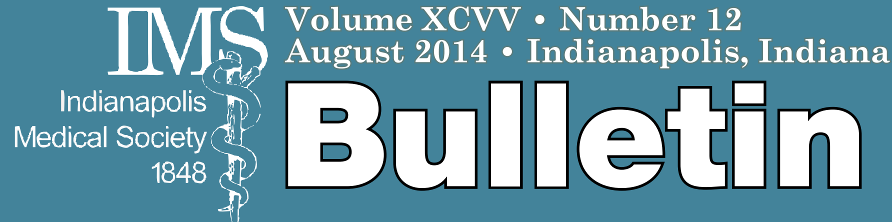

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Vol. XCVV • Number 12
August 2014 • Indianapolis

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Official monthly publication of the
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Bulletin Subscriptions: $36.00 per year
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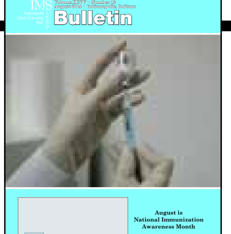

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National Immunization Awareness Month.

Recognizing National Immunization Awareness Month (NIAM)

Each year in August, National Immunization Awareness Month (NIAM) provides an opportunity to highlight the value of immunization across the lifespan. Activities focus on encouraging all people to protect their health by being immunized against infectious diseases. In 2014, the National Public Health Information Coalition is coordinating NIAM activities.

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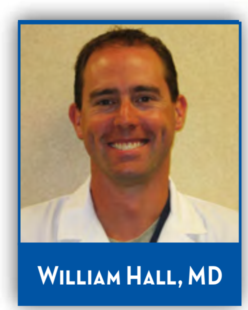

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President's Page

Mark M. Hamilton, MD

The Future of Medicine for Physicians and Organized Medicine

This being my last column offers a chance for reflection and forecasting. It has been an honor and a real education to serve as President of the Indianapolis Medical Society this past year. I have tried to focus previous columns on several of the pressing challenges in medicine and provide a unique perspective. In this article I want to take the opportunity to look at our future as physicians in medicine and what concrete role organized medicine can play in shaping that.

As physicians, we must continue to take a vocal and active role in organized medicine. We're already starting to see a fundamental shift in the way medical care is delivered. As these transformations shape the future of medicine, it is our responsibility to play a major role and serve as a voice for the physicians and patients of future generations.

Things have changed since the days of small town hospitals and physicians making regular house calls. We have entered an era of statewide health systems and multispecialty hospital physician groups. Our patients have changed too – the incidence of chronic ailments is on the rise, with obesity and diabetes topping the list.

Advances in technology might make the biggest impact on the profession. Telemedicine can allow evaluation and diagnosis from a distance. Data gathered from health records and devices in patients' homes will allow doctors to monitor vital health statistics in real time.[1] Google Glass holds the promise of offering physicians access to all available data in plain view while still tending to the patient in front of them. In addition, it allows the transmission of a surgeon's perspective in real time; valuable both for education and expert consultation.

Technology does not just facilitate diagnosis at a distance — it allows surgery at a distance, too. Robotic instruments allow doctors to be more precise, as well as more present, making incisions more neatly than human hands can. These tools will only continue to improve physician's abilities, however, not replace them.

The collection of medical data will also fundamentally transform the way hospitals and doctors are reimbursed for the care they provide. Both the federal government and insurance companies are already crunching the numbers to reward hospitals and doctors that deliver the most effective care, while punishing those that don't. Hospitals that don't show results will either be fined or see cuts in Medicare reimbursement.

In fact, Medicare is preparing to penalize about 750 hospitals that have the highest rates of infections and patient injuries. The sanctions are estimated to total $330 million over a year.

The Hospital-Acquired Condition Reduction Program, created by the 2010 health law, is the third of the mandatory pay-for-performance programs established under federal health law. The first levies penalties against hospitals with high readmission rates, and the second awards bonuses or penalties based on two dozen quality measures.

Starting in October, a quarter of the nation's hospitals — those with the worst rates — will lose one percent of every Medicare payment for a year.[2]

Patient satisfaction could have a big impact on doctor compensation in the future as well. A survey compiled in 2013, found that two percent of primary care physicians' compensation is already based on "patient satisfaction metrics" while one percent of specialist physician compensation is based on "patient satisfaction metrics."

Across the country, business and health insurance companies are pushing for more patient satisfaction metrics. Most survey questions deal with how well the doctors provide clinical care and improve health outcomes for their patients, but some satisfaction surveys focus on things like how quickly phone calls are returned or how long a patient sits in a waiting area.[3]

Another future trend could be a change in employment and schedules for physicians of the future. As physician-owned practices get bigger, young doctors will likely have more opportunities to join a practice without taking a stake in ownership. A recent study from *Health Affairs* found that, among physicians filing Medicare claims, 35.6% worked in groups of more than 50 in 2011, up from 30.9% in 2009.[4] Among physicians under the age of 40, twice as many are employed, compared to those that run their own practice. About 49% of employed doctors are either working in a hospital or are in a group now owned by a hospital.[5]

We're already seeing a rise in the number of doctors working part-time. A survey released by Cejka Search (a physician search firm based in St. Louis) and the American Medical Group Assn., found that in 2011, 22% of male physicians and 44% of female physicians worked less than full time, up from 7% of men and 29% of women in 2005.

Two of the fastest-growing physician demographics – men near the end of their careers and women at the beginning or middle, are the most likely to demand part-time or flexible work schedules.[6]

It is vitally important that physicians stay engaged and active in advocacy as insurance companies and government continue to dictate how care is delivered. We're already seeing an increase in the layers of bureaucracy as evidenced by the implementation of Obamacare, ICD-10 codes and healthcare delays in the VA Hospital system. Physicians need to be the number one advocate for patients and quality healthcare.

It's up to us as physicians to share our knowledge and to advocate what's right for patients and organized medicine as a whole. I encourage doctors across Indiana to trust their experience and do what's best for patients. Don't rely on recommendations from the government or other entities lead by those who don't actually practice medicine. Keep up-to-date

Continued on page 23.

 Denny Flint, Assistive Coding, LLC

ICD-10 is just the vessel. The real cargo? Data!

Stop focusing on ICD-10! The real elephant in the room is the rapid proliferation of diagnosis-based reimbursement. The role of ICD-10 (if and when it actually comes to pass) needs to be re-evaluated. ICD-10 will merely be the language by which your public face to the outside world (Your coding profile!) is expressed. ICD-10 is a vehicle for capturing more specific, detailed data, nothing more and nothing less.

The nation is rendering itself asunder with an ICD-10 argument that completely misses the point. Forget ICD-10 for a moment and take a look around. Think about all the new acronyms – ACO, HCC, RAF, PCMH and how they relate to chronic disease burden management. The old paradigm that says "the more you treat, the more you make" is changing. Insurance companies are aggressively pushing shared risk programs that stress quality of care at less cost. The only way to do that is to move away from the unsustainable model we have now. The paradigm shift to the new mantra "the less you treat, the more you make" needs to be embraced while upholding the sacred commitment to high quality of care.

We saw the shift start to occur with capitation in the '80's. The "per head" model frankly failed because we didn't have the data to truly assess how sick our assigned patient population really was in order to analyze whether or not the amount of capitation was sufficient to carry the treatment burden for that population. Not having adequate data is also the reason many ACOs fail. With an anticipated 30% of the patient population moving to "shared risk" models within the next year, isn't it time we took the new paradigm of "less is more" seriously? Patient Centered Medical Home with its tiered $1, $2, $3 per head compensation is yet another attempt to open the door to providers taking on more and more risk. We'll "get used" to a capitation model in the same way PQRS started to get us comfortable with "value based" reimbursement.

As we go through the next phase of physician compensation shift, the "value based" model tells us that physicians will not get paid based on what they do, but rather for how well they can prove they do it. Is consumerism the next iteration? Perhaps. In the final drive to diagnosis-based reimbursement, physicians will not be paid based on what they do (CPT), but rather based upon what's wrong with the patient (ICD-9 or 10). For the naysayers and for those of you old enough to remember, I merely remind everyone about what the prevailing hospital-view was when Yale released the original DRG system in the '70's. "Oh, it'll never happen."

It happened to hospitals and it's happening once again to physicians. You see, insurance companies want to take the decision for care out of the provider's hands. Their clarion calls were, "needless diagnostic tests, over-treatment, and unnecessary procedures." When insurance companies shift to paying physicians according to what's wrong with the patients, the ability to "overwork" the system is removed. Before everyone cries foul, please keep in mind our current system is unsustainable.

So how does a practice thrive in this drive to "less is more" ACO's and other related Dx-based reimbursement models? The key is data. Arm yourself with accurate acuity level data that indicates how sick your patients really are and what amount of care can be expected to be delivered. This is where an ACO decision-to-participate needs to begin. Without this data you are flying blind. Specificity, at least in as much as ICD-9 currently affords, is key. When asked about the best way to begin an ICD-10 transition, I always say, "It starts with clinical documentation improvement that mandates physicians must provide the documentation elements to meet the specificity." Specialty-specific physician documentation education, baseline chart reviews that reveal current documentation shortfall, and HCC analysis for your particular specialty are valuable tools.

By doing so, you will reap benefits not only for the future of ICD-10 success for your practice, but also for the current shift in the way physicians will be paid.

Denny Flint is Sr. Consultant and Director of Business Development for Assistive Coding, LLC, a member of The Pinnacle Group family of physician financial, education, strategic planning, and coding suite of services.

He can be reached at dflint@assistivecodingservices.com or at 970-390-8970.

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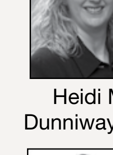
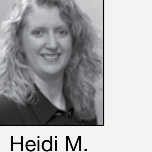
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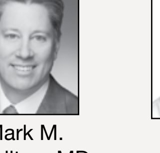

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IMS Past President, **John J. Wernert, MD,** was named by Governor Mike Pence to lead the state's Family and Social Services Administration. Dr. Wernert, a psychiatrist from Carmel, accepted the position of Secretary of FSSA on June 25, 2014. Dr. Wernert served as IMS President 2005-2006.

Heidi M. Dunniway, MD, who was elected by the ISMA House of Delegates to serve as its speaker for 2014, has become interim president-elect of the ISMA, according to ISMA bylaws (Section 4.02), with a special vote by the Board of Trustees. Dr. Dunniway, is with Otolaryngology Associates of Indianapolis and served as IMS President 2007-2008.

Michael H. Fritsch, MD, Professor, authored a review article on plastic surgery of the external ear in the *Journal Aesthetic Chirurgie.*

Todd C. Huntley, MD, from the Center for Ear Nose Throat & Allergy, has been a medical advisor to Inspire Medical (Minneapolis, Minnesota), manufacturer of the recently FDA-approved hypoglossal nerve stimulator implant for CPAP-intolerant patients with sleep apnea, the subject of a recent *NEJM* article. The Inspire system will be available later this summer. Dr. Huntley was recently flown again to the Moffitt Cancer Center in Tampa, Florida, for further advisory work and physician cadaver instruction on the nerve stimulator system, which is expected to have a large role in treating these challenging patients.

Mark M. Hamilton, MD, served as co-guest editor for the May 2014 issue of *The Facial Plastic Surgery Clinics of North America* on the topic of Neck Rejuvenation. This included his chapter on "Adjunctive Procedures To Neck Rejuvenation" highlighting his experience with fibrin sealants in Neck and Mini Facelifts.

Stephen W. Perkins, MD, of Meridian Plastic Surgeons, recently was invited faculty at the FFAS State-of-the-Art in Facial Aesthetics Symposium in Atlanta. He made the following presentations: "Endoscopic Forehead Lift that Works for the Short and Long Term - It is in the Details;" "Why Even Use the Transcutaneous Approach?;" "Why Liposuction and Fat Grafting are Still an Important Part of Facelift;" "Secondary Submentoplasty: A Technique Worth Learning To Do Well;" and "Why I Use the Erbium Fractionated Laser, CO2 Laser and Chemical Exfoliation to Individualize Treatment of Each Patient in Resurfacing."

Dr. Perkins also was invited faculty at the recent 50th anniversary, 11th AAFPRS International Symposium of Facial Plastic Surgery in New York. His presentations included: Technique-Based Video Presentation: "Dorsum and Nasal Bones Hump Reduction/Osteotomies;" Problem Based Video Presentation: "Secondary Alar Retraction;" "Contouring of the Cheek-Midface and Jaw;" "Reworking the Worried Brow;" "Periorbital Rejuvenation;" and "A Structured Approach to Selecting the Appropriate Facelift Procedure." He was sole moderator of a plenary panel on "Avoiding and Managing Complications in Blepharoplasty," a panel member for: "How Aggressive Should Your Facelift Be?" and co-director of the Facelift cadaver dissection course.

Franciscan Physician Network Oncology & Hematology Specialists has been recognized by the Quality Oncology Practice Initiative (QOPI®) Certification Program, an affiliate of the American Society of Clinical Oncology (ASCO). The physicians with Oncology & Hematology Specialists include: **Subhash C. Sharma, MD; Michael T. Slaughter, MD; Laurence H. Bates, MD; and Jaime J. Ayon, MD.**

William Gregory Chernoff, MD, presented three lectures at the 11th Annual International Symposium of Facial Plastic Surgery held May 27-31, 2014 in New York, New York. "The Aging Face: Non-Surgical Volumization vs. Surgical Correction," "Adult Derived Stem Cells in Regenerative and Cosmetic Medicine," and "The Beautiful Cell – Facial Plastic Surgery at the Cellular Level."

News from Goodman Campbell Brain and Spine…

Joel C. Boaz, MD, and coauthors reported on a 32-month-old toddler with a facial rhabdomyosarcoma and cranial fasciitis, diagnosed at 3 months of age, and treated with surgery, chemotherapy, and brachytherapy. The report was published in the June 2014 issue of *Neuropathology*.

Aaron A. Cohen-Gadol, MD, and coauthors published research findings on arachidonic acid, a bioactive fatty acid that increases during neuroinflammation and contributes to cerebral vascular damage and dysfunction. These findings support a previously unrecognized signaling cooperation

Continued on page 17.

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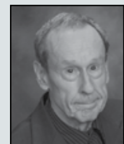
In Memoriam



Nikolas Forbes Hansen, MD
1932 - 2014

Nikolas Forbes Hansen, MD, 81, Indianapolis, passed away June 15, 2014. He was born October 22, 1932 in Detroit, Michigan.

Dr. Hansen started college at University of Michigan in Ann Arbor. He later joined the Navy (1952-1956), became a Photographer's Mate and was Honorably Discharged in June of 1960. He graduated with a BA degree from Wayne State University. Before earning his medical degree from Wayne State University School of Medicine in 1968, he worked as a Paint Salesman with E.I. DuPont in Massachusetts.

Dr. Hansen completed an internship at Detroit General Hospital in 1969. He completed his residency and a fellowship in pulmonary disease at Rush-Presbyterian St. Luke's Medical Center in Chicago, Illinois in 1984. He was certified as a diplomate in the subspecialty of pulmonary disease in 1987.

He initially practiced in Valparasio, Indiana.

Dr. Hansen retired in 1988, after developing Parkinson's Disease.

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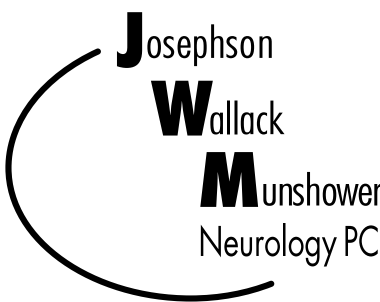

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William H. Dick, MD

Dr. William E. Segar – History of Intravenous Fluids

The Retired Physician meetings of the Indianapolis Medical Society began in 1993 as a result of the efforts of Dr. George Rawls and Dr. Ted Grayson. The group has not often heard a physician talk about a medical topic. Most talks are of general interest: history, biography, science, sports, etc. However, this chance was too good to pass up. Dr. Bill Segar was a pioneer in the area of Fluids and Electrolytes. He was an excellent teacher and an inspiring one. He certainly got me interested in the beauty and logic of the function of the kidney.

Dr. Bill Segar was born in Indianapolis and graduated from Shortridge High School. He earned a BS from Indiana University in 1944 and then took an MD from the Indiana University School of Medicine in 1947. He was on the staff of Riley Hospital for many years and then went to the Mayo Clinic before becoming Chief of Pediatrics at the University of Wisconsin. Over the years, he received many teaching awards and published many papers. He also wrote chapters on Fluids and Electrolytes for Pediatric textbooks. Dr. Segar recently received the I.U. School of Medicine Distinguished Alumni Award at the annual alumni reunion.

Since babies and small children have the most fragile fluid balance, it was natural that early research into Fluids and Electrolytes was done in the Pediatric sections of hospitals. Death rates, even today, are high from diarrhea in young children. Two million children died from diarrhea in 2013 and 8,000 died of cholera recently in Haiti. At this time, causes other than diarrhea are responsible for fluid loss: burns, inflammatory diseases, trauma and complex surgeries.

Dr. Segar pointed out that proper fluid therapy has three goals: restore and/or sustain effective circulation; provide maintenance water, electrolytes and glucose sufficient to meet the patients projected needs; and occasionally to replace pre-existing body fluid losses of both intracellular and extracellular fluid. The first person to describe intravenous fluid therapy was Dr. William Brooke O'Shaughnessy.

Dr. O'Shaughnessy had recently graduated from Edinburgh Medical School. He was 22 years of age when he read his paper on 3 December 1831 to the Westminster Medical Society in England. His research was on Cholera which was spreading through England and Scotland in 1831 and January 1832. He thought that water loss was the main problem. However, he did not actually put his excellent theory into practice. That honor would go to Dr. Thomas Latta, who reported in *The Lancet* on 2 June 1832 concerning his saline therapy. His triumph was not followed by wide acceptance, partly due to the waning of the current Cholera epidemic and the death of Dr. Latta who died of Cholera in 1833. Many of his patients survived IV therapy for Cholera, a disease that was nearly always 100% fatal.

In 1862, Ringer's Lactate was given IV from an open flask poured down a rubber tube into a steel needle, which was in a vein. L. Emmet Holt, Sr. had some success in 1897 with 19 patients surviving the therapy. John Howland of John Hopkins wrote about the physiology of diarrhea in 1913. Henderson and Hasselbach measured the pH of the blood in 1910; and in 1917 Van Slyke measured bicarbonate. Baxter Labs developed the glass bottle in 1933 and plastic bags made their appearance in 1955.

Dr. James Gamble in the early 1920's laid the foundation for fluid therapy by describing the anatomy of the body fluids, the body's response to starvation and its modification by the administration of carbohydrate. Further, he described the body's response against dehydration and acidosis.

Daniel C. Darrow, in the 1950's, quantified deficits and placed maintenance therapy on a rational basis. He described potassium deficits and the relationship to metabolic alkalosis. He was the first to use potassium in the treatment of diarrheal dehydration. He also discovered a useful electrolyte solution. Howland found that babies with diarrhea have organic acids in their urine. In 1928 Alexis Hartman used a sodium lactate solution intravenously. This reduced the mortality rate of childhood diarrhea.

Dr. Segar described the process of measuring sodium and potassium, which was a tedious process that took two days. He used one of the first flame photometers in 1951 while at Yale; it gave rapid results. The equation for the calculation of maintenance fluid therapy was described by Malcolm Holliday and William Segar in the mid to late 1950's. It was the standard one listed in Pediatric textbooks (see diagram). It is still in use today.

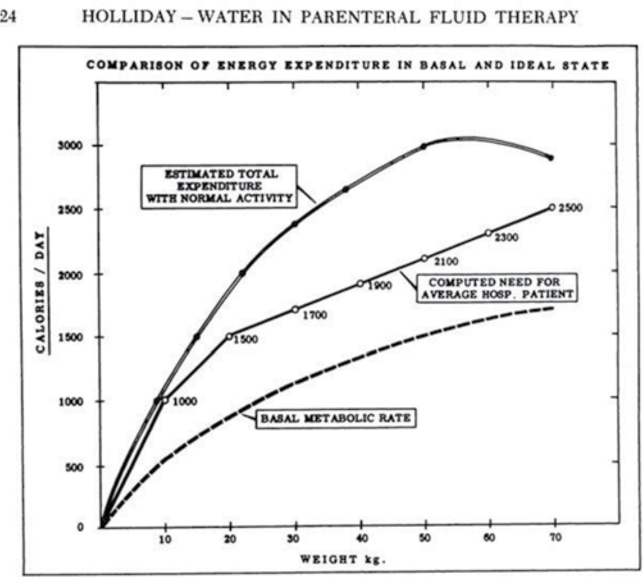

FIG. 1. The upper and lower lines were plotted from data of Talbot.[3] Weights at the 50th percentile level were selected for converting calories at various ages to calories related to weight. The computed line was derived from the following equations:

1. 0-10 kg–100 cal/kg.
2. 10-20 kg–1000 cal + 50 cal/kg for each kg over 10 kg.
3. 20 kg and up–1500 cal + 20 cal/kg for each kg over 20 kg.

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In Summary

Alert – Vaccine Availability – If you are vaccinating fully insured children, you have to purchase private stock vaccine to do so. If you are vaccinating Medicaid or Uninsured children, you can apply to be a part of the Vaccine For Children (VFC) program and receive the vaccine from the state. If need further information, contact the IMS, We have access to information from Vaccinate Indiana and can tell you if there are plans for your local health department to start billing insurance companies for privately insured children any time soon. The other option is, for some vaccine, physicians can write a prescription and the child can get it at the local pharmacy if they vaccinate.

Your Vaccine Recommendation is a Critical Factor in Protecting Patient Health

Patients trust you to give them the best counsel on how to protect their health. You know that immunization is an important preventive measure – but it's unlikely that getting vaccinated is on the radar for your adult patients. Your strong recommendation is critical in ensuring that they get the vaccines they need to help them stay healthy.

Adults are not getting the vaccines they need. The latest data from the Centers for Disease Control and Prevention (CDC) shows that vaccination rates for adults are extremely low (National Health Interview Survey, 2012). For example, rates for Tdap and zoster vaccination are 20 percent or less for adults who are recommended to get them. Even high risk groups are not getting the vaccines they need – only 20 percent of adults 64 years or younger who are high risk for complications from pneumococcal disease are vaccinated. This means that each year tens of thousands of adults needlessly suffer, are hospitalized, and even die as a result of diseases that could be prevented by vaccines.

Most adults don't realize that they need vaccines. A recent national survey revealed that most adults were not aware of recommended vaccines beyond influenza.

Your patients are likely to get the vaccines you recommend to them. Clinicians are the most valued and trusted source of health information for adults. Your patients rely on you to let them know which vaccines are necessary and right for them.

"Since adults aren't thinking about vaccines, we need ALL health care professionals to use every patient encounter as an opportunity to assess whether any vaccines are needed," Dr. Anne Schuchat, director of CDC's National Center for Immunization and Respiratory Diseases.

If the patient is due for a vaccine, make a strong recommendation that you advise getting the vaccine because it can help protect them against a disease that could be serious. For some patients, this may be sufficient information to accept the vaccine. Others may want to learn more about the vaccine and why it is right for them. For these patients, sharing the following can help them make an informed decision.

- Share the reasons why the recommended vaccine is right for the patient, given his or her age, health status or other risk factors.
- Highlight your own experiences with vaccines (personal or in your practice) to reinforce the benefits and strengthen confidence in vaccination.
- Address patient questions and any concerns about the vaccine, including side effects safety, and vaccine effectiveness in plain and understandable language.
- Remind patients that many of the diseases prevented by vaccines are common in the U.S. and can be serious – and getting vaccinated can protect them and their loved ones.
- Explain the potential costs of getting the disease, including serious health effects, time lost (missing work, activities and family events), and financial costs.

Some patients may need additional time to consider information about vaccines or want more details than can be provided during a single office visit. There are a number of things you can do to help these patients stay on track with recommended vaccinations.

- Emphasize the ease and benefits of getting vaccinated during the current visit.
- Provide educational materials or trusted websites for them to review.
- Send reminders about needed vaccines.
- Document the conversation and continue the discussion at the next visit.

To download free patient education materials or find resources on addressing patient questions and concerns about adult vaccines, visit: www.cdc.gov/vaccines/hcp/adults.

August is National Immunization Awareness Month – a reminder of the importance of immunization in keeping our communities healthy. Your strong recommendation can make a difference.

Recommended Vaccines for Healthcare Workers

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines.

Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff.

Vaccines Recommendations in brief:

Hepatitis B: If you don't have documented evidence of a complete hepB vaccine series, or if you don't have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should •Get the 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2).

•Get anti-HBs serologic tested 1–2 months after dose #3.

Flu (Influenza): Get 1 dose of influenza vaccine annually.

MMR (Measles, Mumps, & Rubella): If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles or mumps (i.e., no serologic evidence of immunity or prior vaccination), get 2 doses of MMR (1 dose now and the 2nd dose at least 28 days later).

If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to rubella, only 1 dose of MMR is recommended. However, you may end up receiving 2 doses, because the rubella component is in the combination vaccine with measles and mumps.

For HCWs born before 1957, see the MMR ACIP vaccine recommendations.

Varicella (Chickenpox): If you have not had chickenpox (varicella), if you haven't had varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.

Tdap (Tetanus, Diphtheria, Pertussis): Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get Td boosters every 10 years thereafter. Pregnant HCWs need to get a dose of Tdap during each pregnancy.

Meningococcal: Those who are routinely exposed to isolates of N. meningitidis should get one dose.

To learn more about these diseases and the benefits and potential risks associated with the vaccines, read the Vaccine Information Statements (VIS) http://www.cdc.gov/vaccines/hcp/vis/index.html.

IMS

Bulletin Board

Continued from page 11

between p38-MAPK and intracellular calcium signaling, suggesting its relevance to neurological disorders associated with vascular inflammation. The article appeared in the May 5, 2014 issue of *Microvascular Research*.

Dr. Cohen also published ahead-of-print a 3-D video case report of a 32-year-old man with newly diagnosed pontine cavernous malformations near the floor of the 4th ventricle. The patient presented with 2 brainstem hemorrhages within a 2-month interval. This video report appeared online in *Neurosurgery*, June 12, 2014.

Daniel H. Fulkerson, MD, and coauthors published a case report of Rathke's cleft cysts in twin sisters with Type 2C von Hippel-Lindau disease in the May 2014 issue of the *Journal of Neurosurgery: Pediatrics*.

Eric M. Horn, MD, coauthored with a resident a case report of subacute posttraumatic ascending myelopathy (SPAM) occurring in a 15-year-old boy who sustained a T3-4 fracture dislocation resulting in a complete spinal cord injury. This case was reported in the June 6, 2014 issue of the *Journal of Neurosurgery: Spine*.

Troy D. Payner, MD, President of Goodman Campbell Brain and Spine, presented the second part of his discussion on the "Business of Neurosurgery" at the IU Department of Neurosurgery Grand Rounds on June 25, 2014.

Richard B. Rodgers, MD, presented "Head Injury Prevention" at the IU Department of Neurosurgery Grand Rounds on June 18, 2014.

Mitesh V. Shah, MD, recently participated in the 67th annual meeting of the Neurosurgical Society of America (NSA) in New Brunswick, Canada. The meeting was jointly sponsored by the American Association of Neurological Surgeons. At this meeting, Dr. Shah presented an abstract titled "Minimally Invasive Parafascicular Approach to Deep Cerebral Lesions: Initial Indiana University Experience" and he presented the introduction to the Presidential Address. Dr. Shah is the current secretary of the NSA.

Dr. Shah will continue his involvement in the Unaffiliated Neurotrauma Consultant (UNC) program with the National Football League (NFL) during the 2014 season. In 2013, he joined the program in its inaugural year, contributing expert neurotrauma care on game days to improve the post-injury outcomes of NFL players who experienced traumatic brain injury.

Scott A. Shapiro MD, directed the local Junior Resident Course sponsored by the Society of Neurological Surgery and the American Association of Neurological Surgeons. The course was taught at Goodman Hall and the Indiana University School of Medicine, 4-7 June. Course faculty members included local faculty from the Indiana University Department of Neurosurgery and Goodman Campbell Brain and Spine, and visiting faculty from Rush Memorial Hospital, Mayo Clinic, University of Florida, St. Louis University, and Northwestern University. The faculty taught neurosurgical procedures and competencies to 68 PGY1 neurosurgery residents from over 30 neurosurgery residency-training programs in the United States. Dr. Shapiro is the Indiana University Robert L. Campbell Professor of Neurosurgery and the Program Director for the Indiana University Neurosurgery Resident Training Program.

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Delegates to the State Convention, September 5-7, 2014, Westin Hotel, Indianapolis

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

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Douglas J. Horton (2014)
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Jason E. Rieser (2014)
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Kenneth N. Wiesert (2014)

James P. Bastnagel (2015)
John H. Ditslear, III (2015)
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Tod C. Huntley (2015)
Norman Mindrebo (2015)
Robert Michael Pearce (2015)
David M. Ratzman (2015)
Michael A. Rothbaum (2015)
Jeffrey M. Rothenberg (2015)
Richard M. Storm (2015)
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H. Jeffery Whitaker (2015)
Allison E. Williams (2015)
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Community Hospital East

First Wednesday — Critical Care Conference
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Second Tuesday — Medical Grand Rounds
Bradley Board Room, 12:00 - 1:00 p.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.

Every Other Month 4th Thursday — Psychiatry Grand Rounds
7250 Clearvista Dr.
Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m. begin 1/23/14

Community Heart & Vascular Hospital

First Wednesday — Imaging Conference:
rotates Cath & Echo Case Presentations
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00.- 8:00 a.m.

Third Wednesday — Ken Stanley CV Conference
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00 - 8:00 a.m.

Fourth Wednesday — Disease Management Conference:
rotates CHF & EP Case Presentations
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00 - 8:00 a.m.

2014 Cancer Conferences

Community Hospital East

Third Thursday — East General Cancer Conference - CHE
Medical Staff Conference Room
12:00 noon to 1:00, lunch provided

Fourth Tuesday — East Multidisciplinary Breast Cancer Conference - CHE
Medical Staff Conference Room
7:00 to 8:00 am

Community Hospital North

First & Third Tuesdays — North Multidisciplinary Breast Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:00 to 8:00 am

Second & Fourth Wednesdays — North Multidisciplinary GI Oncology Conference - CHN
8040 Clearvista parkway, Suite 550
7:00 to 8:00 am

Second & Fourth Fridays — North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN
8040 Clearvista Parkway, Suite 550
7:30 to 8:30 am

First Wednesday — North Chest Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:00 to 8:00 am

Third Wednesday — Melanoma Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:30 to 8:30 am

Community Hospital South

Second Wednesdays — South Multidisciplinary Breast Cancer Conference - CHS
Community Breast Care Center South
533 E. County Line Rd., Suite 101
8:00 to 9:00 am

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

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IU – Methodist – Riley

August 15 — Pediatric Neuroscience Symposium
IU Health Neuroscience Center, Indianapolis

August 20 — Advancing the Medical Role in Child Protection
Columbus Learning Center, Columbus, Indiana

August 22 — 2nd Annual Brain Injury Rehabilitation Conference
Neuroscience Goodman Hall, Indianapolis

Sept. 10- Nov. 26 — Redefining Health Care Response to Interpersonal Violence
Petticrew Auditorium
IU Health Methodist, Indianapolis

Sept. 19-21 — Wilderness Trauma Life Support
Bradford Woods Outdoor Center
Martinsville, Indiana

Sept. 20 — Practical Pearls General and Community Pediatrics 2014
ROC, Riley Hospital Outpatient Center, Indianapolis

Sept. 26 — Pain Symposium III
Latitude 39, Indianapolis

Oct. 10 — Acute Care in Neurotrauma Symposium
Goodman Hall Auditorium, Indianapolis

Oct. 23-24 — Fundamental Critical Care Support
Wile Hall and Methodist Hospital, Indianapolis

Oct. 31 — Pediatric Gastroenterology for the Primary Care Clinician
IU Health North, Learning Center
Conference Rooms
Indianapolis

Nov. 14 — 13th Annual Lingeman Lectureship
TBD

Nov. 18-20 — Biostatistics for Health Care Researchers: A Short Course
HITS Building, Indianapolis

Dec. 14 — Treatment Options for Adolescents and Young Adults with Hip Pain
IU Health North Hospital, Indianapolis

2015

Jan. 24 — Breast Cancer: Year in Review
TBD

May 13-14 — 50th Annual Riley Hospital for Children's Pediatric Conference
TBD

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CME & Conferences

Indianapolis Medical Society

August
- 19 Executive Committee, Society, 6:00 PM, Sandwiches

September
- 5-7 ISMA Convention, Indianapolis Westin. Indpls., 46204.
- 10 Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker TBA
- 16 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Dr. David R. Diaz will be installed as 141st IMS President.

October
- 15 Executive Committee, Society, 6:00 PM, Sandwiches
- 15 ISMA's Fall Legislative Dinner, Downtown Marriott

November
- 8-11 AMA House of Delegates, Dallas, TX
- 18 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg

December
- 10 Senior/Inactive Luncheon Meeting, 11:30 AM, Society TBD
- 16 Executive Committee Holiday Dinner, with Spouses

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(Continued from page 7)

on the issues and challenges facing healthcare. Get involved with advocacy groups like the Indianapolis Medical Society, Indiana State Medical Association and the American Medical Association as well as your specialty societies.

We know that our advocacy has produced several key victories recently:

- Earlier this year, Congress voted to delay the implementation of the new ICD 10 healthcare codes, based on feedback from members of the medical community and physician advocacy groups.[7]
- In June, based again on feedback from doctors, the AMA's House of Delegates drew the line on this year's hot button topic – maintenance of certification (MOC), saying it should not be mandatory, nor should it be a condition of licensure.[8]
- On the state level, the Indiana State Medical Association (ISMA) successfully defended the state's statutory limitation on damages in medical malpractice suits against a challenge of its constitutionality. This was a major win for physicians and protections against unwarranted medical malpractice lawsuits.

I believe physicians who take pride in and enjoy caring for their patients will always find fulfillment in medicine. That will not change in the long run. But if we relinquish the opportunity to be involved, weaken our coalitions, or give up the fight, decisions will be made by bureaucrats and the medical landscape will continue to change without our input. As Formula One leader Bernie Ecclestone once said: "*if you're not sitting at the table, the chances are you are on the menu.*" As healthcare professionals, we all must continue to speak up for patients and the trajectory of organized medicine as a whole.

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One final note – Thank you to the members of the Board and especially the Executive Committee who helped with sage advice and support. I also need to thank Marcia Hadley for her help with these columns over the past year and the entire IMS Staff for their efforts in keeping the Society on track. A special thank you to Beverly Hurt for her dedication, leadership and simple ability to make my job easier.

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