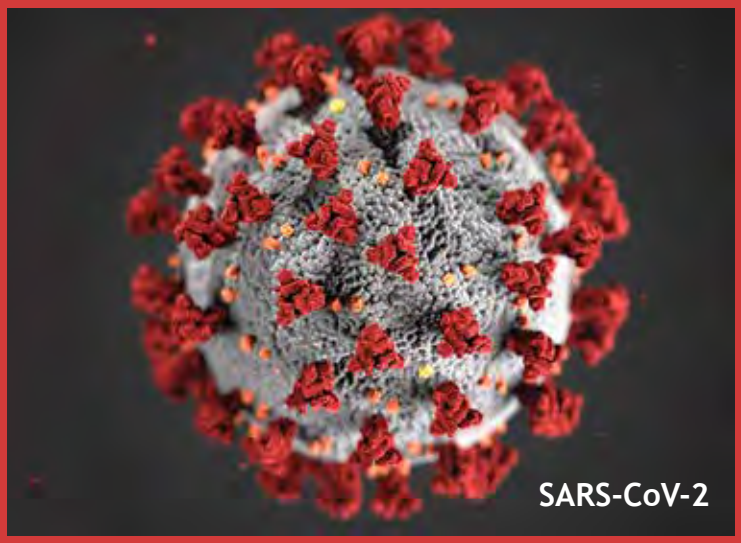
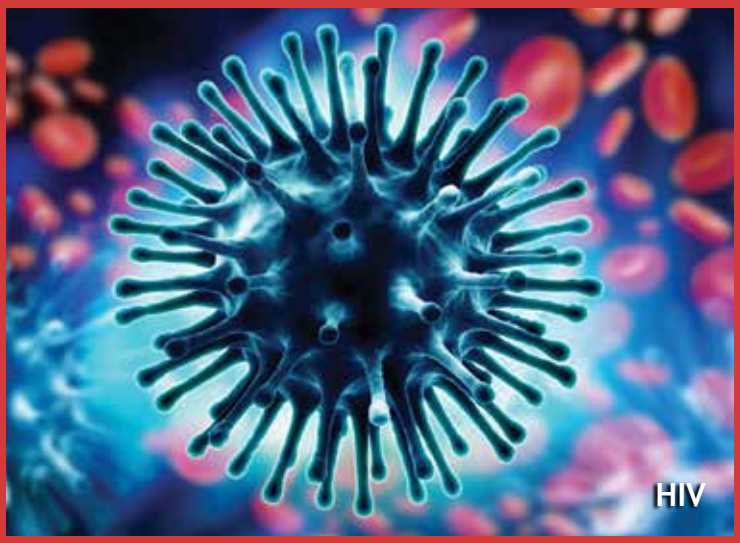
FORT WAYNE
# MEDICINE QUARTERLY

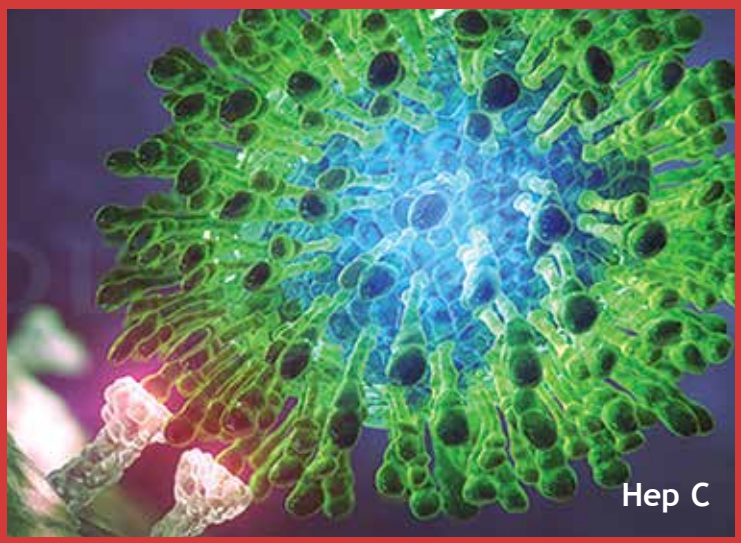
SPRING 2020 · VOLUME 18, ISSUE 1

*Official Publication of the Fort Wayne Medical Society*

# INFECTIOUS DISEASES



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## Fort Wayne Medical Society Mission Statement

**The Fort Wayne Medical Society** is committed to the goals of the American Medical Association, the purpose of which is the preservation of the art and science of medicine, the personal development of member physicians and the protection and betterment of the public health.

**The Fort Wayne Medical Society** is committed to the principles of physician autonomy and self-determination in the practice of medicine.

**The Fort Wayne Medical Society** is committed to fulfilling the role of an active cohesive leader of the healthcare resources of our community by maintaining and assuring the quality, availability and the responsible economic utilization of our healthcare resources.

**The Fort Wayne Medical Society** is committed to active involvement in the decision-making process regarding medical, social, political and economic issues affecting patients and physicians within hospital and all various inpatient and outpatient settings.

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The views expressed in *Fort Wayne Medicine Quarterly* articles are those of the authors and do not necessarily represent those of the Fort Wayne Medical Society.

Editorials are welcome and members are encouraged to respond to an opinion that might be different from their own.

References from articles will be included, if space allows. When not included, references can be obtained through the editor.

# Editor's Note | Elizabeth J. Canavati, M.S.

The Spring *Quarterly* was a bit challenging to work on because the coronavirus has become such a huge part of our lives and there is still so much we don't know. It is best to refer to the in.gov/isdh, CDC and WHO websites for the most up to date information.

When I selected the topic of infectious disease for the Spring *Quarterly*, there were just a few cases of an unknown virus in China.

Wow, how COVID-19 has evolved in just a few months and impacted millions of people around the world!

We left for a Florida vacation on the first week in March. There were around 120 cases in the US then. While we were there, we heard of two new people infected in Florida (both have since died). I found myself captivated by news reports and anxious about the possibility of spreading the virus in groups, restaurants and at the airport.

When we returned home there were over 400 cases in the US. In just 5 days, the number had quadrupled. I had a busy weekend participating in our 25th Annual Doctor's Day and two fundraisers. All the while, I worried about spreading this seemingly virulent virus to other people in Fort Wayne even though I felt fine and had zero symptoms. We have since learned that SARS-CoV-2 is able to spread between people even if the infected person isn't showing symptoms yet.

One week later, the number of cases was more than 1700. (That number was based on very limited testing.) People were told to work from home. Businesses, schools, sports and public events were cancelled. The grocery stores were busy and overwhelmed. I was going to pick up a few groceries on my way home one Friday afternoon, but the parking lot was full. I decided I could wait. We stopped at a Kroger around 9 pm on that same day and many shelves were empty. An employee told us it was the busiest day they had ever experienced. It was a very odd experience.

We must be vigilant in our own behaviors and set a good example by staying home as much as possible and not contribute to the spread of this nasty pathogen. I hope and pray that this virus is contained soon and that all our health-care family makes it through this pandemic without loss of life.

Anyone interested in volunteering to assist your community's needs, please check **volunteerfortwayne.org/content/volunteer-center-rsvp-0**

My inbox is waiting for your opinions and expertise. We are always open to topic ideas and contributors. Please feel free to send me your ideas or articles at lizjcan612@gmail.com

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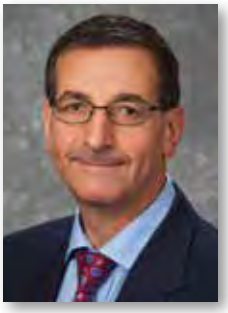
*The secret of health for both the mind and the body is not to mourn for the past, not to worry about the future, nor to anticipate troubles, but live the present moment wisely and earnestly.*

***– Buddha***

## About the Cover:

The image of the SARS-CoV-2 coronavirus is recognizable as it has been in newspapers, magazines, websites and on television. The other images of viruses that share the cover (HIV, Hepatitis C and Syphilis) are illnesses still prominent and important to diagnose and treat. They have taken a back seat to the current pandemic but are also a reminder that people still have other infectious diseases and health issues beyond COVID-19.

# Zoonotic Disease and COIVD-19 | Isa Canavati, M.D., F.A.C.S.



## Zoonotic Disease

Zoonotic diseases are caused by germ transmission from animals to humans. It's estimated that six out of ten infectious diseases and three out of four novel infections are zoonotic.

Examples of zoonotic diseases are:

- HIV (monkeys and chimps),
- Asian Avian flu-H5N1 (poultry, geese and wild birds),
- 1918 Spanish flu-H1N1 (believed to be from poultry),
- 2009 Swine flu (pigs),
- Ebola virus (believed to be from bats, non-human primates, such as monkeys, chimpanzees and apes),
- Zika virus (monkeys and chimpanzees).

## Coronaviruses

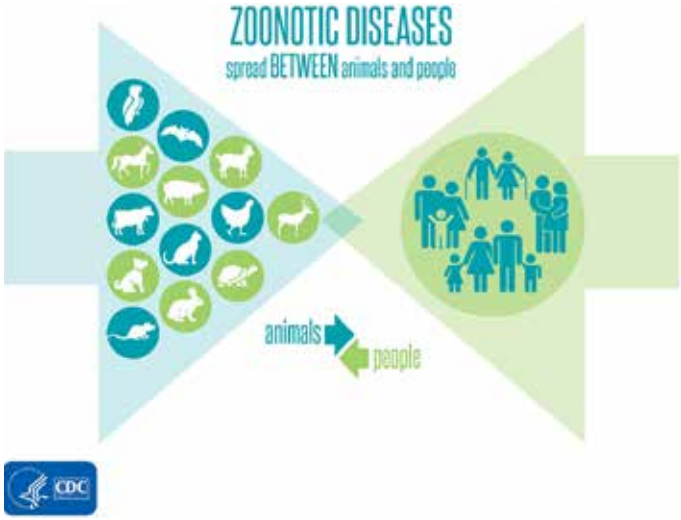
A large family of zoonotic viruses that cause illness ranging from the common cold to Middle East Respiratory Syndrome (MERS) 2013 with 2494 cases and 900 deaths, Severe Acute Respiratory Syndrome (SARS) 2003 with 8000 cases and 800 deaths and SARS-CoV-2 causing COVID-19 illness, a novel strain in humans identified in 2019 with 292,142 confirmed cases and 12,784 deaths (WHO as of 3-21-2020). (The COVID-19 numbers have doubled since I originally wrote this article a week ago.)

## What is the source?

Bats are believed to be the primary reservoir for coronaviruses. The coronavirus spread through intermediary animals-MERS through camels, SARS through civet cats and COVID-19 through pangolins, which is an endangered species trafficked in China for its scales and meat. There is no clear evidence of the need for an intermediate host for the trans-species jump to humans.

## Inter-species jump

Coronavirus has surface glycoprotein structures called spike (S) protein, that in turn has a subunit (S1) that does the actual binding to the epithelial cell receptors, believed to be ACE2 receptors. Host proteases may alter the S1 structure and its ability to attach to the receptors. The S1 subunit has considerable versatility, thus its ability to infect different mammals.




## Life span of the epidemic

Three main factors determine how fast and how far the epidemic will spread:

- Virulence
- Contact
- Duration of the infectious phase.

An important tool society has is social distancing/quarantine in the hopes of mitigating the epidemic and "flattening the curve". The ultimate goal being to decrease the number of infections at the same time and not overwhelm the health care delivery system.

## Disease X

This is a "placeholder" name adopted by the World Health Organization (WHO) in February 2018 for any new and unknown pathogen that can potentially cause an epidemic. It is a "known unknown" that requires preparedness with a research and development response. Some scientists believe the COVID-19 fit the Disease X category.

There are 1000 bat species with more than 200 viruses associated with them. It is estimated that 17 unknown bat viruses could make the jump to humans. Laboratories are working on deciphering the viral genome and devise a vaccine. However, its timely availability is in question given the need for animal testing and required human clinical trials.

# What's The Difference?

| Symptoms | Coronavirus<br>Symptoms range from mild to severe | Cold<br>Gradual onset of symptoms | Flu<br>Abrupt onset of symptoms |
|---|---|---|---|
| Fever | Common | Rare | Common |
| Fatigue | Sometimes | Sometimes | Common |
| Cough | Common* (usually dry) | Mild | Common* (usually dry) |
| Sneezing | No | Common | No |
| Aches and pains | Sometimes | Common | Common |
| Runny or stuffy nose | Rare | Common | Sometimes |
| Sore throat | Sometimes | Common | Sometimes |
| Diarrhea | Rare | No | Sometimes for children |
| Headaches | Sometimes | Rare | Common |
| Shortness of breath | Sometimes | No | No |

Sources: World Health Organization, Centers for Disease Control and Prevention

## Thank You.

To the more than 1,000 physicians and providers of Lutheran Health Network and to our healthcare colleagues across northeastern Indiana, we thank you.

Thank you for your dedication, commitment and service to our community.

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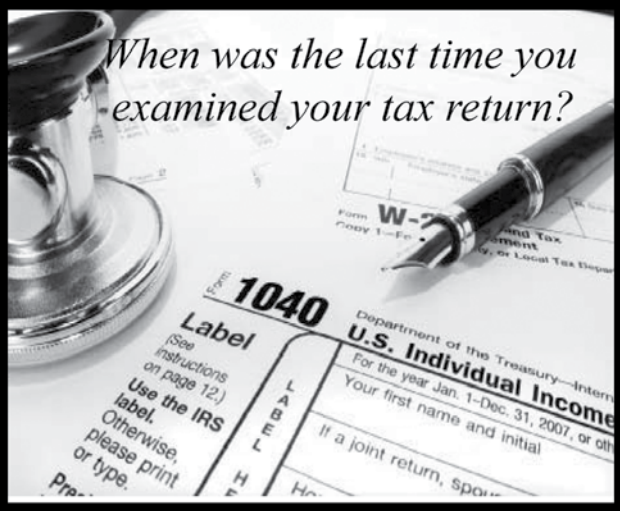


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# What Can We Learn from Canada's Severe Acute Respiratory Syndrome (SARS) Tragedy?

Scott Stienecker, M.D, Medical Director of Epidemiology and Infection Prevention, Parkview Health

Looking back at Canada's SARS outbreak, we see a tale of two cities: Toronto and Vancouver.

Toronto had one index SARS patient resulting in 247 cases and 43 related deaths, many of whom were health-care workers. Two patients came to Vancouver from China (all infected at the same location) and there were only five confirmed cases, of which four were imported! There were no deaths in Vancouver. That's a total of 247 cases in Toronto and one in Vancouver. Toronto experienced sustained transmission. Vancouver did not.

How could that be, when 2,000 patients a day land in Vancouver from China and only 500 land in Toronto? What was the difference?

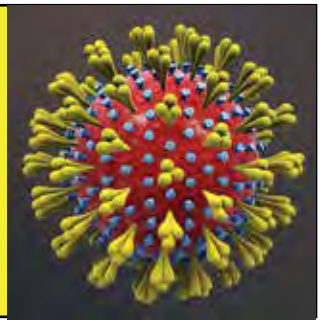
The SARS outbreak in Vancouver highlights how a well-coordinated response of baseline precautions, reinforced through timely public health alerts and periodic infection control audits, can mitigate outbreaks due to emerging respiratory-borne pathogens.

The answer, as published by the British Columbia Centre for Disease Control (BCCDC) Emerging Infectious Diseases*, reveals two key differences. (1) Recognizing the risk to North America, the BCCDC had a regular network to electronically disseminate communicable disease bulletins to hospitals across the region. (2) The ER in Vancouver had drilled on the use of barrier precautions (such as N-95 masks, gowns, gloves, goggles, etc.) for all respiratory ill-nesses.

Toronto, in contrast, utilized no isolation, no masks and very few gloves. If a mask was used, it was a standard surgical mask. Once standard droplet and contact precau-tions were implemented, most, but not all, of the spread was curtailed. Sadly, aerosolizing procedures (bronchoscopy and aerosol treatments) still lead to transmission and death among healthcare workers.

As the BCCDC authors conclude, "While favorable random chance may have played a role, Vancouver's response to SARS should not be dismissed on the basis of luck alone. Pasteur's edict that 'chance favors only the prepared mind'

> **"Those who cannot remember the past are condemned to repeat it."**
>
> **– George Santayana**



may have modern relevance to the prepared healthcare sys-tem. The response to patient zero in Vancouver highlights the importance of central coordination, baseline prepared-ness at the local level, and an efficient network of com-munication in mitigating outbreaks. Baseline preparedness should include barrier precautions in the care of all acute-onset respiratory infections. These should be reinforced through timely public health alerts and periodic infection control audits."

*www.cdc.gov/eid – Vol. 12, No. 1, January 2006

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# DIRECTOR TO DIRECTOR | Joel Harmeyer, Executive Director

The following is a new column that will be featured in the *Fort Wayne Medicine Quarterly*. Each issue we highlight a local non-profit leader making a difference in our community. For the first column, we are excited to have a conversation with **Jeff Markley, Executive Director of Positive Resource Connection (formerly AIDS Taskforce).**

1. ***How do you describe Positive Resource Connection to someone unfamiliar with this organization?*** We are the only HIV/AIDS service organization in Northeast Indiana. We serve twelve surrounding counties and have an annual operating budget of $1.8 million. We are part of a world-wide effort to eliminate HIV/AIDS. This critical work starts at the local level with the number one goal to prevent new cases. My organization views HIV/AIDS as a public health issue instead of a moral one. We've been doing this important work since 1985.
2. ***What is the history of your organization?*** We started as the AIDS Taskforce in 1985 and were the first organization of this type in Indiana. Early on, the organization relied on volunteers with the patients themselves researching treatments and sharing information with area physicians. Once AZT was available in our area, it became the first real treatment available to patients. To illustrate how far we've come, AZT was given initially with hopes that it would keep a patient alive long enough for the next (and hopefully more effective) treatment to be approved. Over the years, treatment options greatly improved, allowing patients to live full lives. With these treatment advancements, in 2015, the organization changed its name to Positive Resource Connection to better reflect its new initiatives. The resolve to prevent new infections in our community remains.

3. ***What is a typical day at work for you?*** When you are a non-profit, you don't have as many resources. I lead a staff of twenty-four employees. In addition to my duties as Executive Director, I also take care of financial reporting and human resources issues as needed. Up until just recently, I took care of a lot of the payroll and bookkeeping responsibilities. I enjoy collaborating with other organizations in mutually beneficial ways. Collaboration is particularly satisfying when working together to solve problems both organizations face. Most days I brainstorm and trouble-shoot with staff on specific client-related cases and issues.
4. ***How do you strike a work/life balance?*** I love my job and the work I do, so sometimes it is hard to disconnect. Over the last few years, I've really tried my best to keep the weekends for me. When not at work, I enjoy trying new restaurants with friends, travelling and landscape design.
5. ***What is the biggest challenge your organization faces?*** Our clients and my staff still address, daily, the stigma surrounding HIV/AIDS. It's a constant battle to reeducate and inform the community. Finances are another issue we face. Finding the resources to do the work that we need to do remains challenging. We have so few unrestricted dollars. Most of our funds are closely tied to a certain grant.
6. ***How can our readers help?*** I have two specific answers and would like to add a third. I mentioned previously our need for unrestricted gifts. Donating to our organization has never been easier. Simply visit our website to contribute – **www.positiveresourceconnection.org.**

**The message we want to convey to the community is that undetectable equals non-transmittable.**

Learn more about what we do and how that has evolved over thirty years. We offer so many more services than we did when we started in 1985. HIV is still here in our community. It is still an issue. We serve over 450 HIV positive clients a year. We are at the cusp of prevention. We can't give up.

Study and become up to speed on the oral drug called PrEP (Pre Exposure Prophylaxis), as it is the latest treatment advancement in the work we do. We believe this drug to be the breakthrough we need to drastically lower new HIV cases in Allen and surrounding counties.

# HIV Initiative in Indiana: African American Men Who Have Sex with Men | Jeff Markley, Executive Director, Positive Resource Connection

According to the Indiana State Department of Health, in 2018 there were 522 new HIV diagnoses in Indiana. Black individuals accounted for 45% of those new infections but only make up 9.7% of Indiana's total population per the 2017 Census Bureau population estimates. The rate of new HIV diagnoses among Black/African American individuals (36.2/100,000) is eight times higher than the rate for white individuals (3.6/100,000). When risk factors are reviewed, men who have sex with men (MSM) have the highest rate of new diagnosis (5.9/100,000). In 2018, white MSM made up 42% of new HIV infections among MSM, black MSM accounted for 37.9% and Hispanic MSM totaled 14.9% of new MSM infections.

The Northeast Indiana Positive Resource Connection, the regional HIV/AIDS service organization serving 12 counties in northeast Indiana, has joined the 13 month Community Health Improvement Initiative (CHII), African American MSM (AAMSM), along with The Midwest AIDS Education and Training Session, The Health Foundation of Greater Indianapolis, The Community Action Groups of Indiana, The Indiana State Department of Health, Brothers United Inc, The Indianapolis Pride of Color and other Indiana AIDS service organizations. The purpose of the initiative is to bring together HIV treatment and prevention organizations, as well as other community-based organizations that serve AAMSM, in an effort to reduce HIV disparities experienced by AAMSM.

***HRSA key strategies to end the epidemic are:***

1. **Diagnose** all people living with HIV as early as possible after transmission.
2. **Treat** HIV rapidly and effectively to achieve sustained viral suppression.
3. **Prevent** HIV transmission among people at highest risk with Pre-Exposure Prophylaxis (PrEP) and prevention education.
4. **Respond** rapidly to detect and respond to HIV clusters and prevent new HIV infections.

NORTHEAST INDIANA Positive RESOURCE CONNECTION

## 2020 Upcoming Fundraising Events Open to the Public

**May 9th – AIDS Walk**

**October 3rd – Dinner Dance**

For more information and how you can help, please visit:
**www.positiveresourceconnection.org**

Over the past 6 months, the Northeast Indiana Positive Resource Connection has been facilitating focus groups, engaging with community leaders, and reviewing internal operations in order to better serve the African American community in our region, especially African American MSM. We know there are trust issues between some African American individuals and medical providers and institutions. We know that stigma – HIV stigma as well as the fear of being labeled as gay or bisexual – is a real and thick barrier to acknowledging self-risk and pursuing testing, education and treatment, if positive. We know that men in general will often put off seeking medical care until long after manageable symptoms become increasingly more difficult to manage. This is no different with African American men.

We also know that men care about their families – their spouses, partners, children, brothers and sisters, friends and parents. And those people care about the men in their lives. We need to change the narrative. We need to encourage and celebrate African American men in general, and MSM in particular, enough so they care enough about each other and themselves to see the value of internally acknowledging risks and seek confidential HIV testing.

We will continue our CHII African American MSM in an official capacity for an additional six months and then for as long as it takes to make ourselves more accessible and trusted as an African American ally for all residents of northeast Indiana and especially for those most at risk for HIV infection.

To be part of the solution in ending the world-wide HIV/AIDS epidemic, we have to do our part in northeast Indiana – that is our mission. We hope you support that work and support the people who could use the resources we have to offer. Feel free to reach out for more information or to become an active partner with the Northeast Indiana Positive Resource Connection. 260-744-1144 or Jeff@neiprc.org

# Antibiotic Resistance | Angel Heyerly, PharmD, BCIDP

Antibiotic resistance is one of the biggest public health challenges of our time. Antibiotic resistant infections are affecting more than 2.8 million people every year in the United States. Unfortunately, more than 35,000 Americans every year are dying from untreatable infections. In 2050, antibiotic resistance is expected to be the number one cause of death worldwide.[1] We can no longer believe that antibiotic resistance is a future problem or a problem in someone else's hospital, state, or country. We can no longer rely on the development of new antibiotics to fix this problem. Rising infections in the community puts more people at risk and makes spread more difficult to contain. There is no safe place from antibiotic resistance. Like nearly 3 million people, you or someone you care about may face an antibiotic-resistant infection.

The misuse and overuse of antibiotics in health care and agriculture has led to the current state of widespread antibiotic resistance. Centers for Disease Control and Prevention (CDC) estimates that 30% of outpatient antibiotic courses are unnecessary.[1] Unnecessary antibiotic use can select for antibiotic-resistant germs, disrupt the microbiome, and put the patient at risk for adverse events. The resistant germs that develop can be spread to other people. Because of travel, a resistant threat anywhere can quickly become a threat here.

CDC recently released an updated Antimicrobial Resistance report which lists the top 18 pathogens that need attention. The pathogens are divided into three categories: urgent, serious, and concerning.

**URGENT PATHOGENS INCLUDE:**

- Carbapenem-resistant Acinetobacter
- Candida auris
- Clostridioides difficile
- Carbapenem-resistant Enterobacteriaceae (CRE)
- Neisseria gonorrhoeae (N. gonorrhoeae)-drug resistant

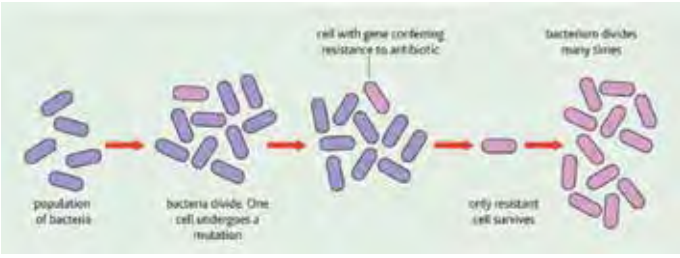
It is important to be aware of all the threats on this list. The full list can be found in the 2019 Antimicrobial Resistant Threats Report.[1]

Antibiotic-resistant infections are difficult to treat. These infections often require extended hospital stays and extensive resources. Limited treatment options exist and may be more toxic and costly. We desperately need new antibiotics with novel mechanisms. Unfortunately, there has been a dramatic decrease in antibiotic drug approvals. As a result of various obstacles, many pharmaceutical companies are getting out of the antibiotic business. Historically, only 1 out of 5 antibiotics in development will receive FDA approval. Most either do not have a novel mechanism or will not address urgent threats. Even new antibiotics with novel mechanisms do not guarantee our chances of treating a resistant infection. Once a new antibiotic is used, it is only a matter of time before resistance will develop. It is crucial that we use the antibiotics we have judiciously and correctly to protect their effectiveness. The right drug at the right dose for the shortest appropriate duration is of utmost importance.

Besides appropriate antibiotic use, there are several additional things that health care providers can do to help protect patients from resistance.

- Ensure patients receive recommended vaccines
- Promote good hygiene and infection prevention practices to prevent spread
- Stay informed of current outbreaks
- Diagnostic testing to guide antibiotic therapy
- Know local resistance patterns in your facility and community
- Educate patients

The fight against resistance is complex, but not hopeless. Preventing infections protects everyone. Improving antibiotic use slows the development of resistance. We can all make a difference, but we have to start now.




1 CDC. Antibiotic Resistance Threats in the United States, 2019. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2019.

# Syphilis – A Review | Deborah McMahan, M.D., Commissioner

While we continue to add new infectious disease issues, such as Candida auris and COVID-19, the old ones never seem to disappear and in fact, periodically resurface in terms of an outbreak. Sadly, that is what we are seeing with syphilis. The first well-recorded European outbreak of what is now known as syphilis occurred in 1495 among French troops. In 2020, it is becoming an important public health issue once again. As you know, syphilis is a genital ulcerative disease caused by the Treponema pallidum. It is associated with significant complications, if left untreated and it can also facilitate the transmission and acquisition of HIV infection. We also know that untreated syphilis in pregnant women, if acquired during the four years before delivery, can lead to infection of the fetus in up to 80% of cases and may result in stillbirth or infant death in up to 40% of cases. So in this issue I would like to do a brief review of syphilis and the treatment. But first, the numbers.

## Sexually Transmitted Infections

Thus far this year we have identified 7 cases of early syphilis and 2 cases of HIV.

## Transmission

Syphilis is transmitted by direct contact with a chancre, which can occur on or around the external genitals, in the vagina, around the anus, or in the rectum, or in or around the mouth. For those of us who have been practicing a while, it is important to remember that in 2020 any orifice is fair game, and transmission can occur during vaginal, anal, or oral sex. In addition, pregnant women with syphilis can transmit the infection to their unborn child. The incubation period from exposure to onset of chancre can range for 10 to 90 days, the average is 21 days.

## Signs and Symptoms

### *Primary Stage:*

The appearance of the chancre marks the primary (first) stage of syphilis but there may be more than one lesion. It is usually (but not always) firm, round, and painless. It appears at the location where syphilis entered the body and therefore can be difficult to see. The chancre lasts 3 to 6 weeks and heals regardless of whether a person is treated or not. However, if the infected person does not receive adequate treatment, the infection progresses to the secondary stage.

**https://www.cmaj.ca/content/183/17/2015**

**https://www.cmaj.ca/content/183/17/2015**

## Six Year Comparison of STD Morbidity Allen County: 2014-2019

| YEAR | Gonorrhea | Chlamydia | Early Syphilis | Late Latent Syphilis | HIV | Total cases reported | NOTES: % change of all reported cases from previous year (YTD) |
|---|---|---|---|---|---|---|---|
| **2014** | 557 | 1,874 | 15 | 10 | 21 | 2,477 | |
| **2015** | 684 | 2,021 | 17 | 21 | 23 | 2,766 | +12% |
| **2016** | 702 | 2,215 | 7 | 15 | 28 | 2,967 | +7.3% |
| **2017** | 947 | 2,264 | 13 | 11 | 24 | 3,259 | +9.9% |
| **2018** | 1,049 | 2,496 | 10 | 11 | 29 | 3,595 | +10.3% |
| **2019** | 1,041 | 2,793 | 24 | 10 | 21 | 3,889 | +8.2% |

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### *Secondary Stage:*

The secondary stage typically starts with the development of a non-itchy rash on one or more areas of the body. Rashes associated with secondary syphilis can appear when the primary chancre is healing or several weeks after the chancre has healed and is NOT pruritic. It may appear as rough, red, or reddish-brown spots both on the palms of the hands and the bottoms of the feet. However, rashes with a different appearance may occur on other parts of the body, sometimes resembling rashes caused by other diseases.

Symptoms of secondary syphilis may also include: fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. The symptoms of secondary syphilis will also go away with or without treatment. Duration of secondary symptoms may range from 2-6 weeks, with an average length of 4 weeks. However, without treatment, the infection will progress to the latent and possibly tertiary stage of disease.

**https://www.cmaj.ca/content/183/17/2015**

### *Latent Stage*

There are no visible signs or symptoms of latent syphilis, despite the fact they are infected and can last for years. Early latent syphilis is where infection occurred within the past 12 months. Late latent syphilis is latent syphilis where infection occurred more than 12 months ago.

### *Tertiary Syphilis*

Tertiary syphilis is rare and develops in a subset of untreated syphilis infections; it can appear 10–30 years after infection was first acquired, and it can be fatal. Tertiary syphilis can affect multiple organ systems, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Symptoms of tertiary syphilis vary depending on the organ system affected.

### *Neurosyphilis*

Syphilis can invade the nervous system at any stage of infection and causes a wide range of symptoms, including headache, altered behavior, difficulty coordinating muscle movements, paralysis, sensory deficits, and dementia.

### *Ocular Syphilis*

Ocular syphilis can occur at any stage of infection and can involve almost any eye structure, but posterior uveitis and panuveitis are the most common. Symptoms include vision changes, decreased visual acuity, and permanent blindness. Clinicians should be aware of ocular syphilis and screen for visual complaints in any patient at risk for syphilis (e.g., MSM, persons living with HIV, others with risk factors and persons with multiple or anonymous partners). A great article regarding a cluster of ocular syphilis can be found at:
**https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6440a6.htm**

### *Congenital Syphilis*

All pregnant women should be tested for syphilis at the first prenatal visit. For women who are at high risk for syphilis, live in areas of high syphilis morbidity, are previously untested, or had a positive screening test in the first trimester, the syphilis screening test should be repeated during the third trimester (28 to 32 weeks gestation) and again at delivery. Any woman who delivers a stillborn infant after 20 week's gestation should also be tested for syphilis. Untreated syphilis in pregnant women results in infant death in up to 40 percent of cases.

An infected baby born alive may not have any signs or symptoms of disease. However, if not treated immediately, the baby may develop serious problems within a few weeks. Untreated babies may become developmentally delayed, have seizures, or die. All babies born to mothers who test positive for syphilis during pregnancy should be screened for syphilis and examined thoroughly for evidence of congenital syphilis.

## Diagnosis

Both nontreponemal tests and treponemal tests are needed to confirm a diagnosis of syphilis. Most providers screen with either a VDRL or RPR each should include an antibody titer, which is what we follow post treatment. Nontreponemal titers are followed to determine if treatment was effective. They are also helpful in any future syphilis diagnosis for an individual as well. The confirmatory (treponemal) test result will remain reactive for life. It is only useful in the initial diagnosis of syphilis. People can become infected with syphilis multiple times in a lifetime if exposed. Whenever there is no history of prior syphilis, a positive venereal disease research laboratory (VDRL) or rapid plasma regain (RPR), with a titer, needs to be confirmed with a fluorescent treponemal antibody (FTA) or other enzyme immunosorbent assay (EIA) or rapid treponemal assays. A lab from a plasma donation center or just being a partner to a case is not enough – you must screen and confirm.

| Treatment – Primary and Secondary Syphilis | |
|---|---|
| *Recommended Regimen for Adults* | |
| **Early Latent Syphilis** | Benzathine penicillin G-2.4 million units IM, single dose |
| **Late Latent Syphilis or Latent Syphilis of Unknown Duration** | Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals |
| *Recommended Regimen for Infants and Children* | |
| **Early Latent Syphilis** | Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units in a single dose |
| **Late Latent Syphilis** | Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units, administered as 3 doses at 1-week intervals (total 150,000 units/kg up to the adult total dose of 7.2 million units). The Department of Health can provide this treatment for your patients. |

Again, we follow the RPR titer so please do both. If a patient is unresourced for syphilis please call our Director of HIV/STD Prevention, Kathy, at (260) 449-3021.

## Follow-up

At the time of diagnosis, we will interview the patient and ensure treatment and will also test for other STIs. At that time, we will also identify contacts and offer them testing.

Follow-up includes both clinical and serologic evaluation at 6 and 12 months after treatment. Serologic response (i.e., titer) should be compared with the titer at the time of treatment.

## At Risk Populations

In 2018, the majority of syphilis cases occurred among gay, bisexual, and other men who have sex with men (MSM). However, in recent years, the rate of Primary & Secondary syphilis has been increasing among MSM as well as heterosexual men and women. Increasingly heterosexual syphilis transmission and drug use, particularly methamphetamine use, are intersecting epidemics.

According to the CDC, during 2013–2017, the syphilis rate among women increased 155.6%, and the rate among all men increased 65.7%, indicating increasing transmission between men and women in addition to increasing transmission between men. A CDC analysis revealed that a substantial percentage of heterosexual syphilis transmission is occurring among persons who use these drugs, particularly methamphetamine. As you know, meth (from Mexico not one pot labs) has significantly increased locally in the past few years. Table 2 (on the following page) is from the MMWR article and is quite shocking:

**https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a4.htm#T2_down**

## Summary

We are entering a new era in STIs, where the world of addiction is compounded by the spread of infectious diseases that are not limited to Hepatitis C and HIV, but now syphilis and other STIs. Please keep this in mind when seeing patients.

**https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm**

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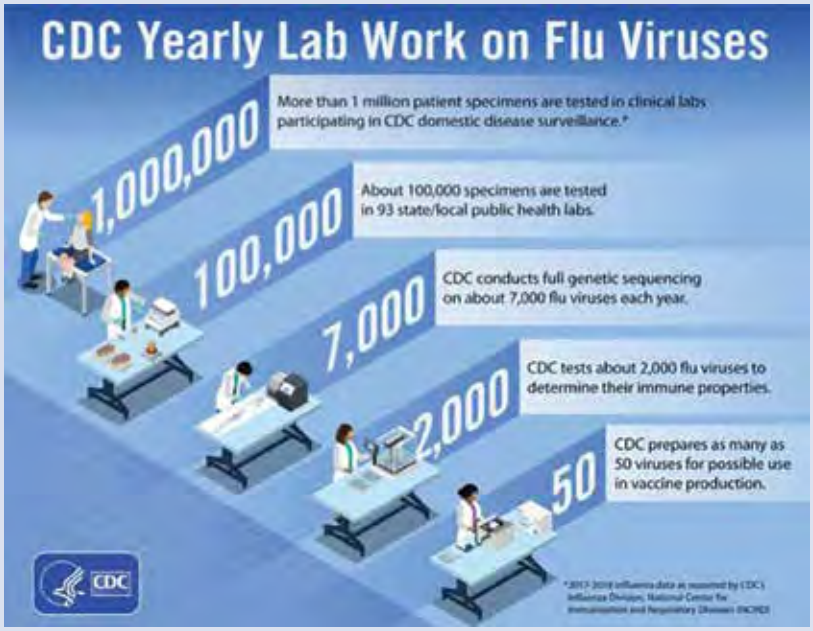
**TABLE 2. Prevalence* of Selected Drug-related Behaviors among Women with Reported Primary and Secondary Syphilis, by U.S. Census Region†**

| Behavior during past 12 months | No. (%) | | | | |
|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 |
| **Used methamphetamine** | | | | | |
| Women | 69 (6.2) | 92 (6.8) | 184 (10.6) | 317 (13.7) | 456 (16.6) |
| MSW | 88 (5.0) | 151 (7.4) | 194 (7.6) | 347 (11.1) | 482 (13.3) |
| MSM | 805 (9.2) | 867 (8.7) | 855 (7.5) | 1,039 (7.9) | 1,132 (8.0) |
| **Total†** | **987 (7.9)** | **1,136 (7.9)** | **1,253 (7.4)** | **1,738 (8.5)** | **2,106 (9.6)** |
| **Had sex with person who injects drugs** | | | | | |
| Women | 64 (5.5) | 113 (8.3) | 135 (7.9) | 217 (9.9) | 325 (12.4) |
| MSW | 64 (3.6) | 119 (5.8) | 167 (6.4) | 201 (6.6) | 325 (9.3) |
| MSM | 368 (4.3) | 495 (5.0) | 537 (4.7) | 594 (4.6) | 725 (5.2) |
| **Total†** | **499 (4.2)** | **734 (5.3)** | **847 (5.2)** | **1,015 (5.5)** | **1,380 (6.7)** |
| **Used injection drugs** | | | | | |
| Women | 44 (4.0) | 81 (6.1) | 119 (7.0) | 179 (8.1) | 281 (10.5) |
| MSW | 48 (2.8) | 78 (3.7) | 96 (3.6) | 152 (4.8) | 230 (6.3) |
| MSM | 288 (3.5) | 365 (3.6) | 345 (2.9) | 406 (3.1) | 514 (3.5) |
| **Total†** | **388 (3.5)** | **534 (3.8)** | **569 (3.4)** | **745 (3.9)** | **1,042 (4.9)** |
| **Used heroin** | | | | | |
| Women | 23 (2.1) | 42 (3.1) | 59 (3.4) | 109 (4.7) | 156 (5.8) |
| MSW | 15 (0.8) | 37 (1.8) | 44 (1.7) | 66 (2.1) | 97 (2.7) |
| MSM | 57 (0.7) | 49 (0.5) | 78 (0.7) | 102 (0.8) | 117 (0.8) |
| **Total†** | **95 (0.8)** | **131 (0.9)** | **182 (1.1)** | **279 (1.4)** | **375 (1.7)** |

* Calculated among persons for whom data for that behavior were reported (persons with missing or unknown responses were excluded from the denominator.
† Includes case records with unknown sex and men with unknown data on sex of sex partner.

# The Puzzle — What Will Next Year Bring? | Betty Canavati, MS

The flu season duration, severity and strains of virus evolve from year to year. Influenza A viruses are based on two surface proteins-hemagglutinin (H), which has 18 subtypes and neuraminidase (N), which has 11 subtypes. (All known subtypes of influenza A are found in birds, except H17N10 and H18N11 which have been found only in bats.) Data on the current year flu viruses is used to formulate the three and four flu strains that will be used in the trivalent and quadrivalent flu vaccine for the next flu season.




Once selected, vaccine manufacturers combine the strains to develop standardized vaccine dosing. This season 81% was quadrivalent and 19% was trivalent. Each manufacturer must submit their application to the FDA for approval.

The FDA is responsible for approving the new formulation and ensuring that all distributed vaccines have met the required standards set. Manufacturers provide the FDA with the results of their testing and samples for each lot. These "lot releases" generally begin in late summer and continue through the fall.

According to the CDC, 174.5 million vaccines were distributed for 2019-2020.

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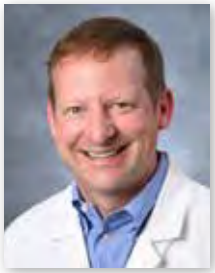

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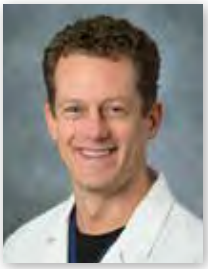

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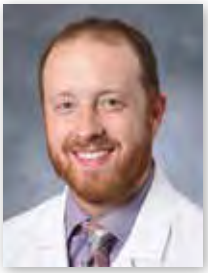

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Fort Wayne, In 46845
Phone: 482-4440 Fax: 482-4442
Medical
School: University of Nebraska, 2013
Residency: Western Michigan University, 2013-2016

**MICHAEL ROSEN, DO**
Specialty: Orthopedic Surgery
Group: Fort Wayne Orthopaedics
7601 W Jefferson Blvd
Fort Wayne, In 46804
Phone: 436-8686
Medical
School: Michigan State University College of Osteopathic Medicine, 2013
Residency: Michigan State University, 2013-2018

**AHMAD SAFRA, MD**
Specialty: General Surgery
Group: Lutheran Health Physicians
7910 W Jefferson Blvd Ste 200
Fort Wayne, In 46804
Phone: 260-435-7680 Fax: 260-435-7670
Medical
School: Damascus University School of Medicine, 2006
Residency: Damascus University Hospitals, 2007-2011

**ALINDA SARMA, MD**
Specialty: Internal Medicine
Group: Parkview Physicians Group- Hospital Medicine
11109 Parkview Plaza Drive
Fort Wayne, In 46845
Phone: 260-672-6620 Fax: 260-672-6639
Medical
School: Crimea State Medical University, 2014
Residency: Cleveland Clinic Fairview Hospital, 2016-2019

**JAMES SCHLOTMAN, MD**
Specialty: Anesthesiology
Group: Parkview Physicians Group-Anesthesiology
3810 New Vision Dr Fort Wayne, In 46845
Phone: 425-6030 Fax: 425-6028
Medical
School: University of Cincinnati College of Medicine, 2010
Residency: Baylor College of Medicine, 2010-2014

**TRAM SCHROEDER, MD**
Specialty: Diagnostic Radiology
Group: Fort Wayne Radiology
3707 New Vision Drive
Fort Wayne, In 46845
Phone: 260-469-4763 Fax: 260-484-5919
Medical
School: University of Iowa Carver College of Medicine, 2013
Residency: Broadlawns Medical Center, 2013-2014 and Indiana University School of Medicine, 2014-2018

**ASHLEY SCOTT, MD**
Specialty: Obstetrics & Gynecology
Group: Women's Health Advantage
2518 E Dupont Rd
Fort Wayne, In 46825
Phone: 260-432-4400 Fax: 260-969-6891
Medical
School: University of Illinois, 2013
Residency: Mercy Hospital and Medical Center, 2014-2018

**JONATHAN SHIRAZI, MD**
Specialty: Cardiovascular Disease
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11108 Parkview Circle
Fort Wayne, In 46845
Phone: 260-266-5700 Fax: 260-266-5910
Medical
School: Southern Illinois University School of Medicine, 2010
Residency: Indiana University School of Medicine, 2010-2014

**CHRISTOPHER STEFFY, MD**
Specialty: Emergency Medicine
Group: Professional Emergency Physicians
3640 New Vision Dr Ste A
Fort Wayne, In 46845
Phone: 482-4440 Fax: 482-4442
Medical
School: Indiana University School of Medicine, 1992
Residency: Methodist Hospital of Indiana, 1992-1995

# Fort Wayne Medical Society | New Members

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Medical
School: Indiana University School of Medicine, 2009
Residency: Indiana University, 2009-2012

**LAUREN STOFFEL, DO**
Specialty: Family Medicine
Group: IU Health Physicians
10215 Auburn Park Dr
Fort Wayne, In 46825
Phone: 234-5400 Fax: 234-5110
Medical
School: A.T. Still University Kirksville College of Osteopathic Medicine, 2014
Residency: Fort Wayne Medical Education Program, 2014-2017

**RAKESH SUBRAMANIAN, MD**
Specialty: Internal Medicine & Pulmonary Disease
Group: Parkview Physicians Group- Pulmonary and Critical Care
11104 Parkview Circle Ste 410
Fort Wayne, In 46845
Phone: 266-5260 Fax:266-5279
Medical
School: Madras Medical College, 2008
Residency: John Stroser Hospital, 2012-2016

**DUSTIN THOMAS, MD**
Specialty: Cardiovascular Disease
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11108 Parkview Circle Fort Wayne, In 46845
Phone: 266-5700 Fax: 266-5910
Medical
School: Indiana University School of Medicine, 2008
Residency: Madigan Army Medical Center, 2008-2011

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Medical
School: Indiana University School of Medicine, 2015
Residency: Indiana University School of Medicine, 2016-2019

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Specialty: Emergency Medicine
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Phone: 482-4440 Fax: 482-4442
Medical
School: Indiana University School of Medicine, 2015
Residency: Central Michigan University, 2015-2018

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Medical
School: Indiana University School of Medicine, 2014
Residency: University of Virginia Health Sciences Center, 2014-2018

**BRAD WARNER, DO**
Specialty: Emergency Medicine
Group: Professional Emergency Physicians
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Fort Wayne, In 46845
Phone: 482-4440 Fax: 482-4442
Medical
School: Arizona College of Osteopathic Medicine, 2013
Residency: Western Michigan University, 2013-2016

**CAREY WATSON, MD**
Specialty: Pediatric Surgery & General Surgery
Group: Great Lakes Pediatric Surgeons
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Medical
School: Texas Tech University, 2010
Residency: University of Cincinnati, 2010-2017

**JEFFREY WITT, MD**
Specialty: Family Medicine
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Medical
School: Indiana University School of Medicine, 1985
Residency: Fort Wayne Medical Education Program, 1985-1988

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Medical
School: Wayne State University, 2011
Residency: Michigan State University, 2011-2014

**SREEYA YALAMANCHALI, MD**
Specialty: Otolaryngology
Group: ENT Associates
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Fort Wayne, In 46825
Phone: 207-1674 Fax: 918-1682
Medical
School: St Louis University, 2013
Residency: University of Kansas Medical Center, 2014-2019

# Meeting Our Patients Where They Are

Erika Pitcher, MPH
Director of Community Health & Case Management Services, Allen County Health Department

Over the last several years, the health department has had a few significant public health issues that seem to be affecting the same populations. It started with sexually transmitted diseases (STDs), then tuberculosis (TB), and eventually crossed over into hepatitis A. Through working with these populations while completing contact investigations, we started noticing a lot of similarities and new trends developing over the last three years. The trends have greatly affected the way we structure our clinics and outreach today and have pushed us into a new era of "Public Health on the Move."

When talking about tuberculosis and hepatitis A populations specifically, I am primarily referring to people under the age of 45. They may also have additional risk factors of: drug use, recent incarceration, men who have sex with men (MSM), mental health issues and homelessness.

(As a disclaimer, these trends do not represent characteristics we see in all our patients.) Working with some of these populations, we noticed two major trends that we hadn't seen before in working with other diseases. The first is that people do not want to pay for their medical care services, regardless of ability to pay. Even something as simple as a $10 fee was too much of a barrier to get a patient to come into our clinic for services. The second trend is that patients do not want to make an appointment to come into our clinic to receive services, even if they knew they had been exposed to someone with an infectious disease and the services would be provided for free. We have even attempted to allow walk-in appointments. It is still a barrier to getting patients treated.

Public health differs from private health in the level of responsibility and accountability we are held to in getting patients treated for certain diseases. In the private health care industry for example, when you diagnose a patient with diabetes or hypertension and they leave the office. If they never take any medications, that doesn't reflect negatively on the practice and won't impact the health of the general public. In public health, we are required to not only provide the testing and education for patients infected with communicable diseases, but we also must ensure the patient has been adequately treated. If there are any contacts of that patient, they must be notified, offered testing and also treated when necessary. Their infection could possibly affect the general public, if left untreated. That becomes very difficult to achieve if a patient isn't willing to come into the clinic to be seen or doesn't have any money.

In response to these challenges, we started an unofficial "Public Health on the Move" campaign that allows us to take our STD testing, vaccinations and TB testing to the streets, parks, shelters, community organizations and any other place we feel is necessary. By getting creative and meeting the people where they are, we are able to provide services to a much higher number of people than before.

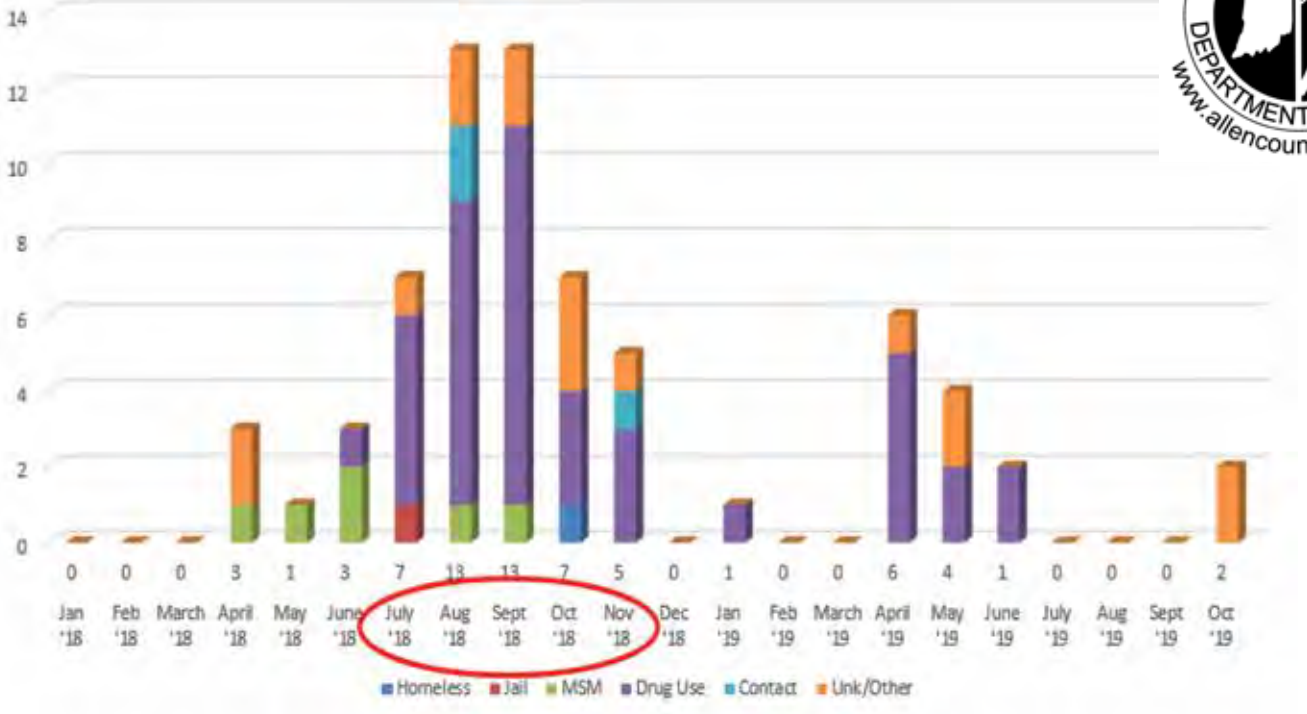
As an example in 2018, we had a significant hepatitis A outbreak that was affecting primarily the populations I listed above, which were the homeless, MSM, and those with a history of drug use and recent incarceration. We took our services to the locations we felt would impact

the most people, including local shelters, community parks, night clubs, downtown library and several other places to get enough people the testing or treatment that they needed to ensure we were promoting and protecting public health. Through these efforts were able to vaccinate around 1,400 people and curb hepatitis A numbers in our community in just a matter of months, where several other communities are still experiencing high numbers of hepatitis A cases today. As you can see from the chart below, the public health community outreach that occurred over the summer of 2018 was very impactful in intervening in our local hepatitis A outbreak and led to a significant reduction in cases for several months.

Even after we had removed the barriers of cost and time, we were still interacting with people that were not interested in participating in the free services we were providing. We learned from speaking with them that this usually occurred for a few different reasons. We often heard that they did not trust the government and did not trust that we were trying to help them for free. We also heard several of them say they didn't really care if they got sick. We noticed that many people were lacking a genuine interest in their own health. To combat this mistrust and disinterest, we piloted offering an incentive for them to agree to take the services we were providing. We purchased $5-dollar fast food gift cards. We handed them out to anyone who was willing to get either a TB or STD test or receive a hepatitis A vaccine. This incentive increased our numbers monumentally! We learned quickly that investing $5 in a person now, saves a lot of public health dollars in the future by preventing the spread of infectious diseases, such as TB, STDs and hepatitis A. We are now evaluating funding resources to continue the incentive program on a more routine basis.

After evaluating these trends over the last several years, we have learned that it is important to not only look at the new and emerging trends in diseases, but also changing intervention methods in the populations you are serving. At the end of the day, we are all serving the same people. If they are non-compliant with us, they are likely not compliant in other medical offices as well. The percentage of these patients has been increasing and becoming more and more expensive to care for. If we don't get creative and step outside of the box with new ideas for outreach, we will quickly reach a point of non-sustainability. We will continue our "Public Health on the Move" campaign for the foreseeable future and would encourage each of you to see what you could do differently in your practices. Together we can make an impact on the spread of infectious diseases in Allen County.

## Allen County Hepatitis A Cases: January 2018 - October 2019



# Breaking Down Barriers to End Hepatitis C | Deborah Nichols, MS, MPH

The 2015 HIV outbreak in Scott County, Indiana, that captured national attention had a parallel story line that has received less attention but is equally significant. More than 94 percent of the individuals diagnosed with HIV in Scott County were co-infected with hepatitis C, known as HCV. Hepatitis C is a disease so ubiquitous that many people, once diagnosed, barely blink an eye. They say things like, "Having hepatitis C is no big deal – my grandmother even has it." Yet there are more hepatitis C deaths in the United States than from 60 other infectious diseases combined (including HIV and tuberculosis).

According to the Centers for Disease Control and Prevention (CDC), in 2017 (the most recent national data published) **Indiana had more than twice the rate of newly-diagnosed acute hepatitis C cases compared to the national average, ranking Indiana third in the country.** These reported acute HCV cases are only the tip of the iceberg. Only a fraction of individuals with acute hepatitis C infections are identified, and for every reported individual with HCV there are an estimated 13.9 infections that go unidentified (Figure 1). It has also been reported that each person with hepatitis C who injects drugs is likely to infect approximately 20 others and that disease transmission occurs within the first three years of infection

***Figure 1. The Indiana Hepatitis C Iceberg, 2018.***

*Note: Confirmed and probable incident cases of acute hepatitis C reported through the Indiana Nationally Electronic Disease Surveillance System (INEDSS) as maintained by the Viral Hepatitis Program at the Indiana State Department of Health.

Many news reports talk about about the shift in the opioid crisis from the urban African American population to the rural white population. Unfortunately, many African American Hoosiers are receiving their first positive hepatitis C lab tests later in life. In 2018, the rate of newly identified HCV cases in Indiana African Americans over age 50 was 241 percent higher than rates for the white population in the same age group. This means worse health outcomes for this population because the disease has had a chance to cause damage to the liver for years, and sometimes decades, before diagnosis and treatment.

From 2014-2018, 57 percent of acute and chronic HCV cases in Indiana occurred in those younger than 40 years old. Moreover, the increased number of HCV infections in people ages 18-39 years is particularly concerning because half of the population in this age range are women of child-bearing age. As a result, the number of infants born to HCV-positive mothers is expected to rise. In 2018, the first year that perinatal HCV was tracked at the state level in Indiana, 20 babies had confirmed HCV – highlighting the need for linkage-to-cure for women of child-bearing age.

Before 2014, treatment of HCV was nothing short of brutal. The treatment often was worse than the disease itself in many patients' eyes, lasting 6-12 months. More than 20 percent of patients experienced serious side effects, including significant neuropsychiatric effects, flu-like symptoms, weight loss, fatigue, arthralgia, nausea, diarrhea, alopecia, and dyspnea, leading to a 10-20 percent premature discontinuation rate. For those who finished therapy, the cure rate for the most common genotype was only about 40 percent.

The release of direct-acting antiviral medications (DAAs) has changed all that. Treatment can cure HCV in approximately 96 percent of the people who complete the course of treatment with little to no side effects and in as few as eight weeks. Not only is there curative treatment for HCV, but the cost while expensive upfront (with prices ranging from $24,000 to $94,500) is a bargain compared to the average cost of $577,000 for a liver transplant, which up to 5 percent of people living with HCV will eventually need.

While the prices of HCV treatments are coming down, the cure remains out of reach for many people living

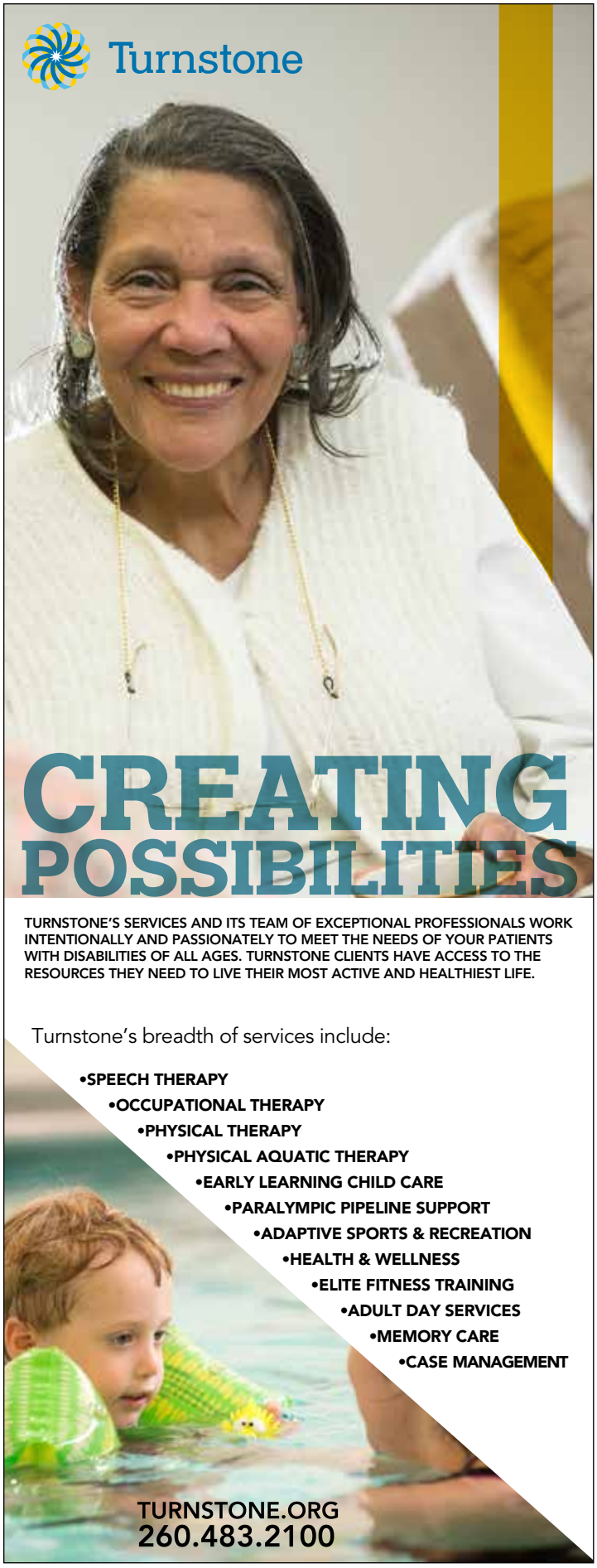
with the disease in Indiana. Innovative approaches at the patient level are needed to increase engagement in care for people who inject drugs, including peer support and linkage to care in settings where patients feel comfortable. At the provider level, expanding the number of non-specialists available to prescribe treatment is needed. Incorporating HCV treatment into substance use disorder treatment programs and syringe service programs may also help reduce barriers for accessing treatment at the system level.

Efforts to address these patient-, provider-, and system-level changes are already happening in Indiana. Medicaid has removed the fibrosis score requirement, the Indiana Department of Corrections (IDOC) has begun to treat everyone with HCV within state prisons, and the ISDH Viral Hepatitis Program has increased education, surveillance and prevention. Linkage-to-cure activities across the state have begun, not only at hospitals and clinics, but also with a new state Viral Hepatitis Services Program specifically designed for patients who test positive at syringe service programs, were previously incarcerated, and those without health insurance.

In partnership with ISDH, IDOC, Step-Up, Inc., and the Richard M. Fairbanks School of Public Health, the ECHO Indiana Peer Education Program (INPEP) trains men and women who are incarcerated on how to be health educators and advocates within the state prison system, with a specific focus on HCV prevention and education. Beginning in May 2019, this unique program (the second of two, with New Mexico being first) has already trained 64 peers (in four facilities) who have in turn provided health education to approximately 1,000 incarcerated individuals. More information about INPEP ECHO can be found at **https://fsph.iupui.edu/news-events/news/inpep-program-echo.html.**

The ISDH Division of HIV, STD and Viral Hepatitis, under the leadership of Director Jeremy Turner, has approved the development of a statewide Ending the Epidemics Plan for HIV, Viral Hepatitis and STDs. This plan will support a data-driven focus to increase the number of people who know their HCV status, guide efforts to use proven interventions to prevent new infections and reach those living with the disease and link them to cure. By continuing to build this infrastructure, we can ensure that everyone living with this disease has access to curative care options.

References available by editor upon request.



**Report incidences of the following infections, diseases, or conditions to the Local Health Department — Phone Number: _____**

## Reportable Communicable Diseases and Conditions for Health Care Providers, Hospitals, and Medical Laboratories

**Effective December 25, 2015**

**410 IAC 1-2.5-75 & 76**

**Report immediately on suspicion (!). Report within 24 hours (*). All others report within 72 hours or as noted.**

Acquired Immunodeficiency Syndrome (AIDS)
*Animal Bites
Anaplasmosis (*Anaplasma* species)
**! Anthrax** (*Bacillus anthracis*)
**! Arboviral** (Eastern Equine, St. Louis, La Crosse, West Nile, California, Western Equine, Powassan, Japanese)
Babesiosis (*Babesia* species)
**! Botulism** (*Clostridium botulinum*)
**! Brucellosis** (*Brucella* species)
Campylobacteriosis (*Campylobacter* species)
*Carbapenemase-producing Carbapenem-resistant Enterobacteriaceae* (CP-CRE)
Chancroid (*Haemophilus ducreyi*)
**! Chikungunya virus**
*Chlamydia trachomatis*, genital infection
**! Cholera** (*Vibrio cholerae*)
Coccidioidomycosis
Cryptosporidiosis (*Cryptosporidium* species)
Cyclosporiasis (*Cyclospora cayetanensis*)
Cysticercosis (*Taenia solium*)
**! Dengue**
**! Diphtheria** (*Corynebacterium diphtheriae*)
**! Eastern equine encephalitis** (EEE)
Ehrlichiosis (*Ehrlichia* species)
**! *Escherichia coli* infection** (Shiga toxin-producing *E. coli* (STEC)) including, but not limited to:
*E. coli* O157;
*E. coli* O157:H7;
Shiga toxin detected; or
Non-O157 *E. coli*
Giardiasis (*Giardia* species)
Gonorrhea (*Neisseria gonorrheae*)
Granuloma inguinale (*Calymmatobacterium granulomatis*)
**!** *Haemophilus influenzae,* invasive disease
Hansen's disease (leprosy) (*Mycobacterium leprae*
**! Hantavirus pulmonary syndrome**
**! Hemolytic uremic syndrome**, postdiarrheal
**! Hepatitis, viral, Type A**
Hepatitis, viral, Type B
**! Hepatitis, viral, Type B, pregnant woman** (acute and chronic) or perinatally exposed infant
Hepatitis, viral, Type C (acute), within five (5) business days
Hepatitis, viral, Type Delta
**! Hepatitis, viral, Type E**
Hepatitis, viral, unspecified
Histoplasmosis (*Histoplasma capsulatum*)
HIV infection/disease (The following conditions related to HIV are laboratory reportable)
*Cryptococcus neoformans*
Kaposi's sarcoma (biopsies)
*Pneumocystis carinii*
**! HIV infection/disease**, pregnant woman or perinatally exposed infant
Influenza-associated death (all ages)
**! Japanese encephalitis**
**! La Crosse encephalitis** (California serogroup viruses)
Legionellosis (*Legionella* species)
Leptospirosis (*Leptospira* species)
Listeriosis (*Listeria monocytogenes*, invasive)
Lyme disease (*Borrelia burgdorferi*)
*Lymphogranuloma venereum*
Malaria (*Plasmodium* species)
**! Measles** (Rubeola)
**! Meningococcal disease** (*Neisseria meningitidis*, invasive)
*Mumps
*Novel influenza A
*Pertussis (*Bordetella pertussis*)
**! Plague** *(Yersinia pestis)*
**! Poliomyelitis**
**! Powassan virus**
Psittacosis (*Chlamydia psittaci*)
**! Q Fever** (*Coxiella burnetti*)
**! Rabies in humans or animals**, confirmed and suspect animal with human exposure
Rabies, postexposure treatment
Rocky Mountain spotted fever (*Rickettsia* species)
**! Rubella** (German Measles)
**! Rubella congenital syndrome**
Salmonellosis, non-typhoidal (*Salmonella* species)
**! Shigellosis** (*Shigella* species)
**! Smallpox** (Variola infection)
Adverse events or complications due to smallpox vaccination (vaccinia virus infection) or secondary transmission to others after vaccination.
**! St. Louis encephalitis** (SLE)
*Staphylococcus aureus,* vancomycin resistance level of MIC ≥ 8 µg/mL or severe *Staphylococcus aureus* in a previously healthy person
*Streptococcus pneumoniae,* invasive disease and antimicrobial susceptibility testing
*Streptococcus,* Group A, invasive disease (*Streptococcus pyogenes*)
Syphilis (*Treponema pallidum*)
Tetanus (*Clostridium tetani*)
Toxic shock syndrome (streptococcal or staphylococcal)
Trichinosis (*Trichinella spiralis*)
*Tuberculosis, cases, suspects, and latent infection (*Mycobacterium tuberculosis*)
*For latent infection, a positive screening test, negative or normal chest x-ray, no evidence of extra-pulmonary disease, and provider diagnosis are necessary. Report latent infection within five (5) business days.*
**! Tularemia** (*Francisella tularensis*)
**! Typhoid and paratyphoid fever**, cases and carriers (*Salmonella Typhi or Paratyphi*)
Typhus, endemic (flea-borne)
Varicella (chicken pox)
Vibriosis (*Vibrio* species)
**! West Nile Virus** (WNV)
**! Western equine encephalitis** (WEE)
**! Yellow fever**
Yersiniosis (*Yersinia* species)

### Other Reportable Conditions and Diseases of Public Health Significance (Non-communicable)

- Report all blood lead results (capillary and venous) in children and adults within one week (410 IAC 29-3-1)
- Report injury resulting from fireworks or pyrotechnics within 5 business days after a person receives treatment (IC 35-47-7-7)
- Report confirmed cases of cancer occurring in residents diagnosed or treated in Indiana to the state cancer registry (410 IAC 21-1-2)

Indiana State Department of Health

## Report incidences of the following infections, diseases, or conditions to the Local Health Department — Phone Number: _____

**Immediately report <u>outbreaks</u> of any of the following upon suspicion**:

1. Any disease required to be reported under this section
2. Newborns with diarrhea in hospitals or other institutions
3. Foodborne or waterborne diseases in addition to those specified by name in this rule
4. Streptococcal illnesses
5. Conjunctivitis
6. Impetigo
7. Nosocomial disease within hospitals and health care facilities
8. Influenza-like-illness
9. Viral meningitis
10. Unusual occurrence of disease
11. Any disease (e.g. anthrax, plague, tularemia, *Brucella* species, smallpox, or botulism) or chemical illness considered a bioterrorism threat, importation, or laboratory release.

---

**Reporting is required of any specimen derived from the human body yielding microscopic, bacteriologic, immunologic, serologic, or other evidence of infection by any of the organisms or agents listed.**

1. <u>Test</u>: name, date, test results, specimen source, normal limits for the test, test result interpretation, and laboratory's accession number or other numeric identifier.
2. <u>Person</u>: name, address, and date of birth (or age if date of birth is not available)
3. <u>Submitter</u>: name, address, and telephone number of attending physician, hospital, clinic, or other specimen submitter
4. <u>Laboratory</u>: name, address, telephone number, and CLIA ID number of the laboratory performing the test

---

**Laboratories shall submit all isolates of the following organisms to the ISDH Laboratory for further evaluation within three (3) business days of isolation:**

1. Carbapenamase producing-carbapenam resistant Enterobacteriaceae (CP-CRE)
2. *Haemophilus influenzae*, invasive disease
3. *Neisseria meningitidis*, invasive disease
4. **Escherichia coli* (Shiga toxin-producing *E. coli* (STEC)) isolates
5. *Staphylococcus aureus,* vancomycin resistance level of MIC ≥ 8 µg/mL
6. *Mycobacterium tuberculosis*
7. *Streptococcus pneumoniae,* invasive disease, isolates from persons less than five (5) years of age
8. *Listeria monocytogenes*
9. **Salmonella* species isolates
10. **Shigella* species isolates
11. **Vibrio cholerae* isolates
12. **Vibrio* species, *Grimontia hollisae* (*Vibrio hollisae*), and *Photobacterium damselae* (*Vibrio damsela*) isolates

*If isolate of organism is not available, submit clinical specimens per IAC 1-2.5-76(f)

Any infection, disease or condition submitted via electronic laboratory reporting should continue to be reported to the Indiana State Department of Health. Any questions on submission should be directed to the Epidemiology Resource Center at 317-233-7125. For facilities unable to submit via ELR please fax reports to 317-234-2812.

Any questions on isolate submission should be directed to the Indiana State Department of Health Laboratories at 317-921-5500.

Indiana State Department of Health

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# IUSM-FW Rhythm and You

Gina Bailey, Assistant Director of Program Development

On February 6, 2020, IU School of Medicine-Fort Wayne hosted friends, faculty, students and staff to a recognition dinner in the International Ballroom on the campus of Purdue Fort Wayne. The theme of the event was Rhythm and You with a jazz ensemble featuring Pyle Styles enhancing the festivities.

Speakers at the dinner included the Executive Vice President of University Clinical Affairs and Dean of the School of Medicine, Dr. Jay Hess, and the Associate Dean and Director of the Fort Wayne campus, Dr. Fen-Lei Chang. They both recognized the accomplishments of our faculty, students and staff as well as acknowledged the efforts of our community. Dean Hess also discussed the scholarly concentrations, a relatively new addition to the curriculum.

Awards were presented to two of our dedicated clinical faculty members for their contributions to our program and student success. Both of the recipients have taught for over 25 years.

***Dr. Kevin Murphy*** received the **Outstanding Clinical Medical Education Award** for his teaching activities encompassing all three phases of our curriculum. Dr. Murphy has demonstrated excellence in his teaching and content development for the Neuroscience and Behavior course, is the Site Leader for the Psychiatry clerkship, and offers an elective to fourth-year students.

Continued on page 30

Continued from page 31

***Dr. Jonathan Walker*** received the **Outstanding Medical Education Award** for his teaching in the Foundation of Clinical Practice II and Neuroscience and Behavior courses. Over his career as a volunteer faculty member, Dr. Walker has left students with an appreciation of his approach to teaching difficult materials. Dr. Walker often provided information in his lectures that would be useful outside of ophthalmology, such as observing signs of abuse in patients. Dr. Walker was always patient and gladly offered to teach students how to perform eye examinations on each other.

Two students were recognized for their accomplishments. ***Angelica (Angel) Jones***, a fourth-year student, received the **Dr. Franklin Bryan Award**, which honors a fourth-year medical student for their dedication to the community, patients and the University. Angel has many accomplishments to celebrate over the last four years. She has volunteered to help those in our community as well as abroad. Angel will begin her residency in Emergency Medicine through the Army after graduation in May.

*My name is Angelica Jones and I'm a 4th year medical student at Indiana University School of Medicine-Fort Wayne. I am also a Second Lieutenant in the U.S. Army and will be attending a residency program in Emergency Medicine this upcoming summer. I have lived in Indiana for most of my life, growing up in Pleasant Lake where I attended Angola High School. I started my "medical career" volunteering and shadowing at Cameron Memorial Community Hospital and Dekalb Hospital while also working as a home health caregiver in the Angola area. For my undergraduate degree, I went to Bethel College in Mishawaka, IN, where I studied Biochemistry & Molecular Biology and played collegiate softball as a shortstop.*

*Ever since my mom died of gastric adenocarcinoma when I was 5 years old, I knew that I wanted to enter some sort of caregiving occupation. During my undergraduate career, my professional goals were cemented as a passion to become a physician after I found an interest for human physiology. It was soon after that when I became a caregiver for my father. He suffered a large myocardial infarction and a stroke. I was ecstatic upon acceptance to my top-choice medical school and even more happy when I found out I was placed at the Fort Wayne campus. The city is not only closest to family and friends for my husband and me, but also the city with the physicians and medical staff that helped save my father's life.*

*Attending IUSM-FW for my pre-clinical years was a great experience, from the small class size and classmates that have turned into my closest friends, to the personal connections I have been able to foster with faculty and staff. All my clinical rotations in Fort Wayne have been very impactful. Being here has enabled me to have one-on-one teaching with attending providers and with some of the Fort Wayne Medical Education Program's residents. I have been able to make connections with mentoring physicians and preclinical professors that I do not think I would have otherwise been able to make if I were at a larger academic center. I have enjoyed every single specialty that I was able to rotate through, which is the reason that I ultimately chose emergency medicine, a specialty where you see a little bit of everything.*

*Additionally, I have been able to participate in volunteer opportunities in the Fort Wayne area such as Matthew 25 and Erin's House for Grieving Children. I have also been able to be a part of a medical mission trip to Honduras with local physicians, physician assistants and nurses. These organizations have not only helped me feel as if I am giving back to the community but have also given me experiences that will help shape me into the type of physician I hope to become. I'm thankful for my time in Fort Wayne as a medical student and am looking forward to the possibility of coming back in the future after fulfilling my duty working as a physician for the U.S. Army.*

***Grant Adams*** received the **Outstanding Professionalism Award**. Since he began medical school, Grant has always attended activities and gave his best efforts. He has taken on leadership roles in Student Government, Student Interest Groups and has been instrumental in efforts to establish an IUSM-FW Student Outreach Clinic. Grant is always friendly and polite with patients and their families and is a great representative of our program.

*My name is Grant Adams, I was the recipient of the 2020 Exemplary Professionalism Award from Indiana University School of Medicine Fort Wayne. I am a 3rd year medical student.*

*I was born and raised in Fort Wayne and attended Leo High School. I went to IU Bloomington for my undergraduate degree. I am interested in pursuing a residency in pediatrics. I have always loved working with kids and feel like it is an excellent opportunity to positively impact other people's lives.*

*I came back to Fort Wayne for my medical education because of how much this community has done to help me grow. The Fort Wayne campus excels at providing direct, hands-on experience to its students. I have the opportunity to work directly with physicians and patients throughout all my clerkships. Building rapport with a preceptor and their patient population is a wonderful way to help grow closer to the community I hope to serve one day.*

Dr. Fen-Lei Chang concluded the evening with a presentation tied to the theme of Rhythm and You. His presentation outlined the connection between music and our minds. This connection is not well understood but has been recognized for centuries. He spoke about how patients with neurological conditions, such as Parkinson's disease, benefit from incorporating music in their therapy. The end of the presentation featured a choir that was composed of people who had strokes at various ages. Each of them gave a personal tribute to the role music played in helping them recover after their stroke.

## IUSoM students participate in 25th Annual Doctor's Day

# Fort Wayne Medical Society – Alliance | Cammy Sutter, President

Three words. ***Connect. Promote. Support.*** Our tagline is easy to say, but harder to do, yet that's exactly what the physician spouses in the FWMS Alliance have been doing!

***Connection*** among physician families is the bedrock. Our friendships, networking, and dedication to each other provide the foundation upon which we can then build, as we come together in service to our community. Book clubs, self-defense and cooking classes are just a few ways we've been connecting in the past months.

We also had our annual Holiday Luncheon and Bazaar on Dec 4 at Ceruti's, a fun and festive event with giveaways, gift baskets, and fellowship over a tasty lunch. It also included plenty of shopping at the booths of 18 local vendors, who generously donated a portion of their sales back to the Alliance. We raised a record $3,600 that day, which we'll use to fund our annual health career scholarships and other initiatives. And we collected 99 jars of peanut butter (an AMA-Alliance initiative) to donate to our local food pantry!

Now, about that second word—***promote***. It's a more abstract part of our mission, but powerful, nonetheless, as we promote healthy living habits as well as careers in health-related fields. For example, we're providing a $4,000 scholarship at the annual Tapestry event and, we hope, to a deserving student from the Boys and Girls Club this spring, as they pursue a health-related course of study. The Alliance has been providing scholarships such as this for over 75 years!

Our signature community events—Doctors Day and Cinderella Dress Day—are two more examples of promoting. Health-related careers and healthy living habits were once again the focus at our 25th Annual Doctors Day event at Science Central (SC) on March 7. (See article by Co-Chair Maria Krach).

Then two weeks later, on Mar 24, we were ready to hold our ever-popular Cinderella Dress Day at the Grand Wayne Center, where hundreds of teenage girls and their guests experience inspiring speakers as well as a high-quality health fair, addressing a wide range of teen-related topics such as drug use, texting and driving, and sexual health. The girls get to choose a free prom dress, shoes, and accessories – making those special prom moments possible for many who otherwise would not be able to afford it.

Unfortunately, the Alliance co-chairs (Tania Boyd, Tori Esguerra and Tonya Hughes) had to make the tough call to cancel this event because of the COVID-19 pandemic.

These two Alliance events draw in thousands of attendees and provide a great opportunity for local health educators to reach many, many people in just a few hours. We're grateful to Parkview, Lutheran, IU Health, and the FW Medical Society for their partnership in these events. Be sure to check out the photos that tell a fuller story!

Last, but certainly not least, is ***support***. Who or what do we support? For one, our hardworking medical students at the IU School of Medicine. We cheer them on, provide morale-boosting lunches during stressful times, and they always appreciate the extra energy we provide in the form of coffee pods and snacks. We also support local health-related organizations like Super Shot, which administers essential vaccines at no- or low-cost to children.

On Feb 11, we were honored to be given a tour of Super Shot's new Hobson Road facility and to hear more about the magnificent vision they have for growing their services. We're proud that we've been able to support Super Shot financially for 25 years!

**Connect, promote, support.** It's what the Alliance is about. To any physician spouses who have not joined the Alliance and the amazing work we do and the sense of community that we offer, please do so. Membership is what makes it all happen!

The full social calendar, membership information, volunteer opportunities, and more can be found at our website **www.alliancefw.org** or email your inquiries to **alliance@fwms.org**.

# 25th Annual Doctor's Day

Maria Krach, Co-chair

Doctor's Day highlights included:

- Ten local doctors took turns playing "Lucy from Peanuts" by sitting in the Doctor Is In booth and answered the children's questions
- Seven physicians presented in the SC demonstration theater on topics from cow eye dissections, germs, brain health, lungs, bones and pediatric health issues
- The Fort Wayne Medical Education Program residents dressed up as fruits and vegetables and encouraged healthy eating and exercise habits
- IU medical students let the attendees touch human brain, lung and heart samples, while Marian's students had the kids playing pin the organ on the superhero
- The kids loved putting on lab coats and surgical scrubs and using medical props for a great photo op in the Selfie Booth
- The Alliance sponsored 25 bags of healthy groceries, over 30 prizes and 4 bikes were given away to families during the day
- Six 5th graders won the health careers poster contest. They presented their posters highlighting the medical career they would like to pursue in the Demonstration Theater.

This event was co-chaired by Maria Krach and Deann Baker along with committee members: Betty Canavati, Jennifer Bojrab, Preeti Jain, Michelle Gries, Kathy O'Shaughnessy, Dawn Davis, and Liz Hathaway. Over 30 Alliance volunteers came out to make this day a huge success.

We thank our sponsors: FWMS Foundation, Lutheran Health Network, Parkview Health, IU Health, and SYM Financial. Without their support we would not have been able to reach out to 1750 people in our community to enjoy our interactive booths and Science Central at no charge.

## 25th ANNUAL DOCTOR'S DAY 2020 VOLUNTEERS

*Tammy Wheeler, MD*

*Deb McMahan, MD*

*FW Medical Education Program*

*Marian University*

*Bike winner and food bag*

*IUSM-FW – Brain, Lungs, Heart*

## Doctor's 100th Whipple Procedure with LHN Leads to Patient's Courageous Story on Fight with Cancer

A cancer diagnosis can be a challenge, both mentally and physically. After hearing the word "cancer," one patient's journey led her to Lutheran Hospital and fellowship-trained surgical oncologist, Neal Agee, MD. Dr. Agee performed his 100th Whipple procedure with Lutheran Health Network on this patient, giving her a strong advantage in her fight with this disease.

Robin Eagleson's story began with a possible cancer diagnosis, which led to an internet search for a surgical oncologist offering complete cancer care paired with the convenience of being close to home. Shortly into her search, the Ohio resident discovered Lutheran Hospital's surgical oncologist, Neal Agee, MD, and after doing some research, knew this was her answer. "I truly believe I was led to Dr. Agee and his staff," she stated. "This was right where I needed to be at this time."

Pancreatic cancer can be a quiet, inconspicuous form of the disease, generally disguising symptoms in its earliest stages to model other conditions. According to the American Cancer Society, pancreatic cancer diagnoses are on the rise and have recently surpassed breast cancer cases, but there is an answer for patients faced with this difficult diagnosis – right in Fort Wayne.

An option for some patients who have been impacted by a possible pancreatic cancer diagnosis is the Whipple procedure. This complex operation removes the head of the pancreas, the first part of the small intestine, the gallbladder and the bile duct and can often result in the return to a state of normalcy for patients who undergo the procedure. Eagleson not only underwent this extensive surgery, she was also Dr. Agee's 100th Whipple procedure patient with Lutheran Health Network; a milestone which speaks volumes to the complexity of the operation itself and the comprehensive cancer care offered by a team of board-certified specialists at Lutheran Hospital.

"The knowledge that the tumor was gone was such a relief," she stated. "Had he not found it when he did, I might be sharing a different story right now."

After undergoing the Whipple procedure, Eagleson and her family know they are headed in the right direction. "I wouldn't be where I am today without Dr. Agee's in-depth knowledge; his entire team was everything you could ever ask for and I could not praise them enough," she stated. To this day, not only has she enjoyed the feeling of normalcy that has resulted from the surgery, she is also feeling mentally and physically great – and people are taking notice.

"It was after I received my diagnosis, the staff told me, we are family, we will face this together and will get through it someday, somehow - hearing that gave me everything I needed for this fight."

The "Positively LHN" platform serves to provide mission stories and patient testimonials for each facility in the network. For more stories like this one, visit www.lutheranhealth.net/positively-lhn.

## Breastfeeding Mothers Now Have a Private Place to Nurse at the Airport

Dupont Hospital and Fort Wayne International Airport have collaborated to offer breastfeeding mothers a secure, private environment to nurse and pump while traveling. This new specially designed breastfeeding space will serve as the airport's first dedicated nursing pod.

"This concept allows us to enhance the traveling experience for all nursing mothers by providing a more dignified space to feed baby," said Lorenzo Suter, chief executive officer, Dupont Hospital. "When public places provide the proper accommodations with mothers in mind, it enhances the sense of support and attributes to a better overall experience."

A lack of breastfeeding support and education can have a significant effect on a woman's feeding success and duration. Breastfeeding has proven to provide significant health benefits for both babies and mothers, but mothers often struggle to find a comfortable place to do it.

The nursing pod provides mothers with special accommodations to feed their child or pump in preparation for baby's next feeding. There is also a diaper changing station for added convenience. Space is also available in the nursing pod for siblings to be with mom.

"We are happy to be able to provide traveling mothers with an exclusive, private option where they can step away and feel comfortable if they wish to utilize the space for nursing or pumping," said Scott Hinderman, executive director, Fort Wayne International Airport.

Specially designed and fabricated by local company Jensen Cabinet, Inc., the nursing pod is located on the second floor of the secured side of the terminal building near the children's play area. The space supports health and wellness for both mom and baby and is available for all who need it.

## Construction Begins on New Medically-Integrated Health and Fitness Center

Dirt will be turning soon to build a new 99,900-square-foot, multimillion dollar medically-integrated health and fitness center, serving residents on the north side and surrounding communities. Slated to open early in 2021 on the Dupont Hospital campus, Optimum Performance Sports (OPS) and Fort Wayne Orthopedics will be the anchor tenants.

"Our vision is to create a state-of-the-art facility and one-stop shop for athletes and their families," said Dr. Jason Russell, executive director of OPS. "This facility allows our sports medicine physicians to be in the same building as our physical therapists, strength and conditioning coaches and sports nutritionists. This creates an environment for better communication and ultimately better outcomes."

This center represents the vision of Lutheran Health Network, Fort Wayne Orthopedics (FWO) and the center's primary tenant, Optimum Performance Sports (OPS). Twenty FWO providers will staff the new space, which will include an Ortho Stat walk-in clinic. The two-story facility, which will be located on the east side of the medical park, will feature the following:

- 24-hour adult fitness center open to the general public
- Childcare for members
- Technologically advanced strength and cardiovascular equipment
- Four basketball courts
- Indoor track
- Group fitness training rooms
- Athletic performance training center
- Physical therapy/human performance lab
- Teen lounge for OPS athletes
- Restaurant with healthy food options
- FWO offices

"Fort Wayne Orthopedics is proud to be part of the addition of this facility and the services it will offer to the community," said Jerald Cooper, MD, and president, Fort Wayne Orthopedics. "We are pleased to continue our partnership with Optimum Performance Sports and look forward to delivering outstanding sports medicine services."

OPS currently has locations in Fort Wayne at the ASH Centre, 1701 Freeman St., and 6411 Cross Creek Blvd. OPS also has a location at 701 Orthopedic Drive in Warsaw. OPS services offered at the Cross Creek location will move to the new center upon its completion. The project's developer is Catalyst HRE and the architect is Moake Park Group.

*The foundation of Lutheran Health Network is built on an experienced team of more than 7,000 employees working together with the more than 800 physicians who compose its medical staffs. The network's more than 100 access points in northern Indiana include physician offices, urgent care clinics, outpatient centers and eight hospitals.*

## WRITE SUBMIT GET PUBLISHED

### Write it Down:

- A case study of a patient with an 'unusual presentation'.
- A touching or upsetting patient encounter and how you or your staff handled it.
- Something new that you learned at your specialty meeting or journal.
- A Letter to the Editor on an article written in the *Quarterly*, local or national news.

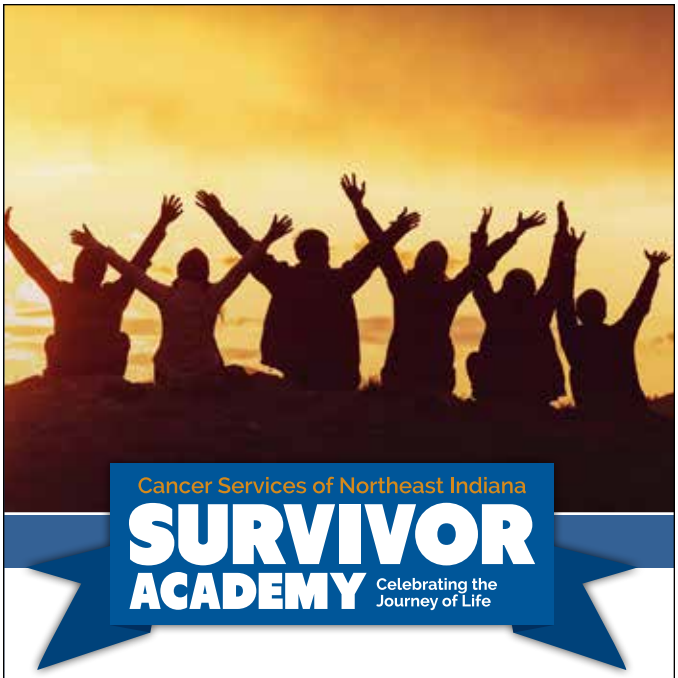
### Submit it to the Editor:

lizjcan612@gmail.com

- 500-2000 words, typewritten in standard fonts, and sent as an attachment.
- Visuals, such as charts, graphs, photos, may enhance your article.
- Citations of references not required, but may be helpful for readers wanting further information.
- "Headshot" picture of you-the author is desirable. If you are a FWMS member, we have you.
- **Deadline dates are second Thursday of February, May, August, and November**. Sooner is better.

### Get Published:

- Congratulations, you made the cut. You are now a *Fort Wayne Medicine Quarterly* published author.
- Thanks for your willingness to share your experience and expertise.



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## Parkview Regional Medical Center Achieves Accreditation as Center of Excellence in Robotic Surgery

Parkview Regional Medical Center (PRMC) has achieved accreditation as a Center of Excellence in Robotic Surgery by Surgical Review Corporation (SRC).

This accreditation distinguishes PRMC from other hospitals by providing the highest quality of care to patients as determined by an independent, external process of evaluation. Robot-assisted surgery is currently used at PRMC in several practice areas including urology, gynecology, colorectal, cardiothoracic and general surgery.

Status as an accredited Center of Excellence means that PRMC has met nationally recognized standards. Not all hospitals and surgeons seek accreditation; not all that undergo the rigorous on-site inspection process are granted accreditation.

"Robotic surgery adds value for patients and providers," said Ben Miles, president, Parkview Regional Medical Center and Affiliates. "I'm proud of our entire surgical team for achieving this accreditation. It's a testament to their world-class teamwork and pursuit of excellence."

"It is an honor to be recognized as a Center of Excellence in Robotic Surgery," said Marcy Rogers, vice president, surgical practices, Parkview Health. "Parkview's standards of care are evolving as we continue to incorporate advanced medical technologies into our practice."

Health care organizations and surgeons seeking accreditation by SRC undergo an extensive self-assessment and on-site inspection. This process includes physicians, nurses and administrators who are actively involved in the accredited program. The inspection is consultative and educational, presenting best practices to help an organization or surgeon improve care and services.

## Park Center to purchase Lafayette Medical Center, expand services

Park Center, an affiliate of Parkview Health, is pursuing the purchase of the Lafayette Medical Center building, located at 2700 Lafayette St. in Fort Wayne, enabling an expansion of existing services and creating greater access to mental and physical health care.

Park Center has had a presence in the building since August 2018, leasing space for a primary care clinic with the intent of one day purchasing the facility. The organization's goal was to create a practice that fully integrated mental and physical health care, with a focus on underserved populations. The clinic is in the 46806 ZIP code, which is a federally designated health professional shortage area.

Several community organizations supported the project through financial contributions. The Lutheran Foundation, English-Bonter-Mitchell Foundation, Edward M. and Mary McCrea Wilson Foundation, St. Joseph Community Health Foundation and AWS Foundation all donated to the project, launching the initial clinic space and supporting the eventual purchase and continued renovation of the building.

"It's very rewarding to see Park Center's vision continue to take shape," said Marcia Haaff, CEO of The Lutheran Foundation. "This project embodies The Lutheran Foundation's values, including strategic partnerships with organizations like Park Center, to positively impact the community. By continuing to grow access to health care, we enhance the quality of life for area residents."

Clyde Nix, president and CEO of Park Center, explained that community support has been key to success.

"In partnership with Parkview Health and our community partners, we are excited to see the medical center grow from primary care to comprehensive physical and mental health services," Nix said. "By combining and expanding our efforts, we can remove barriers to care and better serve the community."

Park Center became an affiliate of Parkview Health in October 2018. The organizations have collaborated to fulfill Park Center's goals for the Lafayette Medical Center, creating an innovative care model that will include new and expanded specialty care staffed by Parkview Physicians Group providers and support teams.

A purchase agreement for the 33,683-square-foot building has been signed, but a closing date has not been set. Following an anticipated closing in the first quarter, renovation will commence and new services could be available later this year.

Other current tenants in the building include Lafayette Foot and Ankle, which operates a 2,432-square-foot clinic on the first floor of the facility, and Indiana University Fort Wayne, which operates a 2,465-square-foot family health clinic on the second floor. Both tenants are expected to continue operating from the building.

## Parkview Developing Health Campus in Southwest Fort Wayne

To meet a growing demand for services, Parkview Health is developing Parkview Inverness, a health campus that will offer access to a wide range of care, in southwest Fort Wayne.

Plans include two new facilities: a medical office building and an outpatient center. When complete, the campus will offer services that meet a significant portion of patients' care needs in one convenient location.

Existing Parkview services at this location include imaging, lab, cardiology, podiatry and other specialties. Following construction of the new facilities, Parkview Inverness will also include a walk-in clinic, adult and pediatric primary care, pharmacy, infusion, therapy, expanded outpatient surgery options and additional specialty services.

The new medical office building, located at the southwest corner of Illinois Road and Glencarin Boulevard, is currently under construction. The building will be one story and cover approximately 19,000 square feet of space. It will initially house a primary care office and walk-in clinic, expected to open in summer 2020.

The new outpatient center will be three stories with a basement, totaling approximately 112,000 square feet; plans include an optional 18,000-square-foot expansion. Construction of the outpatient center, to be located at the southeast corner of Illinois Road and Glencarin Boulevard, is expected to begin in March and is slated to be complete in 2021.

## Indiana State Department of Health certifies Parkview Regional Medical Center for Level III Obstetric and Neonatal Care

Parkview Regional Medical Center (PRMC) has received Level III certification for both obstetric and neonatal care from the Indiana State Department of Health Maternal and Child Health Division, recognizing the hospital for advanced care of complex maternal or fetal conditions along with management of low-risk obstetrical and newborn care.

The Indiana Perinatal Levels of Care program certifies all Indiana birth facilities for obstetric and neonatal care. Based on nationally recognized guidelines, Indiana's program includes four levels of care:

***Level I:*** Basic care for low-risk pregnancies

***Level II:*** Level I care, plus special care for high-risk pregnancies

***Level III:*** Level I and II care, plus specialty management of severe maternal and fetal complications

***Level IV:*** Regional centers capable of Level I – III care, and management of the most complex/critically ill patients Indiana hospitals and birthing centers previously self-identified their level of care. Following the work of the Hospital Levels of care Task Force, established in 2010, the Indiana Perinatal Standards were developed and put into law September 13, 2018.

PRMC is among the first Indiana hospitals to receive certification since the state began surveying Level III and IV hospitals at the end of 2019. The hospital applied for and received Level III certification, verifying its previously self-identified Level III status.

## Parkview Warsaw expanding into full-service hospital

***Parkview Kosciusko Hospital will offer inpatient services, including surgery***

PARKVIEW KOSCIUSKO HOSPITAL

To better serve Warsaw and the surrounding communities, Parkview Warsaw will be expanding to become a full-service hospital. Plans include space for up to 30 inpatient beds, surgical services and additional specialty care.

As inpatient services become available, the facility will be renamed Parkview Kosciusko Hospital, reflecting its ability to better serve the entire county. Parkview Warsaw, which opened in 2016, currently offers outpatient services, including primary care, specialty clinics, rehabilitation therapy, imaging and an emergency department.

"As Parkview continues to grow in Kosciusko County, we look forward to embracing the community as a full-service hospital that offers comprehensive care," said Jeffrey Rockett, vice president, outpatient services, Parkview Warsaw. "Building on the success of Parkview Warsaw, Parkview Kosciusko Hospital will increase access to high-quality care and reduce the need for residents to travel outside the county to see a Parkview provider."

The project will be completed in phases, starting with the build-out of existing shell space on the third floor of the facility. Plans also call for a 44,000-square-foot expansion on the west side of the facility, and a new medical office building on the campus.

All plans are subject to local government approval. An architect for the project has not yet been selected. Groundbreaking is tentatively set for the spring of 2020, with all services projected to be available in 2022.

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