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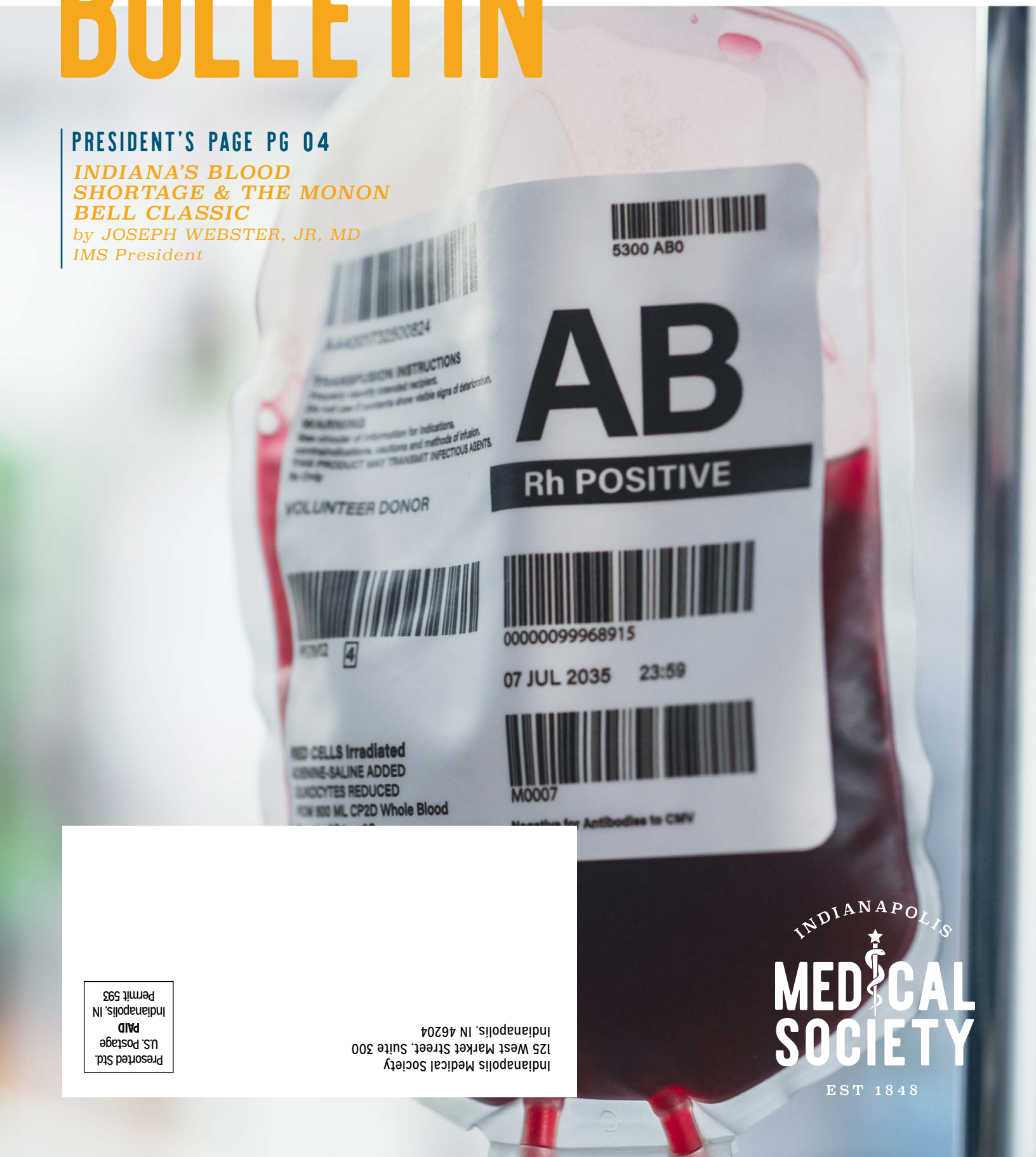
BULLETIN

PRESIDENT'S PAGE PG 04

INDIANA'S BLOOD SHORTAGE & THE MONON BELL CLASSIC

by JOSEPH WEBSTER, JR, MD
IMS President



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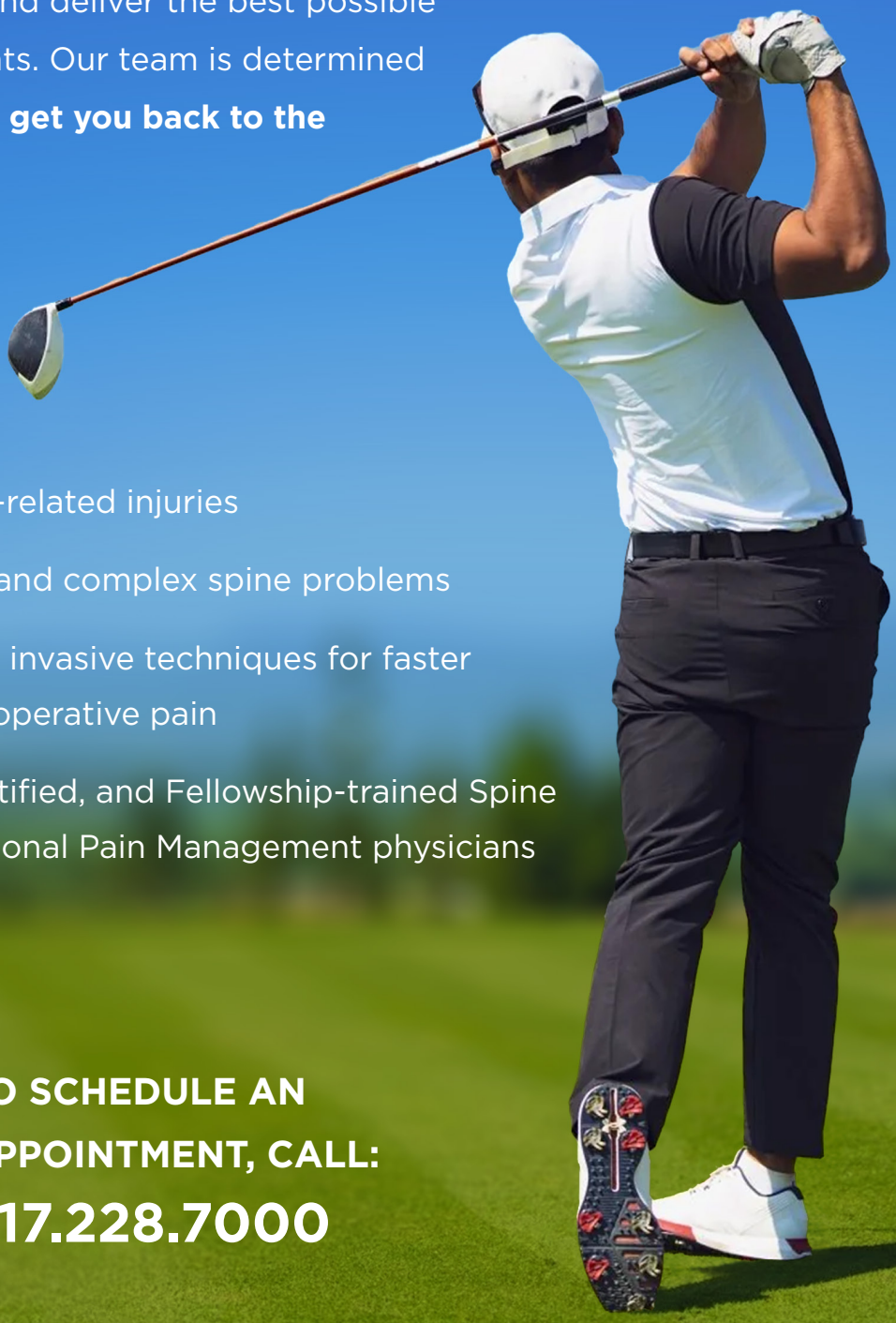

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Please join us at these IMS Events! RSVP Online.

THE PRESIDENT'S PAGE

JOSEPH WEBSTER JR, MD

Indiana is experiencing a blood shortage. Wabash College visits DePauw University November 16th for the 130th Monon Bell Classic.

Versiti Blood Center of Indiana (formerly the Indiana Blood Center) had issued an emergency appeal in July for blood donations due to a dangerously low blood supply. Certain blood types have less than a day's worth of availability, endangering the lives of local patients. Summer donations have plummeted to critical levels and over 4,463 appointments were missed in the past month alone.

More than 90,000 Indiana residents each year give blood through Versiti Blood Center of Indiana. Versiti is a non-profit organization founded in 1952 and operates blood donation centers in Indianapolis, Fishers, Carmel, Greenwood, Lafayette, and Terre Haute. The center also operates thousands of mobile and community blood drives each year throughout the state. Versiti provides a continuous and safe supply of blood and biological services to more than 95 Indiana hospitals, their patients, and beyond.

Versiti is a fusion of donors, scientific curiosity, and precision medicine that recognizes the gifts of blood and life are precious. They are home to the world-renowned Versiti Blood Research Institute which enables lifesaving gifts from donors provides the science behind the medicine through Versiti's diagnostic laboratories. Versiti is a 501©(3) nonprofit organization.

They are on a mission of service to improve patient outcomes, to advance the field of personalized medicine, and to strengthen the health of communities everywhere. The discoveries they make contribute to better patient care. In Versiti's own words, "we are a beacon of hope, care, and innovation in the communities we call home."

Versiti Blood Research Institute

The Versiti Blood Research Institute's work is dedicated to hematology in all its facets, spanning basic, translational, and clinical research. The goal: to make people's lives better.

Versiti Blood Research Institute (VBRI) is a state-of-the-art facility that gives investigators access to cutting-edge research equipment and related specialized services. VBRI is located on the Milwaukee Regional Medical Center campus, along with the Medical College of Wisconsin, Froedtert Hospital, and Children's Wisconsin.

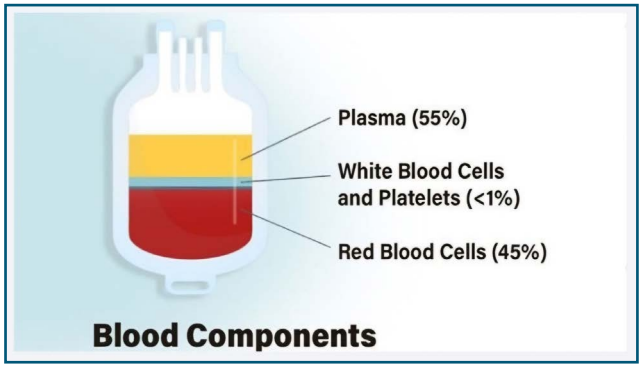
In addition to their intellectual capital and resources, the local density of healthcare and research facilities provides Versiti with a rich environment for biomedical research. Clinical scientists at VBRI facilitate opportunities to identify and engage in collaborative translational research. Their research scientists aid industry partners in custom projects that help advance innovative drugs, products, and services. Research areas include:

- Transfusion Medicine
- Vascular Biology & Cellular Therapy
- Thrombosis & Hemostasis
- Hematopoiesis & Stem Cell Biology
- Immunobiology
- Translational Hematology or clinical trials
- Serologic testing for heparin-induced throm-bocytopenia (HIT)
- Diagnosis and management of alloimmune platelet disorders (neonatal alloimmune throm-bocytopenia and post-transfusion purpura)
- Diagnosis of transfusion-induced acute lung injury (TRALI)
- Diagnosis of drug-induced thrombocytopenia, neutropenia, and hemolytic anemia.

Back to School Time:

Q: What are the types of blood donation?

A: Whole Blood Donation; Double Red Cells Donation; Plasma Donation and Platelet Donation.



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Q: What are the most common blood types?

A: A+, A-, B+, B-, O+, O-, AB+, AB-

A+ Facts:

- 30% of the population have A+ blood, the second most common type, so your donations are always in demand.
- You can give blood to patients with types A+ and AB+.
- You can receive blood from A+, A-, O+ and O- donors.
- Men with A+ blood are a great candidate for platelet donations.

A- Facts:

- Only 6% of the population have A- blood, a rare type, so your donations are always needed.
- You can give blood to patients with types A-, A+, AB- and AB+.
- You can receive blood from A- and O- donors.

B+ Facts:

- 9% of the population have B+ blood, a rare type, so your donations are always needed.
- You can give blood to patients with types B+ and AB+.
- You can receive blood from B+, B-, O+ and O- donors.

B- Facts:

- 2% of the population have B- blood, a rare type, so your donations are always needed.
- You can give blood to patients with types B-, B+, AB- and AB+.
- You can only receive blood from B- and O- donors.

AB+ Facts:

- 4% of the population have AB+ blood, a rare type, so your donations are always needed.
- You can only give blood to patients with type AB+.
- You can receive blood from donors with any type, universal blood recipient.
- You are the universal plasma donor and can donate plasma for patients of any blood type.

AB- Facts:

- 1% of the population have AB- blood, the least common type.
- You can give blood to patients with types AB- and AB+.
- You can receive blood from AB-, A-, B- and O- donors.

O+ Facts:

- 39% of the population have O+ blood, the most common type.
- You can give blood to patients with any positive type.
- You can only receive blood from O+ and O- donors.

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JOSEPH WEBSTER JR, MD

O- Facts:

- 9% of the population have O- blood.

- You can give blood to patients of any blood type, you are the universal donor.

- You can only receive blood from O- donors.

Besides the aforementioned common blood groups, there are over 35 other blood groups and over 600 other known antigens. The unique mix of proteins and sugars (antigens) present on your red cells, which you inherited from your biological parents, determines your extended blood type and whether you fall into one of these rare and uncommon blood groups. A rare or uncommon blood type doesn't mean your blood is better or worse it's just a genetic difference. But it DOES mean you are extremely special!

One of these uncommon blood types is the Ro blood type, which is invaluable for patients with sickle cell disease.

All blood types are needed, with O+ and O- being the most in demand. O+ is the most common blood type, while O- blood is the universal type that can be safely received by all patients in emergencies when the blood type is unknown.

"We know summer is a challenging time for blood donation, and we plan for it every year, but what we see today is dire," said Dr. Dan Waxman, Vice President of Transfusion medicine and Senior Medical Director at Versiti. "Patients' lives are at risk. If you are healthy and able, we are pleading with you to donate blood this week." In addition to unfilled appointments and a rise in cancellations and no-shows, Versiti's partner hospitals have required a significant volume of blood to support organ transplant procedures and other traumas. "The demand for blood simply does not match the number of donors coming through our doors," added Waxman. "While we deeply appreciate our loyal donors who consistently show up, it's important to recognize that about 3 percent of people who are eligible to donate blood actually do. If it's been a while since your last donation or you're a first-time donor, we are excited to welcome you."

What happens if blood is not available for patients?

- When the local blood inventory gets as low as it is now, it jeopardizes the health and safety of patients who rely on life-saving blood transfusions. In some cases, hospitals are forced to postpone surgeries or delay critical treatments.

- Trauma victims from car accidents or shootings are at the highest risk as their survival often de-

THE PRESIDENT'S PAGE

JOSEPH WEBSTER JR, MD

pends on a healthy blood inventory.

• Patients undergoing organ transplants and battling cancer, and even mothers in labor, could face treatment delays or complications due to a limited blood supply.

To schedule an appointment to donate blood, call (317) 916-5150 or visit versiti.org. Walk-in donors are always welcome.

Donor center locations:

- INDIANAPOLIS: 3450 N. Meridian St.
- FISHERS: 11005 Allisonville Road
- CARMEL: 726 Adams St., Suite 150
- GREENWOOD: 8739 U.S. 31 South
- TERRE HAUTE: 2021 S. Third St.
- LAFAYETTE: 2200 Elmwood Ave., Suite D-16

Donating blood takes about an hour. Anyone aged 16 or older who is in good health and meets eligibility requirements is encouraged to give. Parental consent is required for donors aged 16 to donate blood. Donors should bring a photo ID.

How can you help besides giving? Host a Blood Drive! Hosting a blood drive with Versiti at your business, school, organization, or group will help to save lives in your community.

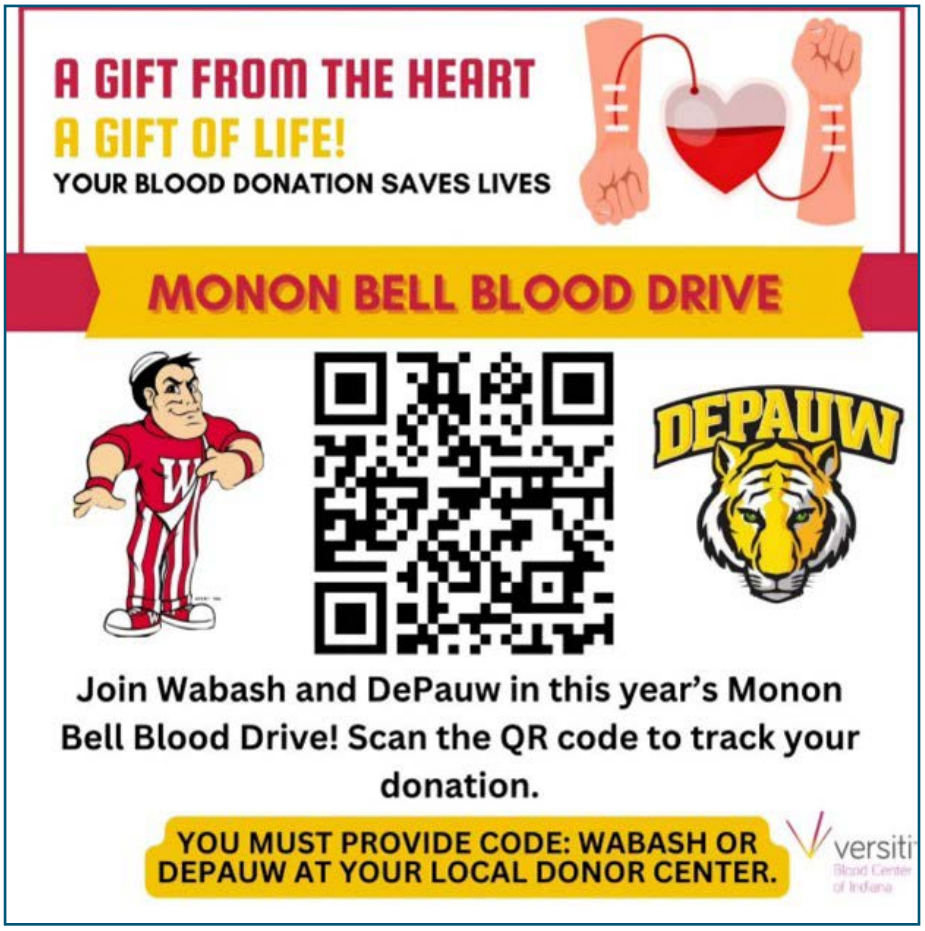
Blood drives are also an excellent way to be recognized as a leader in your community, business, educational institution, or place of worship. They are rewarding to host and provide leadership and project management opportunities for employees. Your blood drive helps maintain a safe, stable blood supply, for patients in your community who rely on your donations. Sources: Versiti.org

After all that, why would I start this article mentioning the Monon Bell Game?

If you are a DePauw University or Wabash College graduate, an affiliate to someone who graduated from these institutions, or just want to participate, the DePauw University/Wabash College Blood Collaborative is for you. Starting the week of the Classic, Wabash alumni and DePauw alumni can use the QR code to register to give blood at a Versiti location. The collaboration ends the day of the Classic which will be held in Greencastle, IN at Blackstock Stadium.

Sincerely,

Joseph Webster, Jr
152nd President
Indianapolis Medical Society



Tobacco Tax: An Age-Based Phase Out

by RICHARD FELDMAN, MD
MHM Board Member, and Past President, Former State Health Commissioner

For decades, public health officials and anti-tobacco activists have talked about the "endgame" in tobacco control. It refers to laws and policies that would virtually end tobacco use.

Great strides have been made in reducing smoking in the past half-century. These measures include smoke-free laws, increasing cigarette taxes, anti-smoking media campaigns, state tobacco prevention and cessation programs, and the Master Settlement Agreement requiring the tobacco industry to pay states billions of dollars to compensate for state-incurred health-care costs.

Congress restricted tobacco advertising, mandated tobacco warning labels on product packaging, banned flavored cigarettes (except menthol), increased the legal age for sales to 21, and gave the U.S. Federal Food and Drug Administration authority to comprehensively regulate tobacco products including product nicotine content (natural or synthetic).

These efforts have resulted in the reduction in the social acceptability of smoking, especially in public. It has also drastically reduced the percentage of adult smoking to an all-time low nationally of 11 percent (Indiana is 19 percent). Adolescent tobacco smoking has also greatly decreased in the past 25 years but unfortunately has been replaced by vaping.

According to the Centers for Disease Control and Prevention, despite these advances, tobacco use still represents the leading cause of preventable disease and premature death in the U.S. with 521,000 tobacco-related deaths yearly. One in five deaths is caused by tobacco use; one-half of smokers will eventually die from their tobacco addiction.

It's widely thought that the remaining percentage of people smoking is extremely difficult to reduce, hence the endgame-strategy discussion. One strategy gaining steam is referred to as a "birthdate phaseout" approach. Recent commentaries including an article in the May 30th issue of the New England Journal of Medicine call attention to this age-based strategy.

The idea is to institute a threshold birthdate after which it would be illegal to sell tobacco products to anyone with later birthdates. For example, using a birthdate of January 1, 2009, would prevent individuals currently too young to legally purchase tobacco from buying it their entire lives. Eventually, no one would be able to purchase tobacco, and depending on the law, other nicotine-containing products.

This strategy would not affect tobacco access to those born before the threshold birthdate and current addicted smokers. It would also not sanction those illegally buying tobacco but only the retailers selling it.

The concept of a birthdate phaseout has been circulating worldwide for decades. New Zealand passed such a law in 2022 but subsequently repealed it with change in governmental leadership. The approach is currently being considered in the U.K., the European Union, Norway, Australia, and some Asian countries. In the U.S., Brookline, Massachusetts, enacted a phaseout in 2020, and since being upheld by the state's Supreme Court as constitutional, it's being considered by other Massachusetts localities. A municipal law would have relatively little impact; eventually it would have to be followed by state or federal laws to be truly effective.

Legislative proposals differ in what products are prohibited. Some include only combustible tobacco products as in the U.K. Others like Brookline's are broader and include vapes.

Endgame strategies including the birthdate phaseout could create a tobacco/nicotine-free generation and eventually a society free from tobacco product toxins and carcinogens. Millions of lives and billions in health-care costs would be saved. But there are substantial barriers to enactment such as loss of state tobacco-tax revenue and opposing business and political pressures.

Next month, I will review another novel endgame strategy.

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Pharmacy Benefit Managers (PBMs)

Pealing Back the Onion on How Pharmaceutical Payments Drive Up the Cost of Healthcare

by FRANCIS W. PRICE JR, MD
IMS Board Member

Article Summary

This is the second article in a series on health care issues and areas needing reform. Few people understand either how pharmacy benefit managers function, or how they can syphon off large profits driving up the cost of health care while providing limited healthcare benefits.

Why it is important

The rising cost of pharmaceuticals, especially biologics, threaten the financial viability of self-insured health plans, and potentially the health care system as a whole. While pharmacy benefit managers (PBMs) were set up to help control costs and steer people to the most efficacious and cost-effective drugs, they have in many cases promoted the over pricing of drugs through an ever-evolving system of kickbacks and inducements from pharmaceutical companies.

Decreasing reimbursement by PBMs to independent pharmacies are forcing independent pharmacies out of business, due to the consolidation and vertical integration of the healthcare system, and as with physicians, consolidation and vertical integration of the health care system is disproportionally affecting rural America's access to healthcare (1).

Pharmacy Benefit Managers (PBMs)

As a trustee for the Medical Practice Consortium (MPC) the health plan for group medical practices in the State of Indiana, I and the other trustees have gained insights into how the health care system works that are not readily apparent to either physicians or consumers. This has led me to investigate further how pharmaceutical reimbursements works. Some could even say that while operating within the letter of the law, pharmaceuticals are the corrupt side of health care. As a disclaimer, Trustees of the MPC are not allowed to be paid for our roles as trustees, and we do this as volunteers to provide cost effective health care insurance for member group practices of the MPC which is a MEWA (Multiple Employer Welfare Association).

The MPC uses a Pharmacy Benefit Manager (PBM), EpiphanyRx, that we pay a per member/per month fee. We chose EpiphanyRx because they have passed back 100% of rebates to our plan. We, in turn, use these rebates to lower the cost of administering the plan.

PBMs were formed to process claims and to determine formularies for drugs to be used in health plans. The idea is to have PBMs determine the most cost effective and most medically effective drugs. Once this is determined, the health plans, or the PBMs set up tier 1 drugs which would typically be covered at the most favorable reimbursement for the patient under that health plan. Other tiers are then set, such as tiers 2 or 3, which would either be paid with less favorable rates than tier 1 drugs or not be able to be used until a tier one drug was tried. So, in the ideal, or moral, world the PBMs could use experts in pharmacy and medicine to set up the tiers of drugs for the best outcomes at the lowest net cost and to also determine drugs that would not be covered at all. As physicians, most of us would expect this is the way it works, and in the MPC with EpiphanyRx, this is how it has worked. In fact, by utilizing our own PBM, instead of the carrier's PBM, we saved our members one month's premium the first year we made the switch primarily because the rebates come back to our health plan instead of staying with the PBM or carrier.

More recently, we moved some of the infusion

drugs, non-oncology ones, from coverage under the medical portion of the health plan to going through our PBM and saved over $250,000 for our plan the first year we did this. Currently, the most rapidly increasing costs in our health plan are the biologics which are coming out with extremely high price points. One might ask, why do PBMs and carriers agree to pay over-priced amounts for these new, or even older, drugs?

What are Rebates?

For physicians, it is illegal to provide inducements, or payments, to others outside our own practice/ corporation for inducing health services. But with pharmaceuticals, it is legal for drug companies to pay rebates and other incentives to PBMs for the drugs that are purchased from them. For brand name drugs, the rebates can be 40 to 50% of the cost of the drug, and I was recently told by a company it can be over 80% if they want to get their drug listed on the formulary! The rebate amounts are closely held secrets and negotiated by each PBM with each drug company for each drug. So, the way it works is if drug A costs the health plan $100, once the drug company gets payment, they send $40 to $50 dollars back to the PBM. Now you understand why many of these high-priced drugs quickly get formulary approval! It also explains why different, but similar drugs may change from year to year as to which ones are tier 1, 2 or 3 – or who gets listed at all. It all depends on who gives the best rebate each year. A transparent and pass-through PBM will pass 100% of the rebates to the plan, but traditionally, many PBMs have kept rebates for their own profit.

Some have proposed giving the rebates to the patients. That would be worse than giving them to the PBMs. Patients would naturally want the drugs with the highest rebates which could easily add up in some cases to more than the premium paid for their health insurance.

Sadly, Rebates are Just the Tip of the Iceberg, or the Outer Peel of the Onion

Many of the higher priced drugs, like the biologics, are typically dispensed through Specialty Pharmacies and the Specialty Pharmacies are typically owned by the PBM. The Specialty Pharmacy buys drugs from the wholesalers and sells the drug to its parent PBM at a higher rate. The pharmacies are also paid fees by the pharmaceutical companies for providing "clinical management" and dispensing data. The development of expensive drugs and specialty pharmacies has led to a shift from PBMs receiving most of their revenue from rebates and "spread" to receiving more revenue from their own Specialty Pharmacy (Table 1). Adding in 16% mark up from mail order dispensing, 55% of a PBM's revenue can come from dispensing a specialty drug.

As if the money trail was not convoluted enough, vertical integration of health care entities has included creation of offshore GPO's (Group Purchasing Organization). This is another way to avoid Federal regulations regarding anti-kickback rules, retain fees, or pay out "bonuses" in a shielded way. As an example: CVS Caremark as the PBM may say they "pass-through" 100% of the rebates "they" receive. However, their owned GPO, Zinc, and CVS Specialty Pharmacy can each receive and keep the rebates and fees from the pharmaceutical manufacturers before sending the medications to the PBM (CVS Caremark).

Health plans pay an administrative fee to the carrier to provide provider networks as well as to pay (administer) all the costs for health care services, but the carrier often pockets portions paid to these other entities that either they or their parent company owns. (Like United Health Group and United Health Care (carrier) and Optum (Physicians). This all demonstrates how vertical integration has allowed carriers to essentially double or triple dip the self-insured health plans.

Carriers have disincentives when it comes to controlling drug costs, because the higher the cost of the drug, the more that comes back to the carrier/PBM as a rebates and other kickbacks and as the cost of the drug goes up, the cost is passed on to the purchaser of the health insurance – the self-insured group, government health plan, and before ACA, individual health insurance policies. If a new drug is not priced so as to give the PBM a substantial rebate, it may not get listed in the formulary, and in fact I had a company tell me they had to have the drug priced high to get listed on the formulary. Also, the higher the cost the more they are allowed to make in "administrative fees". ACA limits the amount of fees carriers an be paid to 20% of claim expenses. Therefore, as the claim expenses are higher, their fees can be higher.

The Federal Trade Commission (FTC) has been investigating PBMs and has found some startling statistics. (1)

- The high cost of drugs has dire consequences for Americans: nearly 3 in 10 surveyed said they either ration or skip doses of medications due to costs.

- Nearly 80% of prescriptions in the US are managed by 3 PBMs, 90% by 6 PBMs.
- Pharmacies associated with the 3 largest PBMs account for 70% of specialty drugs prescriptions.
- The largest PBMs are vertically integrated with the nation's largest health insurers.
- "As a result of this high degree of consolidation and vertical integration, the leading PBM's can now exercise significant power over Americans' access to drugs and the prices they pay."

How To Reform PBMs and the Costs of Pharmaceuticals

1) Make all payments from pharmaceutical companies to anyone in the supply chain illegal.

2) Immediately reduce the cost of all medications by the amount that has been paid for the above inducements – by the highest amount that has been paid. This could lead to dramatic cost reductions for drugs.

3) Require that any pharmaceutical ad list the retail cost of the drug.

4) Break up the vertical integration of pharmacies, PBMs, and carriers.

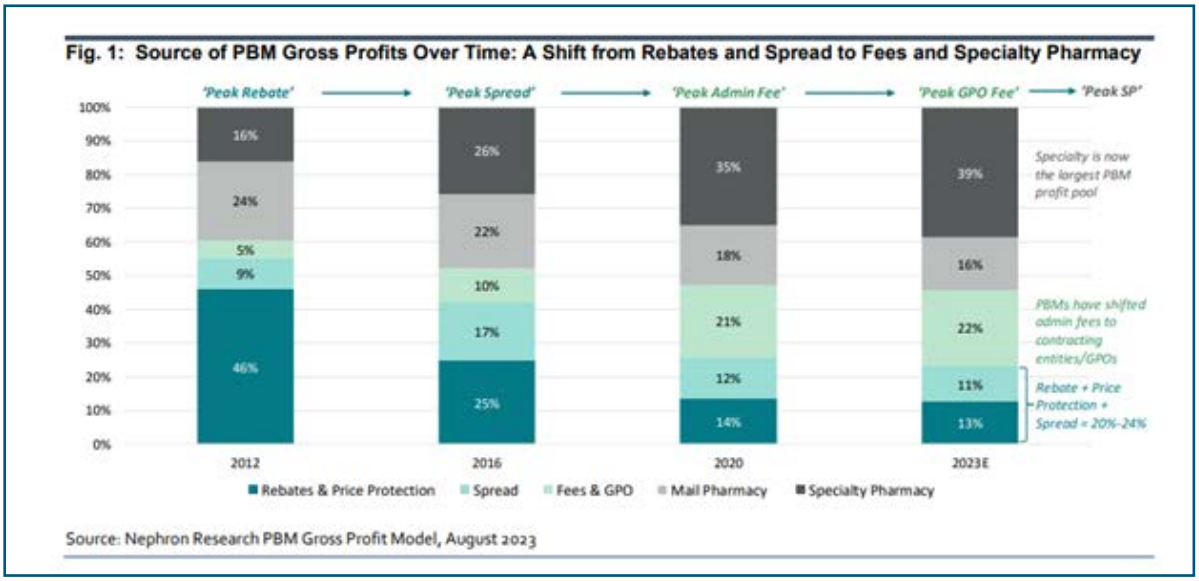
5) Break up and not allow the offshore GPOs.

6) Requiring transparency in all the financial transactions between pharmaceutical companies and the chain of distribution of drugs would help solve a lot of these problems. While it could be argued that this would reveal confidential information, the pharmaceutical companies and PBMs/Carriers have abused the system and transparency is needed.

References

1) pharmacy-benefit-managers-staff-report.pdf (ftc.gov).
2) https://nephronresearch.bluematrix.com/sellside/AttachmentViewer.action?encrypt=1c65fc0e-f558-4f1d-891f-21c196a9f1ad&fileId=7276_04a77b17-d298-48a2-bd15-1c5ed22a6984&isPdf=false

Table 1 (Reference #2)*



Spread is basically a mark-up for what a PBM charges a health plan for the cost of the drug and what they pay the pharmacy to fill it. PBM tells health plan it cost $10 but only paid the pharmacy $8 to dispense it. Also, by having lower payments to independent pharmacies compared to their vertically owned pharmacies, the independent pharmacies are squeezed and made less profitable and competitive.

7) New pharmaceutical approvals should include a cost analysis of the impact of the cost of the drug on the health care system.

What Can Physicians Do?

As physicians, we need to help make everyone aware of the cost of drugs. For physicians, the typical presentation by a pharmaceutical company or "unbiased continuing medical education program" for a new drug involves a drug rep or physician KOL (key opinion leader) presenting the data on how this particular drug can help our patients and treat the ailments we are concerned with. Then they discuss how this great drug will not cost the patient more than some nominal amount, usually because they offer some type of co-pay assistance program that helps the patient get through their deductible and once that is met, the drug is essentially "free" or at minimal cost to the patient but the health plan is stuck with paying the rest of the cost. **The next time you hear one of these presentations, ask them what the total cost of the drug is for the health plan** (or Medicare, Medicaid, etc.). At this point they typically become confused and say things like "well, you don't understand. It won't cost the patient anything", "we don't know they don't tell us that," or "that is not really a question we ever get asked."

At a time when the federal government says that there is no money to give physicians a pay raise to match inflation, physician payments have to be budget neutral, and the conversion factor for physician pay typically goes down each year (proposed 2.8% decrease in 2025 + 2% decrease for Sequester), it is interesting to see the pharmaceutical and insurance industries making record profits and being paid more each year for the same drugs.

Consider becoming more politically active in the ISMA and national specialty groups, because **if you are not sitting at the table, you are likely what is being eaten.**

CME & EVENTS

Community Health Network

Week Day	Monday	Tuesday	Wednesday	Thursday	Friday
First Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM	• GI/Colorectal Tumor Board, 7-8AM • Community Heart & Vascular Conference, 7-8AM • Critical Care Conference, 12--1PM • East Theater, 12-1PM • Psychiatric Grand Rounds, 1-2PM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• GU Tumor Board, 7-8AM
Second Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM • Network Medcal Grand Rounds, 12-1PM	• GI/Colorectal 7-8 AM • Breast & Lung Screening Tumor Board, Anderson 7-8AM • Community Heart & Vasculara Conference 7-8AM • Psychiatry Journal Club, 1-2PM • Head & Neck Tumor Board, 5-6PM		• Neuro Tumor-Board, 7-8AM • South Case Pre-sentation 12 PM
Third Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM • Molecular Tumor Board, 5-6PM	• GI/Colorectal Tumor Board, 7-8AM • Community Heart & Vascular Conference, 7-8AM • Melanoma Tumor Board, 7:30-8:30AM • Psychiatry Grand Rounds, 1-2PM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• GU Tumor Board, 7-8AM • South Case Pre-sentation 12 PM
Fourth Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM	• GI/Colorectal Tumor Board, 7-8AM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• Neuro Tumor Board, 7-8AM

For more information regarding Community Health Network CME or program information, contact Jeff Carter at 317-621-3845.

To submit articles, Bulletin Board items, CME & events, opinions or information, email mperrill@indymedicalsociety.org. Deadline is the first of the month preceding publication.

IMS is not responsible for the events listed. We recommend that before attending any CME/Conference events that you check with the provider to confirm the program is still available.

CME & EVENTS

Indiana University School of Medicine

Indiana University School of Medicine is committed to providing valuable educational opportunities. Many of our educational activities, are now offered in a virtual format.

Online Activities

Cystic Fibrosis Online Education: The Division of Continuing Education in Healthcare Professions at IU School of Medicine has partnered with IU eLearning and Design Services to develop and deliver online courses. With the guidance of the Cardiovascular Institute of IU Health, this program will provide the participants with practice guidance in specific treatment goals of atrial fibrillation classification of atrial fibrillation skills in identifying progression as a disease, initial patient assessment, prevention of stroke, rate control vs rhythm control, attempts to cure, and risk factor modification and monitoring.

Available from 8/31/2024- 8/30/2025
For: Members of Internal and Family Medicine, fellows, nurses, nurse practitioners, pharmacists, pharmacy technicians, physical therapists, physicians, physician assistants. As well as general cardiologists.
More info available at https://medicine.iu.edu/continuing-education/specialized

For More Online Programs, including scheduled series and individual specialties, visit: https://iu.cloud-cme.com

In-Person Activities

Oct 21 - 23	The Science of Compassion in Healthcare: A Workshop on Its Practical Application to Clinical Pracice and Training| University of Notre Dame, Jordan Hall of Science | AMA PRA Category 1 Credits (19 hours)
Oct 25	Addiction, Grief, Attachment, Recovery Conference (AGAR) | 8:00 AM - 6:15 PM | Indiana State Museum, Indianapolis, IN | AMA PRA Category 1 Credits (8.5 hours)
Nov 5	2024 Fall Emergency Medicine Advance Practice Provider Simulation Conference | 8:00 AM - 12:00 PM | Fairbanks Hall, 340 W. 10th Street, Indianapolis, IN | AMA PRA Category 1 Credits (3.75 hours)
Nov 14	Andrea Gianaris Pancreatic Symposium | 8:30 AM - 3:30PM | Joseph Walther Hall, 203, Indianapolis, IN | AMA PRA Category 1 Credits (3.5 hours)

Indiana State Medical Association

To Register For the live webinars, visit: www.ismanet.org

Sept 26
Pints & Politics
2025 Legislative Agenda Preview
Free for Members
6:30 PM
Sun King Brewery
351 Monon Boulevard, Carmel, IN

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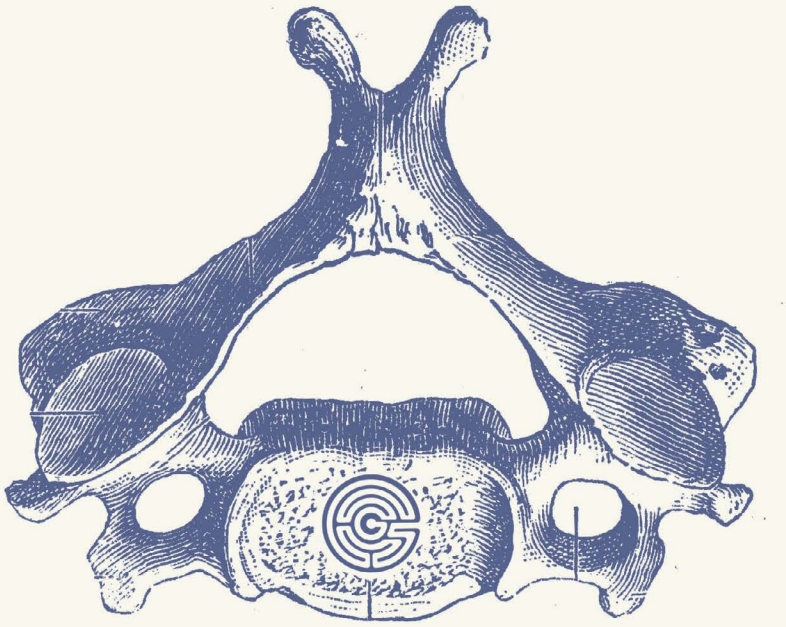
IMS is not responsible for the events listed. We recommend that before attending any CME/Conference events that you check with the provider to confirm the program is still available.

Fig 1c

VERTEBRA



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Diagnostic Radiology
Yale University, 1993

Christina Scifres, MD
IU Health, Center for Women
Maternal and Fetal Medicine
University of Oklahoma, 2002

Joseph F. Webb, MD
Anesthesiology
University of Texas – Southwestern

Residents

Lindsay Adamski, MD
IUSM - Emergency Medicine
Emergency Medicine, Pediatrics
Penn State University, 2024

Hamreet J. Baidwan MD
IUSM - Family Medicine
St. George's University, 2024

Paige A. Bumberg, MD
CHN - Psychiatry Residency
Psychiatry
Oakland William Beaumont, 2024

Joseph Cassell, DO
Franciscan Health Family Med
Family Medicine
Marian University, 2024

Nathan Chou, DO
Franciscan Health Family Med
Family Medicine
Marian University, 2024

Emily R. Coleman, MD
IUSM - Pediatric Residency
Pediatrics
IU School of Med, 2022

Nerina DiSomma, MD
IUSM - Radiology & Imaging
Vascular & InterventionRadiology
U of Illinois at Chicago, 2019

Andrew K. Fraser, MD, PhD
IUSM - Pediatric Residency
Pediatrics
John Hopkins University, 2024

Kirstin Grootenhuis, DO
Franciscan Health Family Med
Family Medicine
Marian University, 2024

Benjamin Herman, MD
Franciscan Health Family Med
Family Medicine
IU, Terre Haute, 2024

Valerie Knight, DO
Franciscan Health Family Med
Family Medicine
Marian University, 2024

Parker E. Ludwig, MD
Diagnostic Radiology
Creighton University, 2020

Francesca R. Mancuso, MD
IUSM - OBGYN
Obstetrics and Gynecology
Sidney Kimmel Med Col, 2022

Saloni Manohar, MD
Franciscan Health Family Med
Family Medicine
Ross University School of Med

Zachary L. Matsko, MD
IUSM - IM Med/Peds Residency
Internal Medicine, Pediatrics
University of Washington

Madison L. McDole, DO
IUSM - Emergency Medicine
Emergency Medicine
Arizona College of Osteo, 2024

Mansi Pandya, DO
Franciscan Health Family Med
Family Medicine
West Virginia Sch of Osteo, 2024

Stephanie Rathjen, DO
Franciscan Health Family Med
Family Medicine
Edward Via Colof Osteo, 2024

Brett J. Riedinger, MD
IUSM - Radiology & Imaging
Vascular & IntervenRadiology
University of Louisville, 2019

Janeishly Roman Gonzalez, MD
IUSM - Emergency Medicine
Emergency Medicine
Ponce Health Sciences U, 2024

Patrick J. Ryan, MD
IUSM - Internal Medicine
Internal Medicine
University of Cincinnati, 2024

Matthew R. Steinhart, MD
IUSM Otolaryngology, Head & Neck Surgery
Otolaryngology
IU School of Medicine, 2024

Ethan B. Tope, MD
IUSM - Pulmonary/Critical Care
Internal Medicine
Wright State U Sch Med, OH, 2019

Matt Turton, DO
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Family Medicine
Marian University, 2024

Andrea Velazquez, DO
Franciscan Health Family Med
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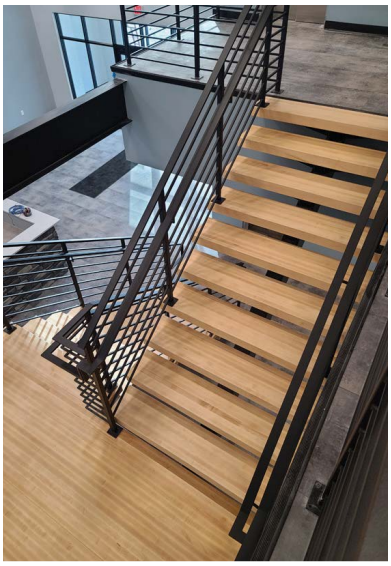
Marian University, 2024

Grace C. Wang, MD
IUSM - Pulmonary/Critical Care
Pulmonary Critical Care Med
Texas Tech University, 2016

Andrea Velazquez, DO
IUSM - Radiology & Imaging
Diagnostic Radiology
Rocky Vista University Col of Ost.



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Doris M. Hardacker *(2026)*
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Penny W. Kallmyer *(2024)*
Clif Knight *(2026)*
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Francis W. Price, Jr *(2026)*
Jodi L. Smith *(2025)*
Eric E. Tibesar *(2024)*
Daniel Udrea *(2026)*
Mary Jean Vorwald *(2025)*
Monica Wehby *(2024)*
Chris Wilson *(2025)*
Maria Wilson *(2025)*

Past presidents' council 2024

** Indicates Voting Board Members, Term Ends with Year in Parentheses*

Linda Feiwell Abels
Christoper D. Bojrab* *(2026)*
Carolyn A. Cunningham
David R. Diaz
Marc E. Duerden* *(2024)*
John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall
Jeffrey J. Kellams
Mary Ian McAteer* *(2025)*
John P. McGoff
Stephen W. Perkins

Delegates

Delegates to the Annual State Convention

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

Ranai Abbasi (2024)
Linda Feiwell Abels (2024)
Laurie L. Ackerman (2025)
Christopher D. Bojrab (2024)
Alison Case (2026)
Ann C. Collins (2026)
Julie A. Daftari (2026)
David Diaz (2024)
Marc E. Duerden (2026)
Richard D. Feldman (2024)
Ann Marie Hake (2025)
Paula Hall (2025)
Ronda A. Hamaker (2025)
C. William Hanke (2024)
Doris M. Hardacker (2024)
Mercy Hylton (2025)
David A. Josephson (2026)
Penny W. Kallmyer (2026)
Kathryn J. Kelley (2026)
Clif Knight (2025)
John E. Krol (2026)
Mercy O. Obeime (2026)
Ingrida I. Ozols (2026)
Robert M. Pascuzzi (2026)
J. Scott Pittman (2025)
Francis W. Price, Jr (2026
Haley A. Pritchard (2025)
David M. Ratzman (2024)
Thomas P. Schleeter (2026)
Jodi L. Smith (2025)
Eric E. Tibesar (2026)
Bree A. Weaver (2025)
Tracey Wilkinson (2025)
Steven L. Wise (2024)

Alternate delegates

Delegates to the Annual State Convention

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

Vinayak Belamkar (2025)
Gabe Bosslet (2024)
David Crook (2024)
Richard Hahn (2026)
Brian S. Hart (2026)
Melanie Heniff (2024)
Richard Huber (2025)
John Kincaid (2024)
Diane Kuhn (2025)
Katie W. McHugh (2024)
Rick Reifenberg (2025)
Caroline Rouse (2023)
Alexandar T. Waldherr (2023)
Joseph Webster (2024)
Monica Wehby (2025)
Maria Wilson (2025)
Chris Wilson (2025)

Indiana state medical association

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**Indicates deceased*

David Diaz
2023-2024

John P. McGoff
2017-2018

Bernard J. Emkes
2000-2001

Peter L. Winters
1997-1998

William H. Beeson
1992-1993

Jon D. Marhenke *
2007-2008

George H. Rawls*
1989-1990

John D. MacDougall*
1987-1988

George T. Lukemeyer *
1983-1984

Alvin J. Haley*
1980-1981

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Immediate Past President
David R. Diaz

Seventh District

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