherence to care guidelines, committed fewer medication errors and monitored patients more closely.⁽⁸⁾ This study came from trials at large integrated healthcare systems that had developed and implemented their own internal system, while most physicians adopt commercially available software EMR and may not achieve the same results. A 2010 Medical Group Management Association physician survey showed significant financial benefit to doctors using EMR. This study of 1324 primary care and specialty practice members showed that independent practices with EMR had an additional \$49,916 in revenue (after operating costs) over paper-based practices.⁽⁹⁾ The U.S. Budget Office concluded that overall cost savings may occur only in large integrated groups and not necessarily in small offices.⁽¹⁰⁾ This cost savings question has also been raised by researchers at Harvard, Stanford, the Wharton School of the University of Pennsylvania and others.⁽¹¹⁾

Regulation/Safety/Liability Issues

Since the eventual plan is to link EMRs to create an effective EHR, the electronic transmission of health information has federal regulation regarding privacy concerns that are defined in the HEITECH Act. These regulations are expanded privacy and security requirements beyond those of HIPPA. The Office of the National Coordinator for Health Information Technology (ONCHIT) is the federal government's resource for the entire health system to adopt and promote health information exchange. Encryption is the key for security, and EMR/EHR systems must meet these standards. Security breaches must be reported, and healthcare providers have experienced 767 such breaches resulting in compromised privacy of 23,625,933 patients in the period of 2006-2012.⁽¹²⁾⁽¹³⁾ Safety is an EMR/EHR

Continued on page 21.

Retaining independence while embracing accountability: care coordination and integration strategies for small physician practices (Part I)

Physicians throughout the country are trying to figure out how to best achieve their professional goals in the changing health care delivery environment. Physician payments are increasingly being structured in a way that incentivizes quality and cost effectiveness over volume, and many place physicians at financial risk. In addition, public reporting of physicians' performance will now be the norm, rather than the exception, with Medicare's expansion of its Physician Compare website in 2013. Will physicians need to be employed by a hospital or a large medical group or health system in order to provide the quality and manage the costs that these payment and reporting systems require and take advantage of the emerging opportunities resulting from health system reform?

Not necessarily. While some physicians may ultimately decide that formal alignment with a large medical group or hospital system is their best option, others are actively working to integrate new care coordination and accountability capabilities into their smaller practices. Indeed, there are a number of avenues that physicians in smaller practices can take that will allow them to retain their independence while also achieving the new capabilities they will need to succeed in this new environment.

Developing new capabilities to coordinate care and improve results

AMA has published a new resource to assist physicians in small and solo practice in taking advantage of the opportunities presented by the changing health care delivery environment, entitled "Retaining independence while embracing accountability: care coordination and integration strategies for small physician practices," available at www.ama-assn.org/go/ACO. This resource identifies the core capabilities physician practices will likely need to enhance to be successful in the future and describes how small physician practices can attain these capabilities, which are summarized briefly below. The resource also discusses options small practices may have to collaborate with other physicians and to obtain financing for practice enhancement, which will be covered in a subsequent article.

Three steps to improve quality

There are at least three things that even the smallest of practices can do to improve care:

- **Standardize care** through the use of accepted guidelines, policies and procedures;
- **Facilitate better coordination** and interaction among all the parties involved with the care, including the patient;
- **Develop and analyze data** to change behavior, produce better outcomes, and provide care more efficiently.

One practice's success story

For example, in "Achieving Clinical Integration with Highly Engaged Physicians," the authors point to Consultants in Medical Oncology and Hematology (CMOH), a ten-physician independent hematology practice in Delaware County outside of Philadelphia. These physicians were dissatisfied with their inability to contract on acceptable terms with managed care plans, and therefore began collecting their own data that would demonstrate the practice's value by measuring performance on issues such as keeping their patients out of the hospital, and producing high satisfaction scores. They implemented an electronic health record to track their patients' utilization of services and provided standardized approaches to care. With collaboration among its clinical support teams, the practice adhered to evidence-based guidelines, provided enhanced patient access to care through same day/next day visits, and educated patients to improve medication, evaluation, and treatment compliance, etc. According to the study, the results of these efforts were impressive, as the practice:

- Increased its financial margin by lowering its full-time employee staffing requirements by 10%;
- Lowered the number of emergency room referrals for its patients;
- Reduced hospital admissions for its patients;
- Increased the number of patients seen within 24 hours of a telephone call five-fold.

By 2010, the group's clinical integration program resulted in it receiving the first oncology patient-centered medical home designation by the National Committee for Quality Assurance. (Id. at 10-11.)

Tools for small practices

Tools are available for physicians to help them make changes to their practices and manage patient referrals and transitions necessary to support coordinated care. For example, the Institute for Healthcare Innovation, funded by the Commonwealth Fund, has provided a toolkit entitled "Reducing Care Fragmentation" that introduces four key concepts for enabling change, and offers activities, model documents, and other tools to support their implementation. This toolkit is available at www.improvingchroniccare.org.

Similarly, there are a number of tools that small physician practices can use to aggregate and evaluate their data efficiently:

Flow sheets. The American Medical Association-convened Physician Consortium for Performance Improvement (PCPI) has developed prospective data collection flow sheets for a number of clinical conditions that incorporate evidence-based performance measures. See www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality.page. These prospective data sheets can serve as a reminder checklist to ensure that all care team members know what needs to be done when the patient is in the office.

Registries. The ability to generate and use registries, that is, lists of patients with specific conditions, medications, or test results, is also considered a proxy for high quality health care. Such registries help office staff identify patients who are overdue for recommended services and facilitate contacting them and arranging for office visits, lab monitoring, referrals and other needed care. Some registries can even be developed using free software. The AMA has provided guidance on patient registries, including information on how to create them. See "Optimizing Outcomes and Pay for Performance: Can Patient Registries Help?" a copy of which can be found at www.ama-assn.org/ama1/x-ama/upload/mm/368/pt_registries_102005.pdf. In addition, the California Health Care Foundation's resource "Chronic Disease Registries: A Product Review," available at www.chcf.org may also be helpful.

Electronic Health Records. Electronic health records (EHR) can also assist with care coordination. Physicians in smaller practices may be particularly interested in investigating some of the newer, cheaper cloud-based EHR systems. "Cloud computing" refers to a number of technology solutions that: (1) operate over the Internet; (2) use shared resources such as storage, processing, memory and network bandwidth with other users; and (3) are "on-demand," meaning capabilities such as network storage can be adjusted virtually, eliminating the need for on-site IT staff. For more information on health information technology, including the Medicare/Medicaid EHR incentive programs, go to the AMA's website at www.ama-assn.org/go/HIT.

Claims data. Another potentially valuable source of information is claims data. AMA has published a toolkit to help physicians use these data for practice improvement activities,

Continued on page 22.



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From left to right: Sandra Dolny, PA-C; Jocelyn Bush, MD; John Fitzgerald, MD; Edward Kowlowitz, MD; Alina M. Clavijo-Passik, PhD
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Bulletin Board

Keith R. Ridel, MD, of JWM Neurology recently presented a poster titled “Survey of Recently Certified Child Neurologists about Education and Practice Needs” at the Child Neurology Society Annual Meeting in Huntington Beach, California.

Jason K. Sprunger, MD, Urology of Indiana, was invited to present a poster on Robotic Radical Nephroureterectomy for Upper Tract TCC-A Novel Approach at the World Congress of Endourology (WCE) of The Endourological Society meeting was held in Istanbul, Turkey in September, 2012. In addition, Dr. Sprunger recently presented the poster at the North Central Section of the American Urological Society in October. Dr. Sprunger is a member of the American Urologic Association, Vanderbilt Urologic Society, Endourology Society, and the American College of Surgeons. His areas of special interest include laparoscopic and endoscopic techniques in robotic surgery.

Douglass S. Hale, MD, Urogynecology Associates, Director Female Pelvic Medicine and Reconstructive Surgery Fellowship, Clinical Professor: Indiana University Health/Methodist Hospital was faculty for International Academy of Pelvic Surgery Annual Fellows’ Program in Cincinnati, Ohio. He presented Laparoscopic Surgery for Pelvic Floor Disorders and was the Moderator for a discussion panel on Prolapse and Incontinence. He also directed the cadaver lab along with other fellowship directors from around the country.

Stephen W. Perkins, MD, of Meridian Plastic Surgeons was recently the invited featured US faculty speaker at the Regensburg Course in Facial Plastic Surgery in Regensburg, Germany. His lectures included the following: “Facelift Lessons From 30 Years,” “Endoscopic Facelift Techniques: Midface Lift,” “Facial Rejuvenation,” “Rhinoplasty: Controlling Rotation,” “Blepharoplasty: The Difficult Lower Eyelid” and “Anatomical Dissections – Facelift and Rhinoplasty.”

Rick C. Sasso, MD, Indiana Spine Group, served as a faculty member at the American Academy of Orthopedic Surgeons’ hands on course, “Spine Surgery: State of the Art Techniques and Science.” This instructional course was held September 20-22, 2012 at the Orthopedic Learning Center in Rosemont, Illinois. Dr. Sasso lectured on surgical indications in cervical myelopathy. He also lectured on cervical disc replacement for radiculopathy and myelopathy. He taught the hands on surgical demonstration of C1 lateral mass screw, C2 laminar screw technique and was the laboratory instructor for posterior cervical fixation techniques.

Franciscan St. Francis Health presented an arthritis and hip and knee replacement seminar Tuesday, November 13, 2012 at Jonathan Byrd’s, 100 Byrd Way, Greenwood.

John B. Meding, MD, explained the latest procedures in joint replacement and arthritis treatments. Dr. Meding is a board-certified orthopedic surgeon specializing in adult reconstructive surgery and joint replacement. He is a surgeon with Franciscan Physician Network Joint Replacement Surgeons, a practice group affiliated with the Center for Hip & Knee Surgery at Franciscan St. Francis Health–Mooresville.

Richard L. Hallett, MD, Board Certified Thoracic/Cardiac Radiologist with Northwest Radiology presented “Vascular



W. Gregory Chernoff, MD



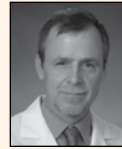
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Stephen W. Perkins, MD



Keith R. Ridel, MD



Rick C. Sasso, MD



Cynthia K. Seffernick, MD



Jason K. Sprunger, MD

Diseases in Athletes” at the annual meeting of the North American Society of Cardiovascular Imaging in Pasadena, California on October 15th. His talk pertained to the use of dynamic CT and MR imaging to evaluate compressive syndromes affecting athletes. This presentation addressed Popliteal Entrapment Syndrome, Thoracic Outlet Syndromes, and Iliac Endofibrosis.

Two Northwest Radiology Network radiologists were recently listed in the 2012 U.S. News & World Report’s Best Hospitals rankings. Pediatric radiologist, **Kathy S. Clark, MD**, and Neuroradiologist, **Benjamin B. Kuzma, MD**, were nationally ranked in five specialties and listed as high-performing in seven specialties. These board certified radiologists are determined to be in the top 10% in their region.

Elizabeth A. Nowacki, DO, an obstetrician and gynecologist, has joined the medical staff at St. Vincent Medical Center Northeast in Fishers. Dr. Nowacki earned her bachelor’s in biology from Grinnell College in Iowa and a master’s degree in physiology and biophysics from the Indiana University School of Medicine. She received her medical degree from the Nova Southeastern University College of Osteopathic Medicine in Fort Lauderdale, Florida. Before joining St. Vincent, Nowacki practiced at Hancock Regional Hospital in Greenfield.

Cynthia K. Seffernick, MD, an obstetrician and gynecologist, has joined the medical staff at St. Vincent Medical Center Northeast in Fishers. She received her bachelor’s in biology from the University of Toledo and her medical degree from the Medical College of Ohio in Toledo. Before joining St. Vincent, Seffernick practiced at Dearborn County Hospital in Lawrenceburg.

W. Gregory Chernoff, MD, served as faculty for FibroCell Science conducting a Physician Certification session in San Francisco, California in October, 2012. The certification was held for Plastic Surgeons and Dermatologists interested in becoming certified to inject fibroblast treatment. Dr. Chernoff reviewed clinical trial data, shared patient data, and taught injection technique on recently FDA-approved autologous fibroblast therapy.

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In Memoriam



Edward V. Schaffer, MD
1923 - 2012

Edward V. Schaffer, MD, died October 1, 2012, at home with his loved ones at his side. He was born in Staten Island, New York, November 17, 1923.

Dr. Schaffer showed his promise early in life by winning the National Soap Box Derby Championship in Akron, Ohio.

He served the Army in WWII as a private. He always said his service as a private wasn't distinguished, as he served on the special services baseball team. After WWII, Dr. Schaffer graduated from Manhattan College and the New York College of Medicine. Later in the Air Force, then Major Schaffer was flying as a physician and studying the pilots and the effects of extended flight time.

Dr. Schaffer completed his internship at New York City Hospital, his residency in general surgery at New York City Hospital and his orthopedic surgery residency at St. Vincent's, Veterans and Riley Hospitals. His practice was centered around Methodist, Community and Franklin Hospitals.

In addition to his practice, Dr. Schaffer always loved teaching Orthopedics to students at Indiana University School of Medicine.

Dr. Schaffer retired in 1990, moved to Atlantis, Florida, and soon was found treating migrant workers at the Caridad Clinic in Boynton Beach. Later moving to Merritt Island, Florida and working at the Path Clinic in Brevard County.

Dr. Schaffer decided to donate his body to Science Care so he can continue in death to aid in his chosen career.



Joseph Riina MD
1967 - 2012

Dr. Joseph Riina passed away October 14, 2012. He was born July 20, 1967 in Brooklyn, New York.

Dr. Riina began his training at Tufts University in Medford, Massachusetts, earning his medical degree at Temple University School of Medicine in Philadelphia, Pennsylvania. He served his internship in surgery at State University in Brooklyn, New York. He completed his residency in orthopaedic surgery in 1999 at State University in Brooklyn. Dr. Riina completed a fellowship at OrthoIndy in Orthopaedic Spine Surgery in 2000. He was board certified in orthopaedic surgery in 2002.

Dr. Riina began his career at Orthopaedics Indianapolis in 2000 and was currently serving as the President of the Orthopaedic Research Foundation, Co-Director of the OrthoIndy Spine fellowship and OrthoSpine Medical Director St. Vincent Hospital, Indianapolis. He was an active member in multiple national and international spine societies and a respected educator and researcher, with numerous publications and presentations.

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Orthopaedic Surgery, 2002
Orthopaedics, Foot & Ankle
Sports Medicine (ORS)
Indiana University, 1994

Henley, Charles E., DO

Marian University
College of Osteopathic Medicine
3200 Cold Spring Rd., #160
46222-1960
Ofc – 955-6295
Family Medicine, 1981, 2007
Oklahoma State University,
College of Osteopathic Medicine, 1977

Hibbard, Roberta A., MD

IU School of Medicine
1001 W. 10th St., #B2109
46202-2859
Ofc – 630-2617
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Pediatrics, 1985
Child Abuse Pediatrics, 2009
Case Western Reserve University, 1980



McKee, Yuri F., MD
Price Vision Group
9002 N. Meridian St., #100
46260-5354
Ofc – 844-5530
Ophthalmology, 2011

Other Specialty
Loma Linda University, 2000

Miller, Christopher A., MD

Resident – IU School of Medicine
Internal Medicine/Pediatrics
University of Wisconsin, 2009



Nelson, Robert P., Jr., MD
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535 Barnhill Dr., #473
46202-5116
Ofc – 948-1186
Allergy & Immunology, 1987

Other Specialty
Indiana University, 1980



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Obstetrics & Gynecology, 2012
Nova Southeastern University,
Florida, 2004

Pandit, Ashwini W., MD

DCL Pathology, LLC
9550 Zionsville Rd., #200
46268-1065
Ofc – 874-1204
Anatomic & Clinical Pathology, 1999
Cytopathology, 2002
University of Bombay, India, 1992

Sanford, Lori J., MD

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Dermatology
Indiana University, 2009



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Obstetrics & Gynecology, 2002, 2011
Medical College of Ohio, 1993

Stiefel, Gretchen R., DO

Resident – St. Vincent Hospital
Obstetrics & Gynecology
University of Health Sciences,
Kansas City, MO, 2011

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Neuropsychology

Donald Layton, PhD



Project Health



Carrie Jackson Logsdon, Director

Thank you, Gerald T. Keener, Jr., MD



Dr. Keener was born in Ft. Wayne where his Dad worked in steel and his Mom was a secretary. He was the first in his family to go to college. He says he didn't know he wanted to be a doctor until mid-way through an engineering major at Purdue. He discovered that engineering was not for him.

He transferred to Indiana University, where he majored in chemistry during his pre-med days. He graduated from the IU School of Medicine, and did his internship at Marion County General Hospital in Family Medicine.

The Navy had other plans for him from 1969 to 1973. He returned to complete a residency in Ophthalmology at IU. "We had an absolutely great Department of Ophthalmology with Fred M. Wilson, MD; Merrill Grayson, MD; and Eugene M. Helveston, MD, among my favorites."

He says any notoriety he has extends from his wife. She is Patricia Keener, MD, Professor of Clinical Pediatrics and Professor Emerita of Pediatrics at the IU School of Medicine, now retired. "I looked her up on the internet and there were at least one hundred references on her, and when I looked at what the internet had to say about

me it always referenced me as the husband of Pat Keener, MD." Dr. Keener says he met Pat in medical school when they shared a cadaver. They had several classes and rotations together. "We were married our freshman year."

The Keeners have one son and two daughters. His youngest daughter runs a landscaping business called, Grow Works; the oldest daughter is an attorney, and his son works in cause-related activities such as Citizens Action Coalition. They also have three grandchildren. As the children grew up, they also shared the house with cats, dogs, a tarantula, and a ferret that cost them a carpet in one bedroom. "They were all so cute, but they are all gone now. We just feed the birds and squirrels."

Dr. Keener is a member of all of the ophthalmologic societies and the AMA. He serves as a Director for the Indianapolis Medical Society. He was awarded Phi Beta Kappa and Outstanding Professor of the Year from the IU Department of Ophthalmology, Physician Teacher of the Year by the Community Hospital Family Residency Program, and the award for "Exemplary Service and Dedication to the Teaching Program from the IU School of Medicine," and has served as Chairman of the Ophthalmology Section of Community Hospital, among others.

He is very proud of the teaching awards and says, "You always learn when you're teaching young doctors. It's nice to have them feel that you're worthy of those kind thoughts."

He has authored a book chapter and also holds a patent for an instrument for small-incision cataract surgery. He developed it at the time when phacoemulsification was just starting and was a little hazardous to learn. It is still used in areas where they don't have the latest equipment or methods.

"There has been a tremendous change in what we have to offer these days, especially with cataracts. When I went into practice, people stayed in the hospital one week, in the VA Hospitals two weeks. We'd have to prescribe very thick glasses, but now we can prescribe within hours of surgery. Most of all today's methods have a positive effect; to keep people from losing eye function or getting their function back."

Dr. Keener just never stops giving. His community service includes having been on the Board of Directors and Chairman of the Program Committee for Prevent Blindness Indiana. He was also President of that organization from 1991-1993.

When the Keeners are not working, they like to explore the less traveled back roads. They recently went to Gettysburg and then back through the Appalachian Mountains. Some of their favorite road trips have been through Wales, Ireland, England, Belgium and France – the non-tour kind of trips. "When the kids were home, we would occasionally spend spring and summer breaks in Aruba, the Caymans, and Florida."

Dr. Keener recommends that everyone volunteer at least a few cases for Project Health. "It is very satisfying to think you've helped people who otherwise fall thru the cracks. Your interpreters have been very helpful and eliminate a lot of hassle on our part. But I also have to credit the hospitals. They are really what makes it all possible." Dr. Keener is too modest. Project Health patients call us after cataract and other eye surgeries crying they are so grateful to go from not being able to see at all, to getting their vision back. Project Health is also so very, very grateful for Dr. Keener's many kindnesses.





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David S. Batt (2013)
Daniel J. Beckman (2013)
Craig S. Cieciora (2013)
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Mark M. Hamilton (2013)
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Frank P. Lloyd, Jr. (2013)
Andrew L. Morrison (2013)
David L. Patterson (2013)
Kenny E. Stall (2013)
Ronald L. Young, II (2013)

William C. Buffie (2014)
Brian D. Clarke (2014)
Robert E. Dicks (2014)
Doris M. Hardacker (2014)
Douglas J. Horton (2014)
Daniel E. Lehman (2014)
Ramana S. Moorthy (2014)
Maria C. Poor (2014)
Philip W. Pryor (2014)
Jason E. Rieser (2014)
Steven M. Samuels (2014)
Kenneth N. Wiesert (2014)

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Robert S. Flint (2015)
Tod C. Huntley (2015)
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Community Hospital East	
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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.

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 7250 Clearvista Dr. 7:30 - 8:30 a.m.

First Friday	North Forum Reilly Board Room; 12:00 - 1:00 p.m.
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Fourth Thursday	Psychiatry Grand rounds 7250 Clearvista Dr. Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m.
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Community Heart & Vascular/ Indiana Heart Hospital

First Wednesday	Imaging Conference: rotates Cath & Echo Case Presentations TIHH MCV Boardroom Videoconference to CHE Bradley Boardroom & CHS Education Center Rm. 2-1910 7:00- 8:00 a.m.
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Third Wednesday	Ken Stanley CV Conference TIHH MCV Boardroom Videoconference to CHE Bradley Boardroom & CHS Education Center Rm. 2-1910 7:00 - 8:00 a.m.
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Fourth Wednesday	Disease Management Conference: rotates CHF & EP Case Presentations TIHH MCV Boardroom Videoconference to CHS Education Ctr. Rm. 2-1910, 7:00 - 8:00 a.m.
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Cancer Conferences

Community Hospital East:	
First & Third Wednesdays	East General Cancer Conference Medical Staff Conf. Room, 12:00 to 1:00 p.m.

Fourth Wednesday	East Multidisciplinary Breast Cancer Conference Medical Staff Conference Room 7:00 to 8:00 a.m.
---------------------	---

Community Hospital North	
First & Third Tuesdays	North Multidisciplinary Breast Conference 8040 Clearvista Parkway, Suite 550, 7:00 - 8:00 a.m.

First Wednesday	North Chest Cancer Conference 8040 Clearvista Parkway, Suite 550, 7:00 - 8:00 a.m.
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Third Wednesday	Melanoma Cancer Conference 8040 Clearvista Parkway, Suite 550, 7:30 - 8:30 a.m.
--------------------	--

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

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

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IU – Methodist – Riley	
Dec. 1	How to Help Your Patients Quit: Practical, In-Office Approaches for Tackling the Problem of Tobacco Venture Out Business Center, Madison, Indiana
Dec. 7	Practical Behavioral and Medical Approaches to Behavior and Self-Care in Autism and Other Developmental Disorders Riley Outpatient Center, Indianapolis
2013	
Jan. 18-20	Musculoskeletal Ultrasound Beginner Level Course Residence Inn, South Bend, Indiana
Jan. 19	Review and Interpretation of the 2012 San Antonio Breast Cancer Symposium Indiana History Center, Indianapolis
Feb. 23	How to Help Your Patients Quit: Practical, In-Office Approaches for Tackling the Problem of Tobacco Franciscan St. Elizabeth Health School of Nursing Lafayette, Indiana
March 13	Pediatric Pulmonary Update Ritz Charles Banquet Facility, Carmel, Indiana
April 13	How to Help Your Patients Quit: Practical, In-Office Approaches for Tackling the Problem of Tobacco Vincennes, Indiana
May 4	How to Help Your Patients Quit: Practical, In-Office Approaches for Tackling the Problem of Tobacco IU Health Goshen Hospital, Goshen, Indiana
May 29-30	48th Annual Riley Hospital for Children Pediatric Conference Indianapolis Marriott Downtown, Indianapolis
July 26	Review & Interpretation of the 2013 ASCO Meeting JW Marriott Indianapolis

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

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IMS Events

Indianapolis Medical Society

December	
12	Senior/Inactive Luncheon Meeting, Noon, Society TBD
18	Executive Committee Holiday Dinner, with Spouses/Guests
2013	
January	
15	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg., Speaker: Dr. Gordon Hughes, ISMA President
February	
10-13	AMA Presidents' Forum, Sun., 4-6:30 PM; continues Mon., from 7:30 AM-1 PM, Grand Hyatt, Wash., D.C.
10-13	National Advocacy Conference (NAC), Monday afternoon and Tuesday.
19	Executive Committee, Society, 6:00 PM, Sandwiches. Nominating Committee appointed.
TBA	7th District Organizational Dinner, Location TBD. Dr. Robert Malizak chairs.
March	
12	Senior/Inactive Luncheon, Society, 11:30 AM. Speaker TBA
17	IMS Advisory Breakfast (Le Peep's), 7:30 AM ... prior to ISMA BOT 9:00 AM, ISMA
19	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg., Speaker
30	HAPPY DOCTOR'S DAY!
TBD	IMS Nominating Cmte., Hale Room, Society Headquarters, 6:30 PM, Light Dinner.
April	
16	Executive Committee, Society, 6:00 PM, Sandwiches
24	Administrative Professional's Day (aka Secretaries' Day)
TBD	IMS Women in Medicine, 7:00 – 10:00 pm.
May	
21	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
TBA	MSE Board Meeting, Society, 6:15 PM, Sandwiches
June	
2	IMS Advisory Breakfast (Le Peep's), 7:30 AM ... prior to ISMA BOT, 9:00 AM, ISMA
12	Senior/Inactive Luncheon Meeting, 11:30 AM, Society
15-19	AMA House of Delegates Annual Meeting, Chicago, IL
25	Executive Committee, Society, 6:00 PM, Sandwiches ... rescheduled from 18th, conflict w/AMA
TBA	Project Health Board Meeting, Society, 6:00 PM, Light Meal
July	
16	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
August	
20	Executive Committee, Society, 6:00 PM, Sandwiches
September	
11	Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker TBA
17	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Light dinner. Dr. Mark Hamilton will be installed as 140th IMS President. NO SPEAKER
20	ISMA BOT, Indianapolis JW Marriott, 10 S. West St., Indpls., 46204. 1:00 PM
20-22	ISMA CONVENTION, JW Marriott Hotel, 10 S. West St., Indpls., 46204
October	
10	ISMA's Fall Legislative Dinner
15	Executive Committee, Society, 6:00 PM, Sandwiches
November	
10	IMS Advisory Breakfast, 7:30 AM prior to ISMA BOT @ 9:00 AM, ISMA Headquarters
16-19	AMA House of Delegates
19	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg

President's Page ...

(continued from page 7)

issue which is difficult to assess as collecting reliable data about safety problems in these systems is problematic. It can sometimes be difficult to attribute problems to the EMR system vs. the user. Soon the federal government will issue a report about EMR patient safety issues and The Institute of Medicine has recommended the government create an independent agency similar to the National Safety Transportation Board to monitor and manage safety concerns.⁽¹³⁾ At this time neither such agency nor system to report and track patient injury or unsafe conditions due to information technology has been adopted. Medical liability for using computerized systems is a new concern. "Hold harmless" agreements by EMR vendors are controversial and may be a deciding factor in the selection process.

Interoperability

The exchange of health information between various EMRs to create an EHR has been an ongoing technological challenge. The Healthcare Information and Management Systems Society (HIMSS) is a very large US healthcare IT industry trade group. It recently announced its opposition to an October 4th 2012 request by a small group of congressional leaders to suspend the distribution of incentive payments until the department of Health and Human Services promulgates universal interoperable standards⁽¹⁴⁾. The new Stage 2 meaningful use requirements for EMR include a greater level of interoperability.⁽¹⁵⁾ Personally, this lack of interoperability is my biggest disappointment since using EMR over the last 10 years. I often see new patients from other provider networks or independent physicians, and the inability of the EMR systems to interface and allow information to electronically transfer reduces efficiency, causes potential duplication of services and relies on US mail to send my office a paper generated chart. Subsequently, this paper chart has to be scanned into our EMR which is not only labor intensive and costly, and I must eventually search for data in the scanned document files. Hopefully, future interoperability improvements will help us achieve the original worthy concept of an effective, user-friendly, safe, and privacy protecting EHR.

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- (10) *Evidence on the costs and benefits of health information technology. Congressional Budget Office May 2008*
- (12) *Privacy Rights Clearinghouse's Chronology of data Security Breaches* (<https://www.privacyrights.org/data-breach/new>)
- (14) www.nytimes.com/2012/09/health/the-ups-and-downs-of-electronic-medical-records-the-digital-doctor.html
- (15) www.healthcareitnews.com/new/himss-rebuffs-efforts-stop-emr-incentives
- (16) *IBID*

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Special Feature - Retain

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whether they are received from health insurers associated with their physician profiling reports or directly from a physician's practice management system or clearinghouse. This helpful resource, "Taking Charge of your Data," is available at www.ama-assn.org/go/physiciandata.

Potential benefits

Finally, this resource outlines the benefits which accrue from engaging in quality measurement programs and using practice data to monitor, report, and improve:

Increased quality. Measurement drives behavior. Measurement can result in both improved outcomes for patients and lower health care costs generally due to the avoidance of duplicative and/or unnecessary health care services. For example, in 2000, "U.S. patients were much more likely—three or four times the benchmark rate—than patients in other countries to report having had duplicate tests or that medical records or test results were not available at the time of their appointment."

Improved "profiles" (and more patients). Private third-party payers have ranked physicians for years. And now, Medicare has gone into the "quality reporting" business by launching a Medicare Physician Compare site which, starting in 2013, will include Physician Quality Reporting System (PQRS) results based first on the 2012 reporting year. Increasingly, anyone who has access to a website can find out information about his or her physician, and how that physician "compares" to other physicians.

While many physicians have been concerned about such public ranking, physicians who are acknowledged as recognized providers in these programs have gotten more patients to treat than non-recognized physicians and often get the opportunity to participate in more networks. Consequently, despite their drawbacks, performance measures can mean that those who score well will be in a better position to obtain: (1) higher payment; (2) increased consumer attention, and (3) better branding opportunities.

Increased financial benefits. The National Priority Partnership, convened by the National Quality Forum, has identified four activities which require physician involvement that reduce costs substantially and improve quality. The opportunity for estimated savings can be summarized as follows:

OPPORTUNITY SAVINGS

Preventing hospital readmissions \$25 billion

Improving patient medication adherence \$100 billion

Reducing emergency department overuse \$38 billion

Preventing medication errors \$21 billion

See www.nationalprioritiespartnership.org.

Thus, not only is performance measurement likely to improve patient care, it may also serve as a foundation for financial incentive and reward programs in value-based purchasing

strategies. In California alone, since 2004 approximately \$400 million dollars have been distributed to physicians by certain health plans participating in a pay for performance initiative. See Results of Integrated Healthcare Association Pay for Performance Program, at www.ihf.org.

In the end, physician practices that enhance their competency with respect to the three core areas outlined above, (1) standardization, (2) care coordination, and (3) data evaluation, will likely perform better, both clinically and financially.

Access AMA resources online

"Retaining independence while embracing accountability: care coordination and integration strategies for small physician practices," is available as part of the AMA resource, ACOs, CO-OPs and other options: A how-to manual for physician's navigating a post-health reform world, at www.ama-assn.org/go/ACO. Stay up to date with all of the new resources from the AMA, by signing up to receive the free AMA Practice Management Alerts emails at www.ama-assn.org/go/pmalerts.

¹See Alice G. Gosfield, JD, and James L. Reinertsen, MD, "Achieving Clinical Integration with Highly Engaged Physicians," a copy of which can be found at http://www.wsma.org/files/Downloads/PracticeResourceCenter/Achieving_Clinical_Integration_GR.pdf.

²See Fleurant, et al., "Massachusetts e-Health Project Increased Physicians' Ability to Use Registries, and Signals Progress Towards Better Care," Health Affairs, July 2011, 30:7.

³Asch, McGlynn, et al., "Comparison of Quality of Care in the Veterans' Health Administration and Patients in a National Sample," Ann. of Int. Med. Vol. 141, No. 12, December 21, 2004, pp. 938-345.

⁴The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, The Commonwealth Fund, July 2008. <http://www.commonwealthfund.org/Publications/Fund-Reports/2008/Jul/Why-Not-the-Best--Results-from-the-National-Scorecard-on-U-S--Health-System-Performance--2008.aspx>.

⁵See 42 U.S.C. §280j-2. Further, although the PQRS was once voluntary, if eligible professionals do not satisfactorily submit data on quality measures for covered professional services for the quality reporting year beginning in 2015, the Medicare Fee Schedule amount for such services will be reduced. (42 U.S.C. §1395w-4.)

⁶See Berry, Emily, "Narrow Networks: Will You Be In or Out?" AMedNews, Oct. 4, 2010.

⁷The AMA Private Sector Advocacy Unit created "A Physician's Guide to Evaluating Incentive Plans" that physicians can use to evaluate such plans for their financial and patient care implications http://www.ama-assn.org/resources/doc/psa/x-ama/pfp_brochure.pdf.

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The Doctors Did It!

Project Health volunteer doctors, hospitals and labs have donated over \$23 Million in health care



YOU have saved many lives and made it possible for patients to return to work and family life without the threat of looming bankruptcy. Here's just a slice of what YOU made possible.

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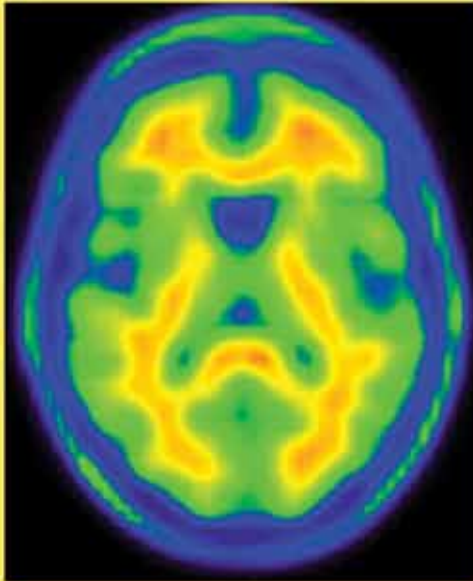
Substantial funding from the Richard M. Fairbanks Foundation expires in 2013 and we need \$88,000 to survive.

**We cannot abandon our patients. Please help us help them.
Donations are fully tax deductible! Thank You!**

To contribute: 1) go online at imsonline.org and click the "donate" button on the right
2) mail your check to Project Health, 631 E. New York St, 46204
3) phone 262-5625. Visa, MasterCard and AMEX.

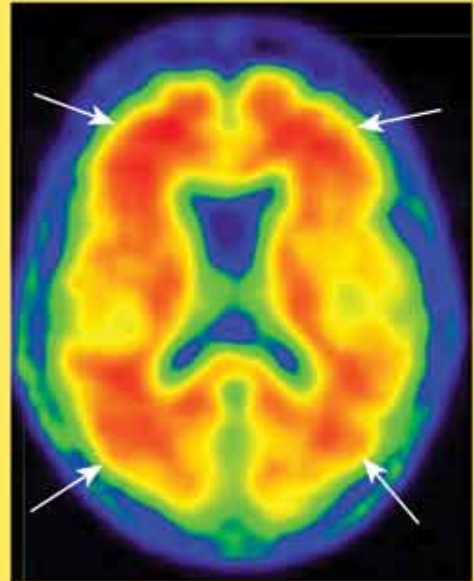
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