IMS Indianapolis Medical Society 1848
Volume XCXII • Number 8
April 2016 • Indianapolis, Indiana
Bulletin

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ATTENTION SOCIETY MEMBERS

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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in this issue

Special Features

Departments

about our cover

On our cover:
Special Events for Indianapolis Medical Society Members during April 2016 highlight our cover.

Extraordinary Opportunity for IMS Members ...

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President's Page

Stephen W. Perkins, MD

Pancreatic Cancer Awareness – "The Silent" But Deadly Cancer

Dear Colleagues,

We, as physicians, continuously strive to be vigilant when it comes to looking out for preventing and diagnosing illnesses that inevitably develop in our patients. We are always cognizant of the need to look out for and diagnose cancer at the earliest stages possible. There is no perfect way to diagnose every cancer at an early stage, but we have made great strides in the early detection of many types of cancer, including colon, breast, lung, prostate, many lymphomatous and hematologic cancers and even melanoma. However, we seem to be stuck in the "dark ages" in diagnosing silent developing cancers, such as dreaded glioblastoma and specifically, pancreatic cancer. Most often, these last two mentioned cancers only present themselves symptomatologically when the tumor is quite advanced and nearly untreatable. In my opinion, it "seems as though" the incidence of patients developing pancreatic cancer, as well as glioblastoma, has increased in the past couple of decades. This may well not be true but, with respect to pancreatic cancer, I personally have lived through two individuals very close to me having developed pancreatic cancer and relatively rapidly succumb to the disease despite heroic efforts on the part of well-intentioned treating physicians caring for these two patients. Their stories are different and somewhat diverse which I will describe subsequently.

Knowledge and awareness are the basis for any of us in the medical community to be able to detect, diagnose and treat these life threatening ailments of our patients. I would like to highlight what we know about pancreatic cancer, ways in which we might make association that could diagnose it earlier, and certainly what we do not know about pancreatic cancer to date.

According to the American Cancer Society's most recent estimates for pancreatic cancer in the United States in 2015 about 48,960 people (24,840 men and 24,120 women) will be diagnosed with pancreatic cancer. About 40,560 people (20,710 men and 19,850 women) will die of pancreatic cancer. What is significant is that the rates of pancreatic cancer have been stable over the past several years, despite my and others' personal impressions. Pancreatic cancer only accounts for 3 percent of all cancers in the United States and 7 percent of all cancer deaths. The average lifetime risk of developing pancreatic cancer is 1 in 67 or 1.5 percent. However, a person's risk may be altered by certain risk factors which I will outline.

A pancreatic cancer type is based on the location of the tumor's origin within the pancreas. More than 95 percent of pancreatic cancers are adenocarcinomas of the exocrine pancreas, with cells that lie in the pancreatic ducts.

Like most other cancers, early detection is crucial in order to offer the patient an opportunity to survive. The problem is, once symptoms have occurred and it is more obvious that something is wrong, requiring diagnostic testing, the cancer stage is usually untreatable. The one year survival rate of people with pancreatic cancer is 28 percent overall, with a 5-year survival rate of 7 percent. The only people who have a 28 percent chance of surviving pancreatic cancer are those with early detection. Once there has been regional spread, the 5-year survival rate is 10 percent or lower and, if it has metastasized beyond the pancreas, the 5-year survival rate is 2 percent.

There are no known specific causes of pancreatic cancer. I will outline some of the signs and symptoms we may want to consider being more aware of, but the range of diagnosis in patients is as early as 19 or 20 years of age to as late as 85 years of age. Most patients are diagnosed with pancreatic cancer entering the fifth, sixth and seventh decades of their lives.

The question is, "Can pancreatic cancer be prevented?" Again, because the cause of many pancreatic cancers is unknown, there is no sure way to prevent it, but there are ways that may possibly reduce your patients' risk for this disease. Smoking is the most important avoidable risk factor in pancreatic cancer, as it is responsible for 20-30 percent of pancreatic cancers. Quitting smoking helps lower the risk. Getting and staying healthy, particularly lowering weight or BMI, lowers the risk of developing pancreatic cancer. Very overweight (obese) people are about 20 percent more likely to develop pancreatic cancer. Increasing physical activity versus being sedentary is also statistically shown to reduce the incidence, as with many other cancers. The American Cancer Society recommends choosing foods and beverages in amounts that achieve and maintain healthy weight, eating a healthy diet with an emphasis on plant foods, whole grains instead of refined grains, eating fish, poultry and beans instead of processed meat and red meat. (The American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention).

Another risk factor to be mentioned is age. The average age at the time of diagnosis is 71 and two-thirds of patients are at least 65 years of age.

Men are about 30 percent more likely to develop pancreatic cancer than women. This may be in part due to a higher use of tobacco in men but this gap has changed in recent years.

African Americans are more likely to develop pancreatic cancer and the reasons for this are not clear but possibly due to higher rates of having other risk factors, such as diabetes, smoking and being overweight.

Pancreatic cancer is more common in people who have diabetes. The reason for this is not known. Most of the risk is found in people with type 2 diabetes. IN SOME PEOPLE THOUGH, THE CANCER SEEMS TO HAVE CAUSED THE DIABETES; (Not the other way around.) This, of course, happens when the cancer spreads through the pancreas and damages enough of the insulin producing cells to cause diabetes. I will mention this as it relates to my father-in-law who recently succumbed to pancreatic cancer at the age of seventy-one after having been diagnosed with the cancer 3

Continued on page 8.

months prior to his demise. However, he developed acute insulin-dependent diabetes eight months prior to this and had never been diabetic or pre-diabetic prior to this. No workup whatsoever was done to look at his pancreas despite this being a newly onset symptom. He did have a long history of smoking but no other family, genetic or hereditary symptoms.

Excess consumption of alcohol, specifically heavy drinking, has been categorized as a risk factor. This may be one of the etiologies of an increased risk of pancreatic cancer in alcoholics due to chronic pancreatitis and cirrhosis of the liver.

One relatively new related diagnostic factor increasing the likelihood of developing pancreatic cancer is the ulcer-causing bacteria of the stomach, Helocobacter pylori (H. pylori). Even more recently, data suggests that periodontal disease and Porphyromonas gingivalis, a pathogen for periodontal disease, may play a role in pancreatic carcinogenesis. These individuals with periodontal disease have elevated markers of systemic inflammation.

Finally, while pancreatic cancer seems to run in some families, this may be due to an inherited syndrome. In other families, it may be a gene that causes increased risk, but this is not known. Inherited genes may cause as many as 10 percent of pancreatic cancers. Without going into genetic markers for hereditary breast and ovarian cancer, familial melanoma, etc., there is a familial pancreatitis gene caused by mutations of gene PRSS1 and a rare one called Von Hippel-Lindau syndrome caused by mutations of the gene VHL that can lead to increased risk of pancreatic cancer. Many of the pancreatic neuroendocrine tumors, such as neurofibromatosis type 1 and multiple endocrine neoplasia type 1 (MEN1), can cause mutations within the eyelet cells of the pancreas.

The real question is, "Can pancreatic cancer be found early?" Pancreatic cancer is extremely difficult to detect in its early stages because even on physical exam it is hard to palpate the pancreas. Patients usually have no symptoms until the cancer has spread to other organs or occluded the bile duct. Currently, there are no known set standards for screening tests for pancreatic cancer. At this time, no professional group recommends routine screening for pancreatic cancer in patients who would be at an average risk. Sometimes people with pancreatic cancer have elevated tumor markers or CA19-9 which is carcinoembryonic antigen (CEA) but this is not even always the case with everyone who has pancreatic cancer.

We, as physicians, need to be acutely aware and always vigilant for the signs and symptoms of pancreatic cancer. Certainly, many of the symptoms seem relatively benign or average and, on the high percentile, are not related to pancreatic cancer. It is relatively obvious that, if a patient develops itching, jaundice or is having acute abdominal pain, such as a gallbladder attack or obstruction of the gallbladder, one needs to make an immediate diagnosis as to the etiology. Much more subtly, patients may have a non-specific abdominal or back pain, unintended weight loss, and decreased appetite. There can be digestive problems with being nauseous after eating or as simple as indigestion. A good friend of mine who was a female at 57 years of age had been complaining of increasing problems with indigestion, some stomach pain, and what she thought to be reflux for a period of 8 or 9 months. She tried multiple ACE inhibitors, antacids, and generally had her symptoms dismissed as benign in nature. An esophageal or gastric workup was not ordered, but after being frustrated over continued symptomatology and no workup being recommended by her internist, she went to a medical center elsewhere where they immediately did a CT scan of her abdomen. A CT scan, had it been done earlier, would have shown her early pancreatic cancer. But by the time the scan was performed, she was at Stage 4. The treatment she underwent prolonged her life, but ultimately did not cure it. Just like my father-in-law who, for no apparent reason, became diabetic, a simple CT scan might have given him the opportunity for his pancreatic tumor to be resectable prior to his acute onset of jaundice, abdominal pain and "gallbladder attack" which then allowed the diagnosis to be made by a CT scan.

Testing people who are at high risk for pancreatic cancer could be done in families with a high risk of pancreatic cancer or patients with any of these symptoms and other risk factors. One of the most specific diagnostic tests is an endoscopic ultrasound with a previous and accompanying CT scan or even MRI. The endoscopic ultrasound takes images of the pancreas from inside the abdomen or trans-endoscopically. A scope can also be used to inject dye into the pancreatic ducts and take tissue samples. Tissue samples are important in potential treatment plans for the patient's particular type of cancer. Once the diagnosis of pancreatic cancer is confirmed, the next step is to stage the cancer. Staging can also be done with laparoscopy, viewing the pancreas and the surrounding areas. Imaging tests, a CT scan or MRI, will give some indication of the extent of the tumor.

Staging pancreatic cancer relates to the possibilities of surgical intervention versus chemotherapeutic and radiation treatments or palliative therapy. Basically, pancreatic cancer is staged by a number or surgical resection category: Stage 1A – the tumor is limited to the pancreas, measuring less than 2 cm and is localized. This is considered resectable; Stage 1B is a tumor greater than 2 cm but still localized and probably resectable; Stage 2A – the tumor extends beyond the pancreas but does not involve celiac axis, the superior mesenteric artery or local lymph nodes. This is resectable or borderline resectable based on a probable Whipple type operation and there are certainly great surgical specialists within our city who specialize in this; Stage 2B – the tumor does not involve lymph nodes but does involve the major local arteries and even may be wrapped around the porta cava. This may or may not be resectable and usually is not. Stage 3 is where the tumor, not only involves the major arteries and veins but there is lymph node involvement. Stage 4 – the disease has already metastasized to the liver, abdominal wall, possibly lungs and distant lymph nodes. Both Stage 3 and 4 are unresectable.

Treatment protocols for pancreatic cancer are still primarily in clinical trials. Conventional chemotherapy and radiation will have a variable effect on length of survival with associated morbidities. Most patients are given a choice as to whether they want to undergo therapy that may statistically prolong their life expectancy on a statistical average of 6 months to 8-1/2 months if they undergo conventional chemotherapy or enroll in a clinical trial that may or may not be available within our local community. Regarding my personal experience with a female of 57 years, it was her desire to go through every conventional treatment available and even a clinical trial. She survived 12 months before succumbing to the disease and was, at various times, extremely physically debilitated by the treatment. My father-in-law was taken to surgery with the overly optimistic expectation of having the Whipple procedure when, in fact, he was found to have metastatic disease in the liver and

Continued on page 17.

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Bulletin Board

Matthew T. Feng, MD, was selected One To Watch by *MillennialEYE* magazine. Dr. Feng is a cataract, LASIK, and corneal transplant surgeon at Price Vision Group. The distinction recognizes a "Rising Star" in ophthalmology. More is published online at *http://millennialeye.com/articles/2016-jan-feb/one-to-watch-matthew-feng-md/*

Stephen W. Perkins, MD, of Meridian Plastic Surgeons was a Key Guest Invited Faculty member at the 40th Annual "Midwinter Symposium on Practical Challenges in Otolaryngology" in Snowmass Village, Colorado, conducted by University of Illinois at Chicago Department of Otolaryngology-Head and Neck Surgery. He spoke on Rhinoplasty Techniques and Effective Endoscopic Forehead Lifting. Dr. Perkins also chaired the recent "Facial Rejuvenation 2016, Master the Techniques" meeting in Beverly Hills, California, conducted by the American Academy of Facial Plastic and Reconstructive Surgery. He gave a talk on the topic of Facelift and was a participant on Blepharoplasty and Facelift panels. He also performed "live" Facelift surgery with direct transmission into the meeting room.

Jeffrey M. Rothenberg, MD, in January 2016, was a Visiting Professor at Sun Yat Sen University in Guanzhou, China for two weeks.

In February, Dr. Rothenberg presented at the Annual Meeting of the Michigan Section of ACOG: "Practice Bulletins - The What, Why and How of the Clinical Management Guidelines."

Theresa M. Rohr-Kirchgraber, MD, was a recent invited speaker for the American Academy of Emergency Medicine annual meeting in Las Vegas, Nevada. Her topics were, "Catch the bad guys: The confidential interview" and "Empowerment of Women Physicians in EM: importance for both genders."

Dr. Rohr-Kirchgraber was selected unanimously by the Awards Committee of the ACP Indiana Chapter to receive the Laureate Award this year. The Laureate Award honors Fellows and Masters of the College who have demonstrated by their example and conduct an abiding commitment to excellence in medical care, education, or research and in service to their community, their Chapter, and the American College of Physicians. The recipient of this award shall bear the title Laureate of the Indiana Chapter and is the highest award the Chapter can bestow on its members.

Tod C. Huntley, MD, of the Center for Ear Nose Throat & Allergy (CENTA) was a faculty member of the Charleston Sleep Symposium, sponsored by the Medical University of South Carolina. He lectured on methods to improve CPAP adherence in sleep apneics and on the role of da Vinci robotic surgery tongue base reduction in the treatment of CPAP-intolerant apneics. He also shared his extensive experience with Inspire hypoglossal nerve stimulation in the treatment of OSA, which dates to the preclinical trials of the procedure. Dr. Huntley is also course director for the upcoming Advanced Surgical Techniques for Obstructive Sleep Apnea and Snoring hands-on cadaver course June 23-25 2016 at the PASE Learning Center at St. Louis University.

Rick C. Sasso, MD, Indiana Spine Group, served as a faculty member of the Congress of Neurological Surgeons (CNS) 2016 for the complications course: "Crossing the Chasm: Critical Peer Review for Spine Surgeons" which was held February 4-7, 2016 in Park City, Utah.

Dr. Sasso lectured on cervical deformity correction, cervical myelopathy due to ossification of the posterior longitudinal ligament, and methods to avoid adjacent segment disease in the cervical spine. He also served as moderator for the session on cervical spine complications.

News from Goodman Campbell Brain and Spine ...

Jean-Pierre Mobasser, MD, was an invited lecturer at the International Congress Innovative Surgery: Spine and Knee held in Coimbra, Portugal, on February 6. Dr. Mobasser presented a discussion on "Advances in Lumbar Fusion."

Mitesh V. Shah, MD, and his co-investigators recently published their research titled, "Minimally-invasive trans-sulcal resection of intra-ventricular and peri-ventricular lesions through a tubular retractor system: multi-centric experience and results." The study included the review of 20 patient cases to evaluate the use of the trans-sucal parafascicular approach surgery compared with conventional approaches to deep-seated cerebral lesions, including biopsy and trans-cortical resection. The investigators concluded the technique was safe and effective for the treatment of intraventricular and periventricular lesions. The study appeared in *World Neurosurgery*.


Laurie L. Ackerman, MD


Aaron A. Cohen-Gadol, MD


Matthew T. Feng, MD


Daniel H. Fulkerson, MD


Tod C. Huntley, MD


Thomas J. Leipzig, MD


Jean-Pierre Mobasser, MD


Stephen W. Perkins, MD


Theresa M. Rohr-Kirchgraber, MD


Jeffrey M. Rothenberg, MD


Rick C. Sasso, MD


Mitesh V. Shah, MD

Laurie L. Ackerman, MD, was an invited presenter at the 2016 American Society of Pediatric Neurosurgeons Annual Meeting that took place in Palm Beach, Aruba, January 31–February 5. Dr. Ackerman lectured on the "Surgical Management of a Very Large Cervical and Anterior Neck Neurofibroma with Follow-up Imatinib."

Aaron A. Cohen-Gadol, MD, and co-authors recently published their research paper titled "Lipid and metabolite profiles of human brain tumors by desorption electrospray ionization-MS" in the February issue of *Proceedings of the National Academy of Sciences.*

Thomas J. Leipzig, MD, was the course director for the American Association of Neurological Surgeon's Maintenance of Certification (MOC) Preparation and Neurosurgical Update: Interactive Case-Based Review that took place in San Antonio, Texas, on February 19–21. He also gave presentations on both MOC and cerebrovascular issues. **Daniel H. Fulkerson, MD,** was also part of the meeting's faculty and participated in a discussion about the general management of a variety of neurosurgical cases.

New Members

Gardner, Megan F., MD
Resident – IU School of Medicine
Vascular Surgery
SUNY, Buffalo, 2012

Henriksen, Timothy J., MD
Southeast Anesthesiologists
8111 S. Emerson Ave.
46237-8601
Anesthesiology
Indiana University, 1998

Masterson, Kevin G., MD
Resident – IU School of Medicine
Psychiatry
Indiana University, 2015

Taylor, Ryan G., DO
St. Francis Family Medicine Residency
5230 E. Stop 11 Rd., #250A
46237-6398
Ofc – 528-8921
Fax – 528-6916
Family Medicine
Chicago College of
Osteopathic Medicine, 2015

Voss, Katherine E., MD
Urology of Indiana, LLC
679 E. County Line Rd.
Greenwood 46143-1049
Ofc – 890-2000 – 859-7222
Fax – 859-7220
1270 N. Post Rd., #A
46219-4209
Ofc – 890-2000 – 895-6095
Fax – 895-6195
150 W. Washington St.
2nd Fl. – Outpatient Clinic
Shelbyville, 46176-1236
Ofc – 890-2000 – 398-5303
Fax – 395-5293
Urology
University of Cincinnati, 2010

Walls, Timothy B., MD
Fellowship – IU School of Medicine
Anatomic/Clinical Pathology
Medical Microbiology
University of Tennessee, 2011

Human Interest & Hobbies Wanted for the *Bulletin*

Do you have an interesting story or a special hobby that you want to share with your colleagues? If you are willing to share, please submit to mhadley@imsonline.org

In Memoriam

Paul Joseph Kirkhoff, MD
1922 - 2016

Dr. Paul Joseph Kirkhoff, 93, passed away February 14, 2016. He was born on May 23, 1922, in Indianapolis

Dr. Kirkhoff attended Our Lady of Lourdes Grade School and Shortridge High School. He attended Butler University, transferring to Indiana University at Bloomington when he decided to pursue a medical degree, which was financed with assistance from the US Army. Dr. Kirkhoff completed a one-year internship at St. Vincent Hospital in Indianapolis and then served two years in the military (Captain 1947-1949) as the post pediatrician at Fitzsimmons General Hospital in Denver, Colorado. While there he learned a blood transfusion technique for newborn babies with deficient RH factors that he brought back to Indianapolis, saving the lives of many children. After serving a residency at St. Vincent Hospital, he took over Dr. J.C. Carter's pediatric practice. Dr. Kirkhoff was one of the first pediatricians in Indianapolis.

He was a charter member of Community Hospitals and helped build Community Hospitals East and North. He operated his pediatric practice until 1978 when he started practicing emergency medicine. Dr. Kirkhoff established emergency room admission procedures, which are still used today in Community Hospitals, referred to as the "Kirkhoff Laws." Dr. Kirkhoff took his services to MedCheck Castleton, operated by Community Hospitals, where he also served as the Medical Director for the MedChecks. Dr. Kirkhoff received the "Physician of the Year" award at the Community Hospital's Awards Banquet held on June 26, 1979. He was honored in 1996 by ISMA and the IMS with membership in the Fifty Year Club.

Save This Information for Tax Filing

Each year at this time, the IMS provides information about your dues payment that you will need for tax filing purposes. Part of your AMA and ISMA dues, that portion used for lobbying, is not tax-deductible. For this year ISMA is 26%; contact the AMA about their nondeductible dues msc@ama-assn.org.

As always, your Indianapolis Medical Society dues are 100% tax deductible as a business expense.

April 20, 2016, 6:00 - 10:00 p.m.

Medical-Legal Dinner*

Featuring Dr. Terry R. Trammel,
"The History of Motorsports Medicine"

Please join your colleagues in the revival of this renowned event bringing physicians and lawyers together for a night of camaraderie and good conversation.

Email: lbailey@indybar.org
RSVP: http://www.indybar.org/events-education/calendar/2016-04-20/1349

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IMS Member $100, IMS Member & Guest $200
Non-Member $125, Non-Member & Guest $250
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*Sponsored by the Indianapolis Medical Society & the Indianapolis Bar Association

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In Summary - *iSALUS*

Security Risk Assessments: What Happens If You're Audited

Over the last five years, Centers for Medicare & Medicaid Services (CMS) has distributed approximately $20 Billion to about ½ million eligible professionals under the Medicare/Medicaid Electronic Health Records (EHR) Incentive Programs. Unfortunately, they have also begun auditing a large amount of those eligible professionals and it's not looking very good for them. In fact, it's the intention of CMS to audit 5% of those who receive incentive payments and, to date, roughly 1 in 4 of those audited have failed. Clearly, the documentation process is strict and the Security Risk Assessment (SRA) is a pretty important factor. In fact, when we took a closer look at the reason ***why*** the audits were being failed, we found that the most common problem was noncompliance with the required SRA and/or a lack of adequate documentation to support responses put forth in the attestation. Unfortunately, if you fail an audit you likely will be refunding some or all of your incentive payments back to the government.

So what if you're notified that you are going to be audited? It's important to note that you only have two weeks to supply your documentation once you've been notified. This is **not** enough time to actually complete the documentation sufficiently so if, by chance, you hurried through your attestation then stop right now and re-visit the entire thing. Make sure that everything is clearly documented and not simply a hurried-through excel file.

Currently, CMS has contracted with Figliozzi and Company to perform their audits. The process looks like this:

- Initial request letters will be sent to providers selected for an audit

The request letter will be sent electronically by Figliozzi and Company from a CMS email address to the email address provided during registration for the EHR Incentive Program

The letter will include contact information for Figliozzi and Company.

- The initial review process will be conducted using information provided in response to the request letter.

Additional information may be needed during or after the initial review process

- In some cases an on-site review at the provider's location may follow

A demonstration of the EHR system may be required during the on-site review

- Figliozzi and Company will use a secure communication process to assist the provider in sending sensitive information
- Any questions pertaining to the information request should be directed to Figliozzi and Company.
- If the provider is found to be ineligible for an EHR incentive payment, the payment will be recouped.

Should you fail your audit, there is a process for appeals:

- Providers may contact the EHR Information Center through a toll free number, 888-734-6433, between 9 a.m. and 5 p.m. EST, Monday through Friday, for general questions on how to file appeals and the status of any pending appeals. States will implement appeals processes for the Medicaid EHR Incentive Program. Medicaid program participants should contact their State Medicaid Agency for more information about these appeals.

Of course, if you want to guarantee that your attestation for 2016 will hold up to an audit, there is a way. You can use an automated tool that prompts you to gather all the correct data and uses automated checks and balances to ensure that everything you need to include will be there.

Chronic Care Management: A Missed Opportunity

For many years, doctors have treated millions of patients with chronic illnesses such as high blood pressure, diabetes, arthritis and many others. Finally, in January of 2015, Medicare recognized the benefit of Chronic Care Management (CCM) services and began offering reimbursement to doctors treating patients with those illnesses.

Unfortunately, to receive reimbursement you had to abide by a long list of regulations and document each step of the way accordingly. As a result, most providers were simply too overwhelmed by the regulations to implement them properly in order to qualify for the reimbursement. In the end, it seemed like the average $42 payment wasn't enough to motivate physicians to carry out the required steps. They simply didn't want to add more burden to their staff who were already showing signs of stress.

As a result, in October of 2015 the Centers for Medicare and Medicaid (CMS) estimated that although 70% of Medicare beneficiaries (approximately 35 million) were eligible to receive CCM services, they had only received reimbursement requests for about 100,000 at that point in time.

Diane Calmus, Government Affairs and Policy Manager at the National Rural Health Association stated, "*There is a concern all this documentation, along with their regular workload, is not worth it for the money they would receive. It's just too many hoops they would have to jump through.*"

Interestingly enough, a study from the Stanford University School of Medicine looked at how much CCM could affect the typical primary care practice and found substantial increases in annual revenue, as much as $77,295 in the first year for a single provider.

Additionally, Dr. Andrew Gurman, President of the American Medical Association (AMA), has expressed his belief that CCM is a game-changer and the AMA will be focusing on educating providers about CCM because there's opportunity for physicians to be reimbursed for services they are more than likely already providing.

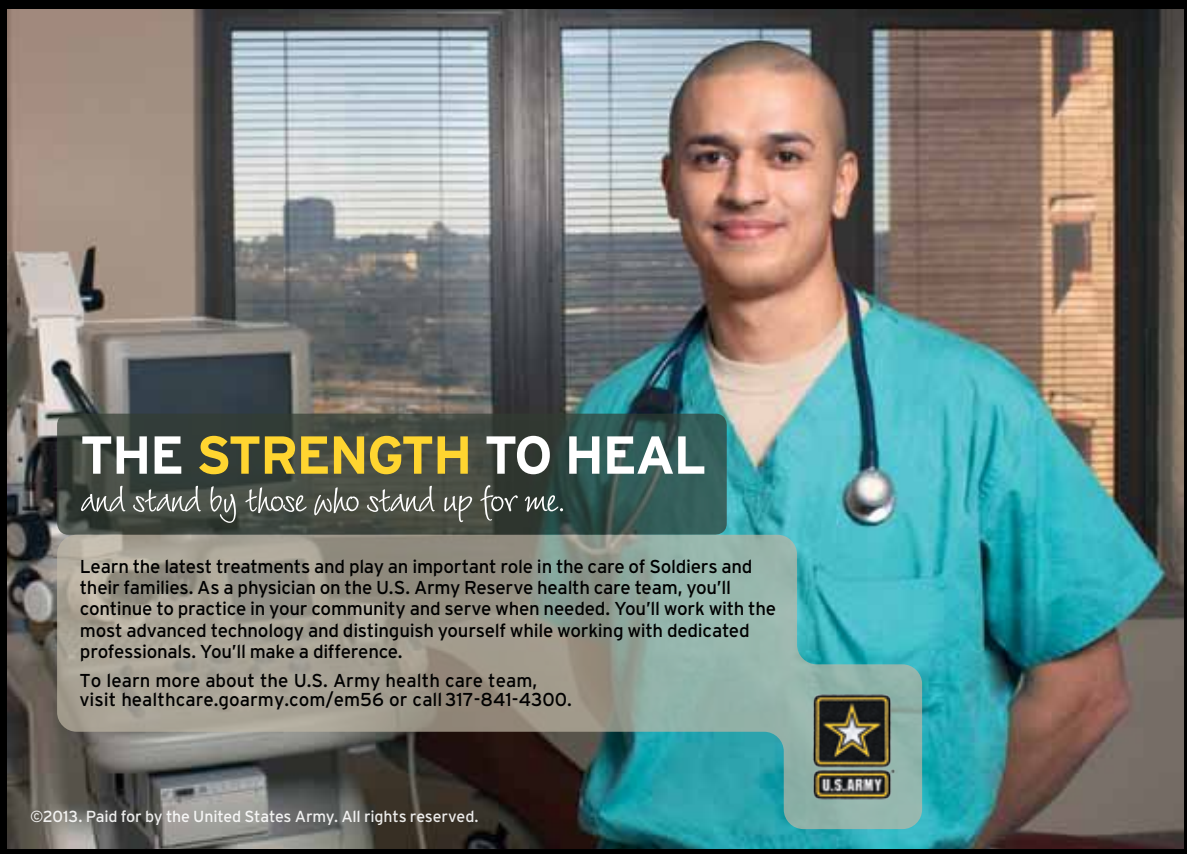
So how do you overcome the seemingly enormous mountain of added paperwork in order to implement CCM Services into your practice without adding extra stress? There's an opportunity that is not being looked at carefully enough to date, and we think it's important enough for every general practitioner to seriously consider. That opportunity is Outsourcing your CCM Services.

At this point, you've had over a year to learn about CCM and add it to the services your practice provides its patients. If you haven't added it yet, ask yourself why? Some of the most common answers have been; 1) I haven't had the time; 2) I'm concerned about having to hire additional staff; 3) I can't add any more stress on my current staff right now; and 4) I don't want to have to worry about whether or not I'm doing it right in order to receive the reimbursement.

By outsourcing your CCM services, you remove every single one of these concerns. With the right vendor, the only thing that should be required by your staff is to hand the patient a pamphlet regarding the CCM services they are eligible to receive and explain what co-pay, if any, they will be responsible for. The rest is take care of by your vendor. Seems like a pretty easy process, right? It is! That's why we're baffled by how many providers have yet to join in. Especially when one of the biggest concerns overall is how to increase the bottom line of your practice. This is one of the most effective ways to do it!

According to the Medical Group Management Association (MGMA) the average practice has approximately 500 eligible patients per provider. Do the math. Even if you have to split the reimbursement payment with your vendor, the potential for increased income is enormous! And when you take away the burdens of medication reconciliations, care plan reviews, providing education and all the regulations that Medicare requires in order to receive the reimbursement, doesn't outsourcing chronic care management suddenly seem to make a whole lot of sense?

We encourage you to immediately begin speaking with a potential vendor and consider adding chronic care management services to your practice as quickly as possible. Not only will you improve patient care in 2016, you will improve your bottom line which will directly result in lowering your overhead.



CME & Conferences

Community Hospital East

First Wednesday	Critical Care Conference Ste. 420, 12:00 - 1:00 p.m.
Second Tuesday	Medical Grand Rounds Ste. 420, 12:30 - 1:30 p.m.

Community Hospital North

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.

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) HVC Kokomo, 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) HVC Kokomo, 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) HVC Kokomo, 7:00 - 8:00 a.m.

2016 Cancer Conferences

Community Hospital East

Third Thursday	East General Cancer Conference - CHE Ste. 420, 12:00 noon to 1:00, lunch provided
Fourth Tuesday	East Multidisciplinary Breast Cancer Conference - CHE Ste. 420, 7:00 to 8:00 a.m.

Community Hospital North

First & Third Tuesdays	North Multidisciplinary Breast Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 a.m.
Second & Fourth Wednesdays	North Multidisciplinary GI/Colorectal Oncology Conference - CHN 8040 Clearvista parkway, Suite 550 7:00 to 8:00 a.m.
First Friday	North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 a.m.
First Wednesday	North Chest Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 a.m.
Third Wednesday	Melanoma Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 a.m.

Community Hospital South

Second Wednesdays	South Multidisciplinary Breast Cancer Conference - CHS Community Cancer Center South 1440 E. County Line Rd., Community Room 8:00 to 9:00 a.m.
Third Wednesday	South GYN Community Cancer Center South, 1440 E. County Line Rd., Community Room 12:00 to 1:00 p.m.
Fourth Wednesday	South Thoracic Community Cancer Center South, 1440 E. County Line Rd., Community Room 7:00 to 8:00 a.m.
First Tuesday	South Multidisciplinary GI/Colorectal Oncology Conference 1440 E. County Line Rd. Community Cancer Care, Community Room 12:00 to 1:00 p.m.

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

Indiana University School of Medicine/ Indiana University Health

IU – Methodist – Riley

Online CME Activity
HPV Documentary, Someone You Love: the HPV Epidemic
http://cme.medicine.iu.edu/hpvdocumentary

Apr. 15-16	Bloomington Pediatric Medical Weekend IU Health Bloomington Hospital
April 15	GYN for the Primary Care Provider Indiana History Center
Apr. 18-20	4th Annual International Health Services Research Symposium Health Information and Translational Science Building (HITS)
Apr. 22	Sickle Cell Disease Conference: Now is the Time The Marten House Hotel & Lilly Conference Center
Apr. 23	Practical Pearls General and Community Pediatrics Riley Outpatient Center
Apr. 25	Indiana Interprofessional Education and Practice Annual Meeting Fairbanks Hall, Simulation Center
Apr. 29	Encouraging Next Steps in Venous Disease Care Hine Hall
May 6	19th Annual IU Gastroenterology/Hepatology Update Indiana History Center
May 10-11	51st Annual Riley Hospital for Children's Pediatric Conference NCAA Hall of Champions
May 14	Midwest Vascular Collaborative (MVC) 2016 Biannual Meeting Columbus Regional Hospital
June 10	32nd Annual Manion-Lingeman Lecture and Research Seminar Riley Outpatient Center
June 10	Garceau-Wray Annual Lecture NCAA Conference Center
July 10-15	101st Annual Anatomy & Histopathology of the Head Neck & Bone Glick Eye Institute
July 15	Review & Interpretation of the 2016 ASCO Review The Tower

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

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

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

IMS Events/Meetings

April 16	**Carmel Marathon, Join "Team IMS"**
April 19	Executive Committee, TBD, 6:00 PM, Sandwiches
April 20	**Medical Legal Dinner, 6:00 - 10:00 p.m.** Ritz Charles, Carmel Featuring Dr. Terry R. Trammel

President's Page *(Continued from page 8)*

the operation was ended. Chemotherapy was recommended, only if he desired, but his oncologist did not recommend the morbidities of chemotherapy and actually just recommended palliative therapy only. He succumbed within 3 months after the diagnosis.

In summary, I obviously write this from a personal perspective but with the idea that the more aware we are of pancreatic cancer, the more likely we can think about a symptom or symptom complex that one of our patients has that may require more diligence in detection and ruling out a disease.

"You can't get people excited unless you help them see and feel the impact."- Bill Gates

I would like to finish by inviting you to be involved in a fundraising event to help advance our knowledge and, hopefully, prevent and better treat pancreatic cancer in the future. Further information about pancreatic cancer can be obtained from the Pancreatic Cancer Action Network (877-573-9971). Indianapolis sponsors one of the national organizations 5K run and walk- PurpleStride which will take place here in Indianapolis, June 18, 2016 at IUPUI-South Meadow.

The PurpleStride signature event is critical in raising awareness and funds to advance research and support of patients and loved ones with a promise of a better tomorrow. You can register in general or you can sign up for a team, usually in honor of a family member, friend or patient who has, unfortunately, died of pancreatic cancer. I encourage you to be there for the support of pancreatic cancer research, as well as your own health and the advancement of your patients' and community awareness.

Sincerely,

Stephen W. Perkins, M.D.

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