Indianapolis Medical Society 1848

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Bulletin

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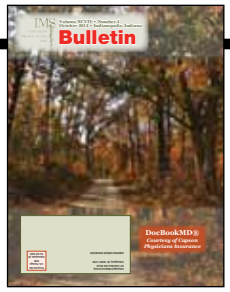

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President's Page

Bruce M. Goens, MD

ACO

History

Accountable Care Organization (ACO) is a term coined by Dr. Elliott Fisher in 2006 at a public meeting of the Medicare Payment Advisory Commission. The ACO model is a product of the Medicare Physician Group Practice Demonstration project established in 2003 by the Medicare Prescription Drug, Improvement and Modernization Act. This term, ACO, had an obvious attractive connotation, gained traction, became widespread in use and was included in the 2010 Patient Protection and Affordable Care Act (PPACA). In the massive new health care law of over 2000 pages, accountable care organizations are discussed in only a few pages, yet it is currently one of the most talked about provisions of the PPACA. The original design model for ACOs was flexible with three primary principles: (1) provider led, with a strong primary care base (2) collectively accountable for quality and cost, and (3) payments linked to quality improvements and reliable performance measures that result in cost savings. In March, 2011, the Department of Health and Human Services (DHHS) proposed the initial set of guidelines for the development of ACOs under the Medicare Shared Savings Program (MSSP). In October of 2011, the DHHS released its final rule on how ACOs should function. These guidelines define the process that voluntary groups of physicians, hospitals, and other health care providers must complete to apply and operate as an ACO entity. The government began taking applications for ACOs for the MSSP in January of this year. In addition to the ACO Shared Savings Program the government created a second ACO approach called the Pioneer Program that was available to high performing health systems that wanted to take on greater financial risk for higher potential financial gain. In July this year, DHHS announced that effective 7/1/2012 more than 2.4 million beneficiaries were receiving care from a total of 154 ACOs, 32 of which are in the Pioneer program.

Definition

An ACO is a healthcare organization that seeks to provide high quality health care in which the payer links a reimbursement agreement to quality measures and reductions in the total cost of overall care for an assigned group of patients. The reduction in total costs (savings) are then shared by the government and the ACO. In addition to the reimbursement agreement an ACO is primarily accountable to the patients and the third party payer for clinical outcomes, efficiency and subsequently the quality of the care provided.

According to the Affordable Care Act (ACA) the Medicare Shared Savings Program (MSSP) is designed to promote accountability for enrolled members and improve coordination of services under part A and B only (not part D). It encourages investment in infrastructure and processes of care to improve efficiency and quality. The MSSP is a required minimum three year program and involves only Medicare Fee-For-Service beneficiaries. The ACO must have the following: a sufficient primary care base, a process to promote evidence-based medicine, the ability to monitor quality and cost measures, leadership/management structure, at least 5,000 beneficiaries already assigned to it, and the ability to coordinate care. Also an ACO must meet certain legal and governance structure requirements. Therefore the ACO structure is flexible to some degree but typically is a network of providers composed of health professionals (doctors, PAs, NPS, clinical nurse specialists) in group practice arrangements, networks of individual practices, partnerships or joint venture arrangements with hospitals, or hospitals that employ providers. Any provider within the ACO may be in the leadership role. However, it is important that the different components of the ACO work together to provide the coordinated care necessary to improve quality and reduce overall costs.

Some critics have indicated that ACPs are HMOs in disguise or an attempt at managed care similar to what existed in the 1990s which limited patient options and led to the HMO backlash. However, the ACO Medicare payment model remains Fee-For-Service and is not a capitation/pre-payment arrangement. The model does not have gatekeeper arrangements, referral restrictions or networks that limit the patient's access to specialist or other providers. Patients do not enroll in an ACO but are attributed to the ACO. Shared Savings ACOs typically get a retrospective attribution which means the ACO does not know up front which patients are used to measure performance. This encourages the ACO to treat all Medicare patients in the organization equally. This benefits all patients in the ACO, but could limit the ACO's ability to use focused measures on those attributed members who need them the most, thus potentially reducing the savings. Pioneer ACOs have the option of choosing prospective attribution patients letting them know ahead of time which patients will be used to judge performance which has obvious advantages. In either case the ACOs are prohibited from doing anything to keep the attributed patient "in the network" of the ACO. The attributed member is free to seek care outside the ACO. It is appealing to Medicare beneficiaries to know that they can visit other physicians and hospitals if they prefer. However, this means an ACO could be either financially rewarded or penalized for cost and quality performance over which it did not have control.

Payers

Currently Medicare is the primary payer to an ACO. However, commercial entities such as private insurance plans or self-funded plans can employ an ACO to manage any given patient population. CMS offers two different payment models for the ACOs in the Shared Savings Plan. An ACO can select either a one-sided or two-sided payment program. Under the one-sided payment model the providers do not assume any financial loss over the three-year period but participate in savings above a specified threshold. Under the two-sided payment model the providers assume some financial risk of any losses but share a higher percent of savings above a specified threshold. Due to potential cost-savings of the ACO model some insurance company may decide to form their own ACOs for the private market, as they have the ability to track and collect patient care data and report the results to providers.

Challenges

The infrastructure costs, anti-trust risks, provider acceptance and patient acceptance are the main challenges Health Care Organizations face in ACO development. Some observers feel patients may not be truly engaged since they will need to assume greater responsibility for their own health behaviors, such as health improvement and maintenance (diet and exercise). Some critics have pointed out that the PPACA was a missed opportunity to include patient incentives and education on the public health issue of obesity with its secondary health problems of diabetes, hypertension, sleep apnea, etc. The infrastructure cost to report on the quality metrics and to institute the information and clinical systems needed by the ACO to manage the entire process is expensive. There are 33 quality measurements that ACOS must report

Continued on page 24.

Special Feature

– Steve Doan, CFP®, CFA, Senior Vice President, Senior Investment Officer and Treasurer at STAR Bank

Building blocks for financial success ... today and tomorrow

No matter the career choice, preparing for retirement generally takes an entire working career in order to create the appropriate nest egg. The size of investable assets necessary to support us in retirement depends upon the amount of income that we will need in order to maintain our chosen lifestyle. Too many people tend to underestimate the amount of investable assets needed and the length of time that it takes to accumulate these financial assets. Many people also find it challenging to focus on long-term goals, such as retirement, when there are so many more current pressing needs present. It seems like there are always financial obstacles that we must overcome throughout our working lives.

For those in the medical community it is no exception. Following completion of the extensive educational requirements, most start out their careers having to deal with large amounts of student loans. After having delayed financial gratification for so long, it is a natural for those new in the healthcare profession to want to spend their income on things for which there is pent up demand. These generally include large ticket items such as cars and homes. Since many are already strapped with student loan debt, the decisions that are made in these first few years following education completion can have a long lasting financial impact. Some reward for the hard work completed is warranted but care must be taken to keep these early purchases of "depreciating assets" to a reasonable level in order to prevent lasting harm to your ability to accumulate retirement assets.

This is well illustrated in the experience of two recent pharmacy school graduates. Both husband and wife attended pharmacy school together. Upon completion the couple graduated school with significant accumulated debt. Following some sage advice, the couple focused on paying off the school loans and getting retirement plans in place prior to accumulating any other debt. The young couple rented and lived on ¼ of their combined salaries for the first three years and completely eliminated all student and consumer debt. They fully funded an emergency reserve fund and saved a down payment for their first home. This may seem rather radical but this couple is now able to invest over 25% of their income into investments and from the beginning they learned to live within their financial means.

The Emergency Reserve

Most financial planners agree that a household should maintain very safe and liquid investments equal to 3-6 months of expenses in case of financial emergency. It is important that these funds be available for use in emergency situations so that personal finances are not adversely affected. Many don't take this important first financial step and it oftentimes leads to high interest rate credit card debt.

Living Within a Budget

Especially in the beginning of one's career, it is important to develop a spending plan in which all sources of income are identified and limitations are placed on spending, especially discretionary items. Wealth is built by spending less than you earn and doing it over a lifetime. This excess income will create the funds necessary for the investment in appreciating financial assets. This formula of spending less than we make works for people of all incomes. It is important for people to get on track as early as possible in order to have the opportunity to invest and take advantage of the power of compounding returns from our investments.

The Retirement Nest Egg

As soon as possible, it is necessary to start saving money for retirement in order for the power of compounding returns to be unleashed over a 30 or 40 year period of time. For example, $1,000 per month invested with a hypothetical return of 8% over 20 years would equal approximately $590,000 but continue the contributions over another 20 years at the same 8% hypothetical return and the future value is equal to nearly $3.5 million, nearly 6 times the amount. The truth is that the only way to plough as much as possible into investments early in order to maximize this long-term compounding is to control the urge to overspend after those long difficult years in school. I'm not suggesting that we never spend; rather, I am suggesting that we temper and delay gratification somewhat until these other important financial steps are in place.

Many investors contemplate the question of how much is enough for retirement especially when it is so far into the future. I like to forecast so I project the amount of income, based upon the desired lifestyle, that I would like to have in retirement. It is easier to see this future the further we move along in our careers and the closer we get to the retirement date. Based upon a well balanced portfolio in retirement, I generally recommend a 4% withdrawal rate in order to maximize the probability that we don't outlive our financial resources. This means that it would take an approximate $250,000 nest egg for every $10,000 of income that we would like to have in retirement. For someone that wanted a retirement income of $100,000 it would require a $2,500,000 nest egg. For the retiree that wanted a $250,000 income it would be $6,250,000. Of course these were simplified calculations and would depend on whether the investments were pre-tax or after-tax. The further away from retirement we are, the less accurate our projections have to be. Another metric to determine if you are on track is the amount of investment relative to your income that you are saving for retirement. 10-15% of income is generally the rule of thumb for contributions.

Perhaps you find yourself in a situation in which you are along in your career and realize that you haven't saved enough for retirement. I would encourage you to get started now. Meeting with a qualified financial planner would be a good first step since he or she can help you evaluate your current situation, assist you in developing financial plans, and even aid in the implementation of the plans necessary for financial success.

IMS

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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

Michael H. Fritsch, MD, Professor of Otolaryngology, IUSM, taught "Cosmetic Surgery of the Ears," at the Otolaryngology National Meeting in September in Washington, DC.

Sara L.P. Schrader, MD, has joined JWM Neurology. Dr. Schrader is a neurologist, and received her medical degree from Indiana University School of Medicine in Indianapolis. She completed her Neurology Residency and Clinical Neurophysiology Fellowship at Mayo School of Graduate Medical Education in Phoenix, Arizona. She recently served as a Major in the US Air Force as a staff Neurologist/ Neurophysiologist at the San Antonio Military Medical Center in Texas. Dr. Schrader sees patients with general neurology conditions and has special interests in Epilepsy/EEG/ EMG.

W. Gregory Chernoff, MD, was an invited symposium lecturer at the 16th World Congress on Controversies in Obstetrics Gynecology, and Infertility on July 20-23, 2012 in Singapore. He presented his Center's latest work on Multimodality Scar Therapy. He also spoke in Kuala Lumpur and Penang Malaysia on this topic.

Vincent P. Mathews, MD, board certified Neuroradiologist and President and CEO of Northwest Radiology gave a CME presentation on "Neuroimaging of Alzheimer's Disease" to staff members at St. Vincent Salem Hospital, in Salem, Indiana on August 28, 2012.

Lynda A. Smirz, MD, chief medical officer and VP of surgical services at Indiana University North Hospital, was recently elected to the Education Committee of the Federation of State Medical Boards. The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories. The FSMB leads by promoting excellence in medical practice, licensure and regulation as the national resource and voice on behalf of state medical and osteopathic boards in their protection of the public.

Dr. Smirz will serve on the 2012-2013 Education Committee and will be involved in the FSMB's collaboration with the National Council of State Boards of Nursing and the National Association of Boards of Pharmacy. Together the groups will lead the first tri-regulated symposium in Washington, DC, in October. As a member of the FSMB's Education Committee, Dr. Smirz will assist in providing consultation and recommendations in the development and review of the FSMB's annual education agenda. In addition, the Committee members are charged with identifying and prioritizing education topics in accordance with the mission, vision, core values and goals of the FSMB.

Tod C. Huntley, MD, of CENTA was in an invited speaker at the 10th World Congress on Sleep Apnea in Rome in August. His participation included chairing a scientific session on surgery for OSA, conducting a workshop on robotic surgery for sleep apnea, and presentation of a paper on hypoglossal nerve stimulator (HGNS) implantation for OSA.

Dr. Huntley's FDA clinical trial on HGNS completed enrollment in September. He conducted a cadaver instruction of the procedure at the University of Minnesota in July and proctored the first cases performed at Stanford University in August.


William J. Berg, MD


W. Gregory Chernoff, MD


Michael H. Fritsch, MD


Harry C. Genovely, MD


Tod C. Huntley, MD


Valerie P. Jackson, MD


Mark A. Jones, MD


Michael O. Koch, MD


Vincent P. Mathews, MD


John B. Meding, MD


Jeffery L. Pierson, MD


Carl L. Rouch, MD


Sara L.P. Schrader, MD


Richard J. Shea, MD


Lynda A. Smirz, MD

News from Franciscan St. Francis ...

Jeffery L. Pierson, MD and John B. Meding, MD, presented the latest treatments for arthritis and joint replacement therapies during a St. Francis "Road Shows" in September.

Several physicians at Franciscan participated in free cardiovascular seminars and screenings: **Mark A. Jones, MD,** and **William J. Berg, MD,** "Avoid a heart attack: Know your numbers; **Richard J. Shea, MD,** "Do you have a heart murmur?;" **Harry C. Genovely, MD,** "How to protect yourself from stroke;" and **Carl L. Rouch, MD,** "Why does it hurt to walk?."

News from IU School of Medicine ...

Two IMS members are serving on the search committee to find a new dean for the IU School of Medicine, they are: **Valerie P. Jackson, MD,** chair and professor of radiology and imaging sciences, Eugene C. Klatte Professor of Radiology and Imaging Services, IUSM and **Michael O. Koch, MD,** chair and John P. Donohue Professor, Department of Urology, IUSM.

Election Results

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IMS Indianapolis Medical Society 1848

Special Feature

Nicole Mensah, MS 4; Theresa Rohr-Kirchgraber, MD

Eating Disorders in Adulthood

A 15-year-old girl flips through a fashion magazine. Photo after photo of beautiful, flawless, obscenely thin models flash before her. Her self-esteem takes an immediate blow, and so it begins. She thinks, "If I just eat a little less, exercise a little more, I too can be beautiful." And once those thoughts emerge it is a slippery slope; a downward spiral towards the realm of disordered eating. Does that scenario surprise you? It is devastating, but we have heard it before. What we do not hear as often are stories of adults suffering from eating disorders (EDs), which they acquired as adults. Yet the reality of the situation is that EDs, historically thought of as diseases of adolescents, are prevalent amongst adults. In fact, it has been estimated that 78% of people whose cause of death was anorexia were 65 and older.[2]

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) divides EDs into the following categories: anorexia nervosa (AN), restricting and binge/purge subtypes; bulimia nervosa (BN), purge and non-purge subtypes; and eating disorder not otherwise specified (EDNOS).[1] While slightly different in their presentation, these diseases share the common feature of a patient having "a morbid preoccupation with weight and shape," [4] But to consider a diagnosis of ED based on weight alone would be a grave mistake, as many people plagued by an ED, especially BN, are of normal weight.[1] What's more, adults are affected by all types of EDs, with EDNOS being the most prevalent at an occurrence rate of 75% among the population of adults with EDs.[6]

Although adult-onset EDs are mainly seen in Caucasian females, EDs plague both men and women from all ethnic backgrounds and walks of life,[5] though EDs manifest differently in men then in women. While the aim of most women with EDs is to lose weight, most men with EDs strive to gain muscle mass, particularly in their arms and shoulders.[2] It is common for women suffering from the purging type of BN, to engage in self-induced vomiting, whereas this practice is not typical seen in their male counterparts.[2]

Situations that trigger adult-onset EDs typically occur during a transitional period in one's life. Often, events such as the death of a friend or family member, a relationship ending, or one's children leaving the home, are the triggers that induce an ED.[2] Whether these people engage in disordered eating for attention, protest, hopelessness, or poor self-esteem, there is still an underlying psychological issue that needs to be addressed. It has become apparent that there is more to treating EDs than reestablishing a normal weight. The ultimate goal is to equip the patient with the tools necessary to eliminate their pathological relationship with food, develop a positive self-image, and lead a healthy and balanced lifestyle. There is not a single, sure-fire way to treat EDs. Treatment must be tailored to the patient's specific needs. Nevertheless, there are some practices known to be very successful. Cognitive Behavioral Therapy (CBT) and other psychological intervention helps patients work through the deep-seeded emotional discrepancies they have with eating and personal appearance.[3] A mental health professional is a vital part of the treatment team. In addition, the treatment team must also include a dietician, as this whose jobs is to ensures that the patient is aware of the appropriate foods necessary to provide sufficient energy and nutrients for his/her physiological needs.[3] Furthermore, the physician has an integral role in the management of ED patients. It is the role of the physicians responsibility to monitor the medical condition, to help prevent medical complications of ED, and to prescribe medications when indicated.

The only approved medication for treating EDs is Prozac (fluoxetine), and when given at high enough doses, it has been noted to reduce binge eating and vomiting in up to 70% of patients.[3] Although not approved for treating EDs, Topomax (an anti-seizure medication) has been implicated in the successful treatment of BN and binge-eating disorders.[3] It is the combination of psychotherapy, nutritional rehabilitation, medical treatment, and in some instances medications, that seems to yield the best results.[7] For the most part, EDs are treated in an out-patient setting. In extreme cases, where a patient is severely underweight, expressing suicidal ideations, or is very medically compromised, hospitalization may be warranted until the patient stabilizes.[3]

Physicians must aggressively treat EDs to prevent the many, severe co-morbidities that can ensue. EDs have been shown to be accompanied by loss of menses (amenorrhea) or irregular menses, thinning of the bones (osteopenia or osteoporosis), irregular heart beats (cardiac arrhythmias), gastrointestinal distress (such as constipation, diarrhea, bloating and abdominal pain), and depression to name a few.[4] As a society, we must abandon the idea that EDs only arise in adolescent populations and acknowledge that EDs do occur in adults. So yes, always be mindful of the 15 year-old girl who feels inadequate when looking through a magazine, but do not forget that her mother may be feeling inadequate as well.

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Ms. Mensah is a second year medical student at IUSM and recently completed a summer research internship with the Adolescent Medicine Section.

Theresa Rohr-Kirchgraber, MD, FACP is an Associate Clinical Professor in Medicine and Pediatrics and the Section of Adolescent Medicine. She is currently the Executive Director of the IU National Center of Excellence in Women's Health. trohrkir@iupui.edu and works with the Charis Center for Eating Disorders.

New Members

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Email – greg@drchernoff.com
Web – www.drchernoff.com
Otolaryngology, 1994
Plastic Surgery
Plastic Surg. within the Head & Neck
Univ. of Saskatchewan, Canada, 1986

Green, Erika, MD
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Advanced Healthcare Assoc., LLP
5150 Shelbyville Rd.
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Internal Medicine, 2009
Geriatric Medicine (IM)
Indiana University, 2005

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Geriatric Medicine (IM)
Indiana University, 1997

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Project Health

Carrie Jackson Logsdon, Director

Thank you, Michael C. Dalsing, MD

Michael C. Dalsing, MD, is Project Health's physician of the month for October. He was born in Dubuque, Iowa, but he grew up in Kieler, Wisconsin, one of seven children. Dr. Dalsing attended St. Mary's College in Winona, Minnesota, where his major interest was in science. But he lived in a house with seven other guys, many of whom were taking the MCATS, so he decided to do the same. He went to the Medical College of Wisconsin which he says was Marquette Medical College in those days. "We even used to scrimmage with the guys on the team during Coach Pat Riley's time."

Dr. Dalsing did his Internship and Residency at the Indiana University School of Medicine and then completed a Vascular Surgery Fellowship at Northwestern in 1984. "They trained us very aggressively at Northwestern, and I was one who took the first Vascular Board Exam in June of 1984." Dr. Dalsing said he came back to Indianapolis because he had a job offer from Russell S. Dilley, MD, in Vascular Surgery at Indiana University. Then, Dr. Dilley left to pursue private practice and Dr. Dalsing was the sole vascular surgeon there for a year and a half.

He is Board Certified in General Surgery, Vascular Surgery, and Surgical Critical Care. His academic appointments include being the E. Dale and Susan E. Habegger Professor of Surgery with Tenure and Director and Chief of Vascular Surgery at IU. He is proud of initiating and leading for many years the Vascular Surgery Residency Program at IU. Dr. Dalsing is also the Medical Director of the Non-invasive Vascular Diagnostic Laboratory at I.U. Health Methodist and North Medical Centers.

He is a Past President of the American College of Surgeons Indiana Chapter, the American Venous Forum, and Midwestern Vascular Surgical Society and current president of the Association of Program Directors in Vascular Surgery, among other professional activities. He was also voted one of the best doctors in Indianapolis by Indianapolis Monthly for the past several years and is named in the Marquis Who's Who in America.

"Vascular disease and the potential surgical options have soared in the past 30 years. Most of it seen in people with high cholesterol, high blood pressure, smoking, lack of exercise and genetic predisposition," he says. "In the past, patients with bad venous disease and leg infections that would not heal could only be offered a rather delicate valve repair to help the problem. We now know that narrowing of the veins might be the cause and we can use a small needle to puncture the vein and place a stent to keep the vein open. What a change! Possibly even more impressive is our ability to fix vessels that are too large from the inside even in the direst of cases. For example, we have a Level one ruptured Abdominal Aortic Aneurysm program which flies in people to us who are leaking from the large blood vessel in the abdomen. In many of these people, we can use a needle to get into the blood vessels in the leg and pass devices into the aorta to seal the leak. In the past, a large cut to get into the abdomen and clamps to control the bleeding was the only answer. We are able to save many of these people because we can get to them early by having the helicopters fly them in." He describes the younger doctors as the vascular surgery superstars of the future. "They grew up on video games and much of what we now do uses these skills to excellent advantage. He says most of his work is clinical and administrative now and that his group is expanding. "We now have nine partners, two pathways of training vascular surgeons, and a large diagnostic vascular lab with eight to nine technologists."

Dr. Dalsing and his wife, Rosa Marie, have three daughters. "Rosa was a teacher until the children came along; we realized how incredibly important it was to have her home with the kids." They like to travel and because of his conferences, they have visited some very nice places – Hawaii, Japan, South America, Australia, London, Paris, and Monte Carlo. He says they try to meet relatives in some of those places and extend the family vacations. The place they spend most of their vacation time at is French Lick, Indiana. "Right after we bought a time-share people questioned what in the world we were doing, but as a family vacation we could take the short drive down every year with kids of various ages and play golf and tennis, horseback ride. The girls learned how to use a bow and arrow and have played golf since age six."

Dr. Dalsing says, personally, he is most proud of and thankful for his wife, "because she gives us all a strong foundation, something that is not work, and all the other good things that come with family life." On the professional side, he is most proud of starting the training programs. "You know these people forever and it's like a whole new family."

All of us at Project Health are very grateful that Dr. Dalsing and his peers have made our patients part of your family – because you have saved countless lives and returned them to active lifestyles and work. These days, we consider that to be a miracle. Thank you!

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Delegates to the State Convention, September 2013

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

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Robert E. Dicks (2014)
Doris M. Hardacker (2014)
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Ramana S. Moorthy (2014)
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Steven M. Samuels (2014)
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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.

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.
Fourth Thursday	Psychiatry Grand rounds 7250 Clearvista Dr. Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m.

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.
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.
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.

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.
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.

Indiana University School of Medicine/ Indiana University Health

IU – Methodist – Riley

Oct. 10-12	Building a Comprehensive Home Dialysis Program JW Marriott, Indianapolis
Oct. 10	Brain Tumor Symposium Update Goodman Hall, Indianapolis
Oct. 19-20	Primary Care of Adolescents: Pearls, Perils and Pitfalls Indianapolis Marriott East, Indianapolis
Oct. 19	Thirteenth Annual John P. Donohue Visiting Professor NCAA Conference Center, Indianapolis
Oct. 22-23	Emergency Medicine and Trauma Conference for Advanced Providers Fairbanks Hall, Indianapolis
Nov. 2-3	20th Annual Trauma/Surgical Critical Care Symposium University Place Conference Center, Indianapolis
Nov. 2-3	The Third Annual Eugene & Marilyn Glick Eye Institute Vision Symposium Eugene & Marilyn Glick Eye Institute, Indianapolis
Nov. 7	Pediatric Endocrinology Riley Outpatient Center, Indianapolis
Nov. 14	Latest Scientific Approaches to Helping Children with Gastroenterology and Liver Disease, Bloomington, Indiana
Nov. 30 - Dec. 1	Advanced Heart Failure Symposium JW Marriott Downtown, Indianapolis
2013 Jan. 19	Review and Interpretation of the 2012 San Antonio Breast Cancer Symposium Indiana History Center, Indianapolis
May 28	48th Annual Riley Hospital for Children Pediatric Conference Indianapolis Marriott Downtown, 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

October	
2	IMS Board, Society, 6:00 pm, Social; 6:30 pm, Dnr/Mtg/ Inaugural
23	Executive Committee, Society, 6:00 pm, Sandwiches
November	
4	IMS Advisory Breakfast, 7:30 am
10-13	AMA House of Delegates, Honolulu, Hawaii
20	ISMA Board of Trustees, 9:00 am, ISMA Headquarters
December	
12	Senior/Inactive Luncheon Meeting, Noon, Society TBD
18	Executive Committee Holiday Dinner, with Spouses/Guests

In Memoriam

James C. "Jim" Harris, MD
1933 - 2012

James C. "Jim" Harris, MD, 79, of Indianapolis passed away peacefully in his home on August 18, following a long battle with PPA & heart disease. He was born on January 28, 1933, in Noblesville, Indiana.

Aside from eight very enjoyable years of retirement in Arizona, Dr. Harris was a life-long resident of Central Indiana. He attended Noblesville High School and graduated from Kentucky Military Institute in 1951 before attending Indiana University. Dr. Harris served two years in the US Army during the Korean Conflict. Upon completion of his undergraduate studies, he attended Indiana University School of Medicine in Indianapolis and graduated in 1960. His internship was at VA Hospital in Indianapolis, his residency was at Coleman Hospital in Indianapolis, and his fellowship was at Indiana University Hospital. Dr. Harris had a private practice in internal medicine in Indianapolis from 1963 to 1980.

In 1980, Dr. Harris began a second career as the Medical Director for American United Life Insurance Company. He served on the Executive Council of the Association of Life Insurance Medical Directors of America, and also served as President of the Midwest Medical Directors Association. He retired from AUL in 2000 as Corporate Medical Director/Sr. Vice President Reinsurance.

Frank Robert "Bob" Brueckmann, MD, FACS
1929 - 2012

F. Robert "Bob" Brueckmann, MD, FACS, was born in Chicago, Illinois on August 4, 1929. Dr. Brueckmann died peacefully on August 20, 2012 after a long illness. He grew up in Hammond, Indiana. After high school, he attended Indiana University where he was a member of Sigma Phi Epsilon Fraternity and Alpha Omega Alpha, a Medical Scholastic Honor Society. Dr. Brueckmann earned his undergraduate degree in 1950 in Anatomy and Physiology. He then enrolled in Indiana University School of Medicine where he earned his medical degree in 1954.

Dr. Brueckmann lived in Sunnyside Tuberculosis Sanatorium where he externed for three years. After graduating from medical school in 1954, he interned at Cook County Hospital. From 1955 to 1957, Dr. Brueckmann was stationed in Livorno, Italy where he served as a captain and worked as a radiologist for the United States Army Medical Corps.

From 1958 to 1962, Dr. Brueckmann completed his Residency in Orthopaedic Surgery at Indiana University in Indianapolis. Then in 1962, he and his partner founded Orthopaedics Indianapolis, now known as OrthoIndy.

Dr. Brueckmann had many academic and hospital appointments. He was Assistant, Associate, and Clinical Professor of Orthopaedic Surgery at Indiana University from 1962 to the present, and Instructor, Medicine in Physical Therapy, from 1992-1993. He was a Visiting Professor in Orthopaedic Surgery at the University of Djakarta, Indonesia. He worked at Methodist, Wishard Memorial, St. Vincent's, Winona, and Hendricks Community Hospitals.

Dr. Brueckmann was a member of the American Medical Association, the American College of Surgeons, the Indiana Committee on Trauma, the American Fracture Association (Board of Governors, Vice President, President, and Program Chairman), American Academy of Orthopaedic Surgeons, American Rheumatism Association, Indiana Orthopaedic Society, Clinical Orthopaedic Society (Program Chairman, Membership Committee, Membership Committee Chairman, Second President-Elect, President), Indiana Bone and Joint Club (President), Great Lakes Orthopaedic Club (President), Orthopaedic Trauma Association, Orthopaedic Letters Club, International Society for Fracture Repair, and the Indianapolis Orthopaedic Club.

Glenn W. Irwin, Jr., MD
1920 - 2012

Former Dean of the IU School of Medicine and Chancellor of IUPUI dies. Dr. Irwin, 92, died on August 23, 2012.

He attended Indiana University where he received a BS degree in 1942 and a MD degree in 1944.

Dr. Irwin interned at Methodist Hospital in Indianapolis and completed a residency in Internal Medicine at IU. In 1946-48 he served in the US Army Medical Corps at Schofield Barracks General Hospital in Hawaii as a Captain and Chief of Medicine. He returned to IU, finished his residency and then joined the department of medicine as an Instructor in Medicine in 1950.

He progressed through the ranks and in 1965 was appointed Dean of the IU School of Medicine. During his tenure the IU Hospital was built and a second phase was under construction, a major addition to the Riley Hospital was completed, the Indiana statewide medical education system was enacted, a major change in the curriculum was adopted, and a new faculty clinical fee plan was produced. There were many faculty positions added both in Indianapolis and at the seven state medical education centers.

In 1973 he was appointed Chancellor of IUPUI. The following year, a reorganization of the university changed his position to Vice President of Indiana University (Indianapolis). During his administration numerous campus buildings were built, including schools of science, business, SPEA, education, social work, physical education, including the natatorium, stadium and track. Also several parking garages and graduate apartments were constructed. Several medical school buildings were added. At the end of his tenure the IUPUI student enrollment was over 23,000. There were substantial increases in total budget, research income, number of degrees, number of full time faculty and number of graduates.

After his retirement in 1986, he was provided an office at the medical school. He belonged to numerous fundraising committees, including those for the the School of Medicine, IUPUI, the School of Nursing, Riley Children's Foundation, and Wishard Health Foundation.

A partial list of his many board memberships include Eiteljorg Museum, Greater Indianapolis Progress Committee, Riley Children Foundation, Skyline Club, Walther Medical Research Institute and YMCA. He had been a member of the American College of Physicians, Columbia Club, Meridian Hills Country Club, Rotary Club. Contemporary Club, Indiana Society of Chicago, Mason-33 Degree, and a Second Presbyterian Church Elder. Some of his honors included AOA, Sigma Theta Tau International Nursing, Sagamore of the Wabash (3 Governors), Indiana Academy, Lifetime Achievement, Indiana Council of Fund Raising Executives, Distinguished Alumni Service Award, Indiana University, Honorary Doctoral Degrees from IU and Marian University.

President's Page ...

(continued from page 7)

(from an original list of 65). Physician acceptance could be an issue after the prior managed care era experience, but there are appropriate ways to encourage physician engagement around shared values and business goals. Actionable date coupled with appropriate financial incentives are strong motivators for acceptance.

Local ACO activity

In Central Indiana there are three ACOs; American Health Network (AHN), IU Health, and the Franciscan Alliance. I interviewed local ACO leaders, Dr. Ben Park of AHN, Dr. John Fitzgerald of IU Health Physicians, and ACO Executive Director Jenny Westfall of Franciscan St. Francis. These three ACO entities are different from each other in that the Franciscan St. Francis ACO is a Pioneer model and the other two are Shared Savings one-sided models. The Franciscan Alliance ACO at St. Francis has approximately 20,000 attributed members, AHN has approximately 28,000, and IU health has approximately 25,000. The interviews disclosed that the ACOs have approximate physician participation of 700 at Franciscan, 150 PCPS at AHN (AHN is a primary care network), and 1500 at IU Health. It should be noted that a PCP cannot participate in more than one ACO. The leaders interviewed indicated that physician acceptance is high because most providers understand and accept the transition from a volume to value-based delivery system with quality-based reimbursement.

Last month I wrote about the "moment of clinical and financial value." In theory, I see this new delivery model as a positive change which attempts to improve the quality of health care and reduce unnecessary costs resulting in savings and enhanced reimbursement to the providers through gain sharing. The economic incentives of an ACO are strongly aligned with the patients' best interests as well. One concern that I have from a personal experience as a PCP in the IU Health ACO is patient willingness to participate. After the announcement and patient notification regarding the ACO, some of my patients have been confused about the details and are leery of participating. Medicare beneficiaries can elect to opt out of the ACO. Opting out relates to claims data sharing, but the patient does not need to acquire a new provider. As we head down this path of ACO health care delivery we will discover whether or not beneficiary participation will be a significant problem and just how successful this new model will prove to be.

References:

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www.wikipedia.org/
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www.cms.gov.

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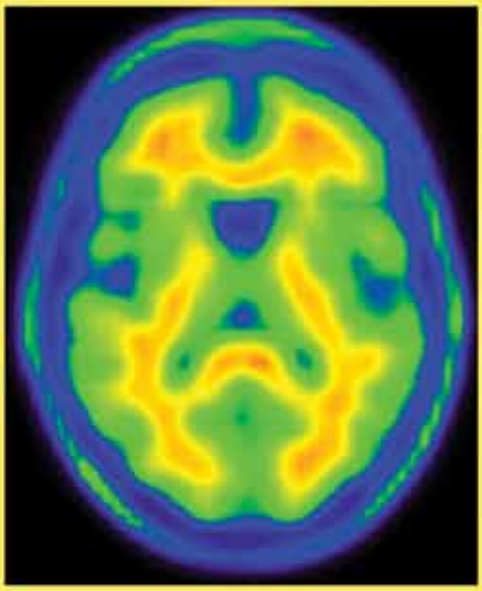
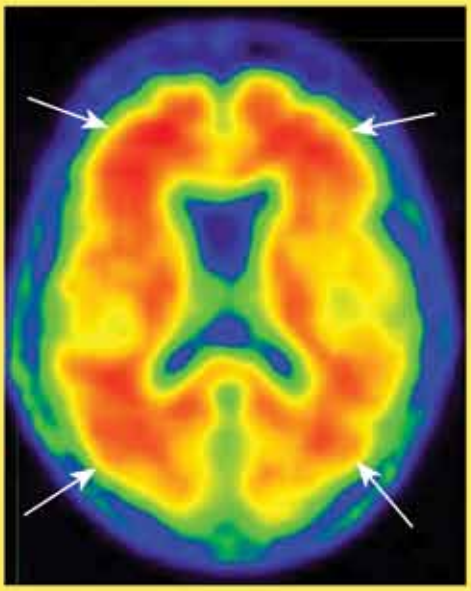


Negative Scan

A negative Amyvid scan indicates that a person has few or no amyloid plaques – consistent with no presence of Alzheimer's Disease.



Arrows Indicate Amyloid Neuritic Plaques

Positive Scan

A positive scan indicates moderate to frequent amyloid plaques – consistent with a pathological diagnosis of AD. However, this amount of plaque can also present in other neurological conditions as well as in older adults with normal mental functioning.

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