Fort Wayne
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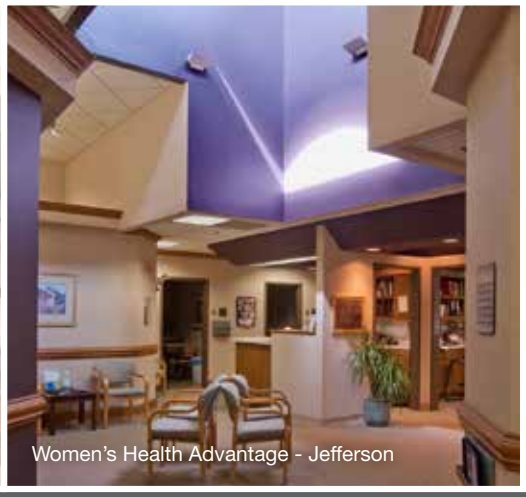
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Editor's Note | Elizabeth J. Canavati

Winter – some people love it and some hate it. I am one of the former. I love winter!

To me winter is a great time to slow down and do things at home that have been postponed because it was too nice outdoors to stay inside. It can be a time of reflection and goal setting for the next year. And a time to relax more, read a book, listen to music, or start a new project. So many options!!

This issue of the Quarterly was like my list of things to do in the winter-so many options. We have Deb McMahan's update on STIs, Ashok Kadambi clarifies testosterone replacement facts vs fiction, and Rudy Kachmann expresses his viewpoint on CBD usage. Isa Canavati updates what is known about glioblastomas and Ann Moore encourages advance care directives. David Sorg has a very informative article about Harry Truman and his personal experience with the 33rd President. There are lots of new FWMS members and we remember four FWMS physicians that have passed. As always, the Fort Wayne Medical Education Program and IU School of Medicine-FW have many new programs and learning opportunities. The Alliance will be gearing up for their two big community service projects: Doctors Day at Science Central and Cinderella Dress Day at the Fort Wayne Convention Center. Of course, the hospitals always have news to share.

Ryan Singerman has mentioned burn out and I would like to share a few tips I learned while attending The HappyMD workshop as part of ISMA's annual meeting.

Dr. Drummond states that burnout is all about whether or not you can cope with the things that you find stressful. If you can't recover from the energy drain of all your stressful situations, then you need to evaluate and refocus.

There is a 22 question survey, Maslach Burnout Inventory (MBI), that is considered the best measure for occupational burnout. This survey measures the severity of the three main symptoms of burnout: your degree of exhaustion, lack of compassion, and efficacy or doubting the usefulness of what you are doing. These three symptoms can be tied to your physical, emotional, and spiritual energy. How can you boost the energy level in each of these categories?

Physical: Are you getting plenty of rest, eating properly, exercising and taking time off to recharge?

Emotional: Are you spending time with the people you love? Can you leave your doctor's badge at the office and focus on your personal relationships after work? Try spending more time with your spouse, children, friends, significant other or family.

Spiritual (sense of purpose): Why did you choose medicine? What about your practice really makes you feel energized? Jot down what type of patient encounters make you feel good and not so good. How can you plan your day so that you have more positive than negative encounters?

Dr. Drummond's mantra is
"You can't give what you ain't got."

As always, my inbox is waiting for your opinions, and expertise. Please feel free to send me your ideas or articles at lizjcan612@gmail.com

The deadline for the Spring edition is Feb. 9th.

About the Cover:

We have a small waterfall on our property. I took this photo last winter after a few very cold days. The photo doesn't really capture the beauty of the frozen water but it is a fantastic reminder of the wonders of nature.

Happiness is not a matter of intensity but a balance, order, rhythm, and harmony. **– Thomas Merton**

President's Message

Ryan Singerman, D.O.

Happy Holidays!

I would like to provide an update to the medical society at large. Within the Board of Trustees we are diligently working on updating our bylaws, which are in desperate need of revision. We will be presenting the update for consideration and voting at the Annual Dinner in the Spring of 2019.

We are also working on safeguarding our future in the ever changing landscape of medical care and organizations. To that end we are discussing partnerships with local not-for-profits, engaging with county programs, revising our website, and have multiple members on key boards and panels at the state level. My vision for our medical society continues to be one that is engaged with our members, supporting the needs of the physician and their family, and to the broader community of patients we serve in Fort Wayne and Allen County. I continue to ask for feedback on current initiatives and for ideas and needs to be presented for us to act upon. Far too often our members feel isolated from each other and this should not be accepted as the norm. Let's be the society that cares after its own, who encourages and lifts up, who builds and seeks to leave the community better than when we began.

That said, we often keep looking for "someone" to do "something". We are all "someone" to someone else. If you have a great idea then take action! Don't know how? Call us! We can help connect people to others and resources.

Recently I was listening to a motivational speaker who was addressing physician burnout--the "Boogeyman" of medicine. She said something that really struck a chord within me. When presented with a challenging situation we have two choices. We can complain and become negative, dragging down our teams and families into a mire, remaining passive and letting it roll over you. Or we can roll up our sleeves and actively work with constructive feedback and thoughtful insight to improve the situation. I'm calling on all colleagues to roll up your sleeves and step into the leadership roles around you. We can continue to make Fort Wayne, Allen County, and Indiana an awesome place to be a physician!

May God richly bless you, your families, and our patients.

Fort Wayne Medical Society | New Members

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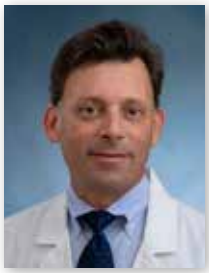

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Transfer from another county

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Sexually Transmitted Infections, Part 2 |

Deborah McMahan, M.D., Commissioner

There were an estimated 38,500 new HIV infections in 2015, which does represent a decline in cases likely due to HIV prevention efforts. However, this decline has not been experienced by all groups and in some populations the prevalence is in fact increasing. In Allen County, we have had 20 new cases of HIV, which is the same as this time last year.

This month I would like to discuss the use of pre-exposure prophylaxis (PrEP) for folks that are at substantial risk for HIV. This will first require taking a sexual and drug history. High risk folks would include the following:

- HIV-uninfected men and women who have an HIV-infected sexual partner with a detectable viral load.
- Men who have sex with men (MSM) and transgender women who have sex with men if, within the last six months, they have had a documented bacterial sexually transmitted infection (STI) or have engaged in high-risk sexual behaviors that include condomless anal sex (insertive or receptive) with multiple or anonymous sex partners (or a main partner with HIV risk factors).
- Heterosexual men who have, in the last six months, been diagnosed with an STI or have engaged in condomless sex with female partners from areas of low general HIV prevalence but who are at high risk of HIV infection (e.g., **sex workers, injection drug users**).
- Heterosexually active men who have condomless sex with female partners from regions with generalized HIV epidemics. According to the World Health Organization (WHO), this refers to geographic regions or populations where the prevalence of HIV is ≥3 percent
- Heterosexual women who have, in the last six months, been diagnosed with a bacterial STI or have engaged in condomless sex with male partners who are at high risk of HIV infection (e.g., injection drug users, bisexual male partners, partners from areas where there is a high HIV prevalence).
- Injection drug users who, within the last six months, report sharing needles/equipment, even if they have initiated substance use treatment.
- PrEP may be an option to help protect women with an HIV positive partner from getting HIV infection while they try to get pregnant, during pregnancy, or while breastfeeding.

Effectiveness:

According to the Centers for Disease Control and Prevention (CDC) PrEP reduces the risk of getting HIV from sex by more than 90% when used consistently. Among people who inject drugs, PrEP reduces the risk of getting HIV by more than 70% when used consistently. PrEP, taken daily, reaches maximum protection from HIV for receptive anal sex at about 7 days of daily use. For receptive vaginal sex and injection drug use, PrEP reaches maximum protection at about 20 days of daily use. No data are yet available about how long it takes to reach maximum protection for insertive anal or insertive vaginal sex. However, the key to effectiveness is consistency in taking the medication daily.

PrEP Treatment Plan

Screening

PrEP can be provided by a *primary care provider*, it does not need to be limited to Infectious Disease Practitioners. This is important as there are relatively few ID doctors and many primary care providers already providing healthcare to these folks.

After taking a sexual history and determining that your patient meets one of the criteria above, determine if the patient consistently uses condoms. According to the data, reported consistent ("always") condom use is associated with an 80% reduction in HIV acquisition among heterosexual couples and 70% among MSM. However, inconsistent condom use is less effective **and** studies have reported low rates of recent consistent condom use among MSM and other sexually active adults. Unless the patient reports consistent condom use you will then want to discuss using PrEP. In fact, most patients taking PrEP are very compliant with the daily medications.

Overall the treatment is well tolerated, but the next step is to determine if they have any chronic conditions that would put them at risk for developing significant side effects to treatment. This would include:

- HIV (preferred is 4th generation antigen/antibody assay test)
- Reduced kidney function (eGFR rate < 60 ml/min/1.73 m2)
- Active Hepatitis B infection
- Osteoporosis
- Pregnancy

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You will then want to screen for STIs (even if asymptomatic) and include:

- Serologic testing for syphilis
- Nucleic acid amplification testing (NAAT) for gonorrhea and chlamydia at relevant mucosal sites (pharyngeal, rectal and genital).

Patients should also have baseline testing for hepatitis B virus (HBV) and hepatitis C virus (HCV) infection. Patients with chronic hepatitis B and C should be referred to ID. The need for routine bone density screening prior to and after initiating PrEP is unclear. Some providers obtain a baseline DXA scan in patients who have a history of osteoporosis if recent testing is not available, as well as those who are at high risk for osteoporosis.

Medication

Tenofovir disoproxil fumarate-emtricitabine (Truvada) is taken daily. If it has been more than 2 weeks since baseline labs were obtained, repeat an HIV test before prescribing. Patients should be monitored every three months to ensure there are no drug-related toxicities and that there is no evidence of HIV acquisition. Patients should continue PrEP as long as the risk of infection persists. You should consider prescribing a 30 day supply and no more than 90 days for the first dispensation. For patients less than 24 years old, you may want to have the first follow-up visit at 30 days rather than wait 3 months

Follow-up

Patients on PrEP should be monitored quarterly. For each visit, include the following tests: HIV test, BMP, STI screening and a pregnancy test for women. And at every visit, counsel patients on risk reduction based on risk factor(s). Most patients tolerate Truvada with minimal side effects.

Paying for PrEP

Most private insurers and Medicaid pay for PrEP. For uninsured patients with household income 500% FPL or less, Gilead offers a Medication Assistance Plan.

How You Can Do this in Your Office

I understand that this looks very complex and like a lot of legwork for your staff. However, there is a great program in our community that can assist you and the patient with a lot of the non-medical but important screening, navigation and assistance with identifying payer source. The Positive Resource Connection (PRC) has a very effective Biomedical Prevention Coordinator, **Timothy Price**, who is willing to talk with patients that you identify as potential beneficiaries of PrEP, assist with obtaining the correct baseline labs (including STI labs), identify payment sources and overall ensure that this is not a time-sink for your practice. He is the reason why I am writing this article. If he is willing to do all the upfront work, we should at least be able to see the patients and write scripts.

HIV is not a highly prevalent condition, but it is a very expensive chronic condition once it occurs. With all of the other expensive healthcare issues, let's try and prevent this one!

Resource:

Timothy Price, Biomedical Prevention Coordinator
Positive Resource Connection
525 Oxford Street, Fort Wayne, IN 46806
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Testosterone: Separating Myth from Fact | Ashok Kadambi, MD

In 1941, Dr. Charles Huggins and his coworkers published findings of dramatic regression of metastatic prostate cancer after castration. Subsequently, this led to the erroneous, long-held belief that testosterone acts like gasoline on fire, fueling the flames of prostate cancer development and growth. Based on this data, researchers developed Androgen Deprivation Therapy (ADT) as adjunctive treatment for patients after radical prostatectomy for prostate cancer. However, ADT also led to increased mortality and morbidity from heart disease and osteoporosis, due to the effects of androgen deprivation. When the topic was later re-examined, it was discovered that it was only in pre-castrated men that testosterone caused the cancer to grow, leading to The Saturation Model for prostate cancer. The Saturation Model can be very simply explained as follows: once the testosterone receptors on the prostate are saturated, which happens at much lower levels than clinical hypogonadism, further increases in testosterone levels have NO effect on the prostate, PSA levels or the growth of cancer.

Fast forward to year 2015….when a group of experts from 11 different countries and 4 continents met in Prague, Czech Republic to review the evidence surrounding testosterone replacement. Upon conclusion of this meeting, these experts unanimously agreed upon nine fundamental principles regarding testosterone therapy. Duly noted, it was indeed remarkable that a group of such diverse experts would agree upon anything unanimously. What was even more incredible is that the prevailing testosterone myth had persisted for over seven decades! We can now safely recommend testosterone replacement therapy to hypogonadal males after treatment for prostate cancer. A group of researchers from Harvard, led by Dr. Abraham Morgentaler, are now studying the effects of high dose testosterone therapy as treatment for very early stage prostate cancer! Amazing!

We in the medical profession profess to be open minded and yet we have let these kinds of myths become the very fabric of our belief system, even despite overwhelming evidence to the contrary. A large swath of physicians from all specialties continue to be afflicted with "Hormone Phobia". All it takes is a couple of flawed studies, such as the VA study on testosterone showing an increased cardiovascular risk, or the Women's Health Initiative (a topic for another day) to feed into their confirmation bias. The belief that testosterone (and/or all hormones in general) are bad for you, is so widespread among us that to even entertain the idea that they could offer tremendous health benefits, prevent disease and frailty, is anathema. Physicians who hold such views are branded as charlatans, practicing "voodoo medicine", and offering patients false hope.

Many physicians have abandoned evidence-based medicine in favor of following the pack. When I see my patients on follow up for their hormone optimization regimen and they open the conversation with "I feel fabulous but my doctor says…", I realize how powerful myths can be. Hence, it is time to dispel several other myths about testosterone and replace them with facts based on good science.

MYTH: Testosterone causes aggression.

FACT: Testosterone helps improve focus and concentration. Many aggressive and irritable men have low testosterone levels.

MYTH: Testosterone causes increase in cardiovascular and venous thromboembolism(VTE) risk.

FACT: This is only true if you watch late night television asking you to call a toll free number if you or a loved one had a heart attack after using testosterone as replacement for low testosterone. The weight of all the published clinical studies points towards tremendous cardiovascular benefits of testosterone. There are a couple of flawed studies, to be sure. In one of these flawed studies, they actually included women by mistake, which when corrected showed no risk! And the other, had no control group and was based on pharmacy claims data. These studies caused the FDA to slap a warning in their package insert for all testosterone products cautioning against this risk. Although those studies were later retracted by the editorial staff of those publications, the retraction did not make the headlines! Needless to say, the FDA warning is unlikely to be retracted anytime soon despite a groundswell of evidence to the contrary. Until then, it is a feeding frenzy for attorneys who can put a spin on those couple of negative yet flawed publications to convince a jury. This has predictably led physicians to severely restrict the use of testosterone in almost all but the most castrate of men.

No interventional study has shown an increased risk of VTE on testosterone replacement therapy. The myth of increased VTE risk is based on extrapolation from data on Polycythemia Vera which also causes an increase in hematocrit, similar to patients on testosterone therapy – guilty by association!

MYTH: The symptoms of Testosterone Deficiency (TD) do not merit treatment as it is a part of normal aging.

FACT: The symptoms of TD are real and easily resolved on treatment and age must not be a criterion to withhold treatment from symptomatic males. That said, treatment must be individualized with an open discussion on expectations and potential risks and costs.

Many medical conditions are age-related such as hypertension, heart disease and elevated cholesterol, diabetes, cataracts and many cancers. There is no justification in singling out TD as a condition that does not merit treatment just because it becomes more prevalent with age.

Continued on page 14

Continued from page 13

MYTH: A testosterone level in the normal reference range of the laboratory should not be treated.

FACT: There is no level of total testosterone that reliably separates patients that will respond to treatment, from those that will not. To further confound the problem, there is a lot of variations from lab to lab on these reference ranges. Also important to note, is that there is varying degrees of sensitivity to the androgen receptor, in addition to increases in sex hormone binding globulin (SHBG) that could dramatically reduce the amount of free testosterone available to the tissues, resulting in clinical manifestations of TD despite total testosterone levels in the "normal" reference range.

For example, the Endocrine Society and AACE guidelines suggest that a total testosterone level of 300ng/ml be the threshold below which treatment could be started. So, a level of 330ng/ml would be grounds to withhold treatment. Under that logic, a patient with a level of 290ng/ml could be treated. However, when we treat such a patient we strive to maintain levels in the mid to upper range of the laboratory reference range which in most laboratories would be 500ng/ml to 1000ng/ml. Merely raising the levels to say 350ng/ml would not achieve clinical goals. Why then deny a symptomatic patient treatment at 330ng/ml and try and raise that to the same extent in order to reap all of the benefits of androgen replacement?

MYTH: Testosterone deficiency is uncommon and treatment must be restricted to only classically hypogonadal males.

FACT: TD is a major global public health concern. The prevalence rate of TD ranges from 2% to as high as 30% depending on how it is defined. A major U.S. study estimated that by treating TD one could save as much as half a trillion dollars in healthcare expenditures over a 20-year time span, resulting from prevention of the devastating complications associated with low testosterone.

MYTH: The benefits of optimizing T levels are marginal.

FACT: Testosterone deficiency is strongly linked to increased prevalence of diabetes and cardiovascular disease, as well as osteoporosis and cognitive decline. Treatment of this condition has the potential to alleviate these risks. The benefits of testosterone replacement can be realized in symptomatic individuals, even with low normal levels of testosterone, when optimized.

MYTH: Most patients with low T are impotent.

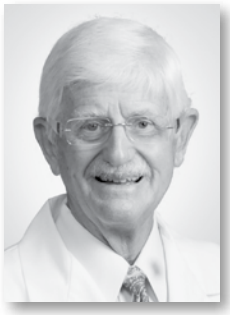
FACT: The most common symptoms of low testosterone are fatigue, depression, weight gain and lack of motivation and drive. Most men still retain potency even at low levels of testosterone. One ought not to wait until the patient is impotent to begin a therapeutic trial with testosterone replacement.

An exciting area of research would be to examine the idea of testosterone optimization as well as other key hormones in the setting of chronic conditions such as Metabolic Syndrome, Diabetes and Cardiovascular disease. I would invite participation or collaboration from any of the fine research groups in town to partner with us at Fort Wayne Endocrinology on this very important area of medical research which otherwise will not be eligible for industry funding due to lack of financial interest in patentable medications.

Let me end with a quote by Mark Twain: "It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so."

Editorial: CBD On the Road to Marijuana

Rudy Kachmann, MD



As of July 1st, 2018, CBD is legal in Indiana. But federal law still states that it is illegal, classifying it as a Schedule 1 Controlled Substance with no accepted medical use and a high risk of dependence.

Anecdotal reports are not science. "I feel great", "It solves my pain problem", "I couldn't live without it." We've been hearing the same types of testimonials for thousands of years.

I have reviewed numerous books and scientific articles, as well as records of the marijuana legalization experiments in Colorado, California, Washington, Oregon, Alaska, and Washington, DC. I can clearly see, along with most of the informed people I speak to, we are on the road to full marijuana legalization.

What no one is talking about though is that there is solid scientific evidence that CBD, as it is currently available to the public in oils, chewables, and candies, can be harmful and potentially deadly.

We are physicians. That means we also have a responsibility to be teachers, hopefully leading the way to good health. We cannot depend on the government to lead the way. We must all step up to bat, and resolve to promote wellness, not illness and addiction.

References:

Understanding Marijuana by Mitch Earleywine CBD: A Patient's Guide to Medicinal Cannabis by Leonard Leinow and Juliana Birnbaum CBD: What You Need to Know by Gregory L Smith, MD Fort Wayne Medicine Quarterly, Fall 2018, Volume 16, Issue 3 Indiana State Department of Toxicology PowerPoint Presentation by Sheila A. Arnold, PHD "The Health Effects of Cannabis and Cannabinoids," 2017 Report by The National Academies of Science, Engineering, and Medicine Going to Pot by William J Bennett Medical Cannabis by Gregory L Smith, MD

"CBD Drug Interactions: Role of Cytochrome P450," by Adrian Devitt-Lee, on Project CBD: https://www.projectcbd.org/science/cannabis-pharmacology/cbd-drug-interactions-role-cytochrome-p450

This article is the opinion of the contributor. The Fort Wayne Medical Society's policy is to publish all physician opinions submitted to encourage further research and discussion.

CBD: THE FACTS		FURTHER INFORMATION	
1	The testing of the chemical contents of CBD products is only around 25% reliable.	**1a**	State law requires the product to be labeled with the name of the manufacturer and the name of the testing company that manufacturer picked. It has been shown that some testing companies are a lot more reliable than others. The public buying the product can't know how reliable the tests are, and so can't know what's really in the product they're buying. Their lives may be at stake. Remember this is not an FDA-approved product they are buying
2	The entourage effect (the interaction of CBD with other chemicals) is unpredictable.	**2a**	CBD oil results in an entourage effect. This is a mechanism by which compounds present in the product modulate other potentially psychoactive compounds in the plant. "I feel great," people say after using CBD products. That could be the THC at work.
3	CBD deactivates Cytochrome P450, which is the body's main detoxifier of supplements and pharmaceuticals.	**3a**	Clearly, the biggest danger to the public is partial inactivation of the Cytochrome P450 enzyme. If the person using CBD is on supplements or pharmaceuticals of any kind, those chemicals will not be deactivated. This can greatly increase or decrease their effects, potentially resulting in great harm or even death. Take a blood thinner for example, or diabetes medication, or seizure meds—their effects could be boosted or diminished. The possibilities are infinite. I personally once took four 200mg Advil pills after eating a grapefruit for lunch, and I was urinating blood by the next day. This was owing to the deactivation of the P450 enzyme by the grapefruit. CBD oil does the same thing on a regular basis. I could have had a heart attack or stroke from eating grapefruit. CBD products can do the same thing.
4	Heating CBD can convert it into THC, the psychoactive component of marijuana. The method is readily available online. Clearly, people are already doing that. And the numbers will only continue to increase as the information gets around. The site I looked at had over 1 million hits. (See www.convertCBDtoTHC.com.)	**4a**	There is potentially great danger to our children or our pets from ingesting or breathing in CBD products. Because of the conversion to THC, addiction to marijuana will play a role. At this time, about 9% of adults and 17% of children who smoke marijuana are addicted.
5	Smoking and vaping CBD automatically results in the conversion of some CBD to THC while at the same time leading to the familiar bad health effects of inhaling smoke, including chronic pulmonary disease and potentially even cancer.	**5a**	In some states, kids can buy the products, go online to learn how to convert them to THC, and off we go down the road to marijuana.
6	Sellers of CBD products have the option to place age restrictions or warnings about the Cytochrome P450 effect, but many choose not to.	**6a**	The undeveloped state of a child's brain means that damaged tissue may never repair itself. That has been shown on functional MRI scans I've examined myself. Marijuana can take an average child and make him or her intellectually challenged; take a brilliant child and make him or her average.
7	Zero tolerance: Periodic workplace surprise blood testing for opioids and cannabinoids may cost you your job.	**7a**	Opioids and alcohol are metabolized in a matter of hours. Metabolism of cannabinoids like CBD can take days or weeks because of the P450 effect. I know of a nurse who lost her job and eventually her RN license because of a positive drug test. The CEO at Steel Dynamics told me that a positive drug test means you're gone. If you work with dangerous machinery, this is understandable.
8	CBD products often contain contaminants and adulterants, unknown to you, and potentially dangerous to your health.	**8a**	The most frequent natural contaminants consist of degradation products, microbes, fungi, bacteria, and heavy metals. These contaminants are usually introduced during cultivation and storage. Growth enhancers and pest-control chemicals are the most common risk to both the producer and the consumer. Cannabis products can also be adulterated for marketing purposes, with psychotropic substances, tobacco, etc., maybe added to low quality cannabis to alleviate its side effects. Additionally, some extraction and installation methods used for certain dosing formulations can result in substantial pesticide and solvent contamination.
9	Manufacturers, distributors, sellers, and testers may all be legally liable if a buyer decides to sue.	**9a**	If a consumer experiences a negative reaction of CBD to other substances, or if the contents of the product are not as advertised, then legal action is a real danger to any of the parties involved. An attorney I spoke to says this danger is very real, and it may just be a matter of time before these cases start being brought before the courts.

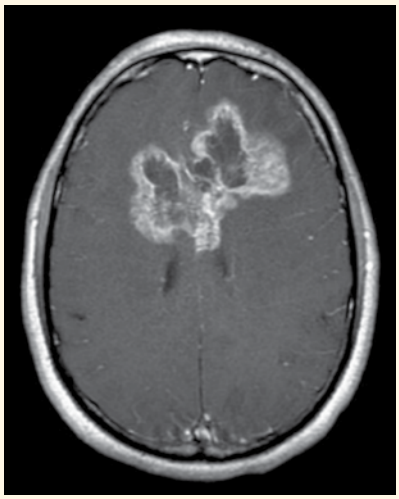
Glioblastoma: An Update | Isa Canavati, MD

Introduction

Glioblastoma Multiforme (GBM), or grade IV Astrocytoma based on WHO classification, is the most common primary cerebral neoplasm in adults. It has lately gained prominence in the news as it has, unfortunately, afflicted a few prominent public figures. GBM has an incidence of 5 per 100,000 adults annually, and it's the fourth most common cause of cancer related deaths. There is evidence of significant increase in incidence of GBM in all age groups, especially patients older than 75 years. This is not fully explained by improved detection and diagnostic tools, which suggests that widespread environmental and lifestyle changes may be implicated.

Molecular Genetics

Most malignant gliomas are not familial. There are several genetic disorders however, that are associated with the GBM. Examples are Turcot's Syndrome, (colonic polyposis/cancer and GBM) and Li- Fraumeni syndrome associated with breast, blood, bone, adrenal and brain cancer. In addition, tuberous sclerosis and neurofibromatosis types 1 and 2 present with multiple CNS tumors. These disorders commonly have an autosomal-dominant inheritance. The p53 tumor suppression gene on chromosome 17p has been identified as instrumental in the development of several malignancies, including colon cancer and glial tumors. Loss of heterozygosity (LOH), i.e., absence of a functioning p53 gene can lead to malignancy. GBM is associated with multiple mutations, including LOH of p53 at 17p, and LOH at 19q and chromosome 10. In addition, one third of GBMs have a mutation in epithelial growth factor receptor (EGFR).



Corpus Callosum Glioblastoma

Glioblastoma Classification

Recent World Health Organization (WHO) classification of CNS tumors includes both histopathologic and molecular criteria in order to achieve more accurate diagnosis, prognosis and design targeted therapies. Most GBM arise de novo or are primary. There is a subset (around 10%) considered secondary, as they evolve from lower grade gliomas, and occur more commonly in younger individuals with average age of 45 years. This subgroup displays isocytrate dehydrogenase 1 or 2 (IDH) mutations, which are also associated DNA-methylation mutant known as MGMT promoter. IDH mutant tumors are generally slower growing, less aggressive and at times more responsive to chemotherapy than IDH 'wildtype' GBM.

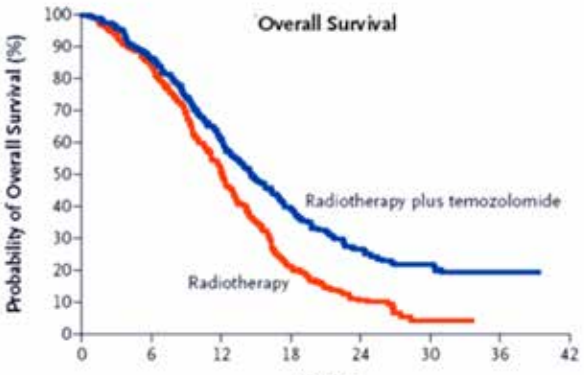
Surgical Treatment

The goal of surgery is to establish tissue diagnosis, reduce mass effect and decrease tumor burden, potentially reducing steroid dependence, and optimize response to adjuvant therapies. Surgical resection is constrained by the fact that GBM tends to invade brain tissue without altering function clinically. Thus resection of what appears as solid tumor radiographically may lead to neurological deficit. Technical advances over the last decade have improved the safety and accuracy of surgery, such as preoperative functional mapping, as well as intraoperative cortical mapping identifying 'eloquent' areas essential for motor, sensory, and speech function. Intraoperative navigation and stereotactic methods have become essential neurosurgical tools. Surgery, however, is not considered curative in the case of GBM, as it is highly infiltrative and areas of increased T2 signal on the MRI, initially thought to represent edema have been shown to represent tumor invasion. Surgery may improve quality of life and prolong survival in certain patients. This is influenced by age, size of tumor, its location and preoperative functional status.

Radiation Therapy

Radiotherapy has a prominent role in treating GBM with at least doubling length of survival LOS from 16 weeks with resection alone, to a median survival of around 39 weeks. It relies on damage to DNA and protein structural damage to rapidly cycling cells by the energy carried by photons. The standard dose is 5000 to 6000 cGy given over a 6-week period. Dosage is usually adjusted for the elderly with concerns for cognitive decline and cerebral edema. Other options include: stereotactic radiosurgery i.e., given as a single high dose, or stereotactic radiotherapy i.e., fractionated stereotactic radiosurgery. These are a consideration in recurrent tumors whereas high dose of ionizing radiation is administered to a defined tumor volume, while minimizing radiation exposure to surrounding brain tissue. Limitations include irregular tumor contours, and chance of radiation necrosis and associated edema.

Radiotherapy plus Concomitant and Adjuvant Temozolomide for Glioblastoma



N Engl J Med 2005;352:987-96.

Interstitial brachytherapy with I-125 seeds has been used with mixed results.

Chemotherapy

TemozolomideTMZ (Temodar) is the standard agent given in conjunction with radiotherapy. It is an alkylating agent, which acts by methylating adenine and guanine that may lead to cell apoptosis. The median survival with radiation and TMZ is 9.3 months compared to radiation alone at 7.6 months. Tumor genotype that carries the methylated MGMT promoter is more sensitive to TMZ with median survival of 13.5 months.

Alternative Therapies

Repeat surgery for recurrent tumors may be an option if the lesion is accessible with a low risk of neurologic deficit. Interstitial chemotherapy using Carmustine impregnated polymers (Glideal Wafers), which are placed within the tumor cavity after resection, has shown mixed results as to survival benefit, tempered by increased risk of infection. Tumor treatment fields (TTF), which is an electromagnetic field emitted by an externally worn device (Optune), attached to the scalp has shown some increase in progression free survival. Tumor angiogenesis inhibitors (Bevacizumab or Avastin) have been used with inconclusive benefits. Multiple clinical research trials are ongoing across the country.

Prognosis

Despite aggressive multidisciplinary therapies, the median survival is 11-15 months. It has not changed significantly with recent technical and scientific advances. GBM results from a complex network of genetic mutations, with heterogeneous cell population harboring a variety of genetic abnormalities. Research continues to focus on tumor-specific pharmacologic and immunotherapy targets.

Advance Care Directive

Ann Moore, DO, FACCOI, CMD, Chief Medical Officer, Visiting Nurse

As a hospice and palliative care physician with Visiting Nurse, most of my patients are facing serious and often life-ending illnesses. I have found most people have strong feelings about what they consider an acceptable quality of life and whether or not they would wish to seek what many consider aggressive medical intervention. Unfortunately, many people don't make their wishes known to those around them. The Visiting Nurse Palliative Medicine team is composed of three full-time physicians and three full-time advanced practice nurses who have had thousands of conversations about goals of care with patients.

Nationally, 63 percent of Americans have not completed an advance directive, according to a 2017 study from the Perelman School of Medicine at the University of Pennsylvania of more than 795,000 Americans enrolled in 150 difference medical studies. While completion of advance directives was nominally higher among patients with chronic illnesses (38.2 percent) than among healthy adults (32.7 percent) and was much higher among patients 65 and above (45.6 percent), the numbers show we have a long way to go in getting people to make their wishes known in advance of a critical medical situation.

As Medicare providers, we are required to ask patients if they have completed advance care directives and this usually happens at check-in. Unfortunately, the discussion usually stops there. Here is a perfect opportunity for us to engage our patients in conversation. If they answer that they have prepared advance directives, we should be asking them what their directions are. If they answer that they have not prepared advance directives, we should be asking why not.

I find that oftentimes, patients and their families need more information or feel that they have to see an attorney to draft these documents. **Caringinfo.org** is an easy-to-understand website explaining advance directives with links to every state's advance directive forms. These forms can be downloaded and completed without an attorney and at no cost. There are forms to name medical power of attorney and to explain your wishes regarding medical care. I find that once we start the conversation, patients and their loved ones are relieved to be given an opportunity to talk about their wishes.

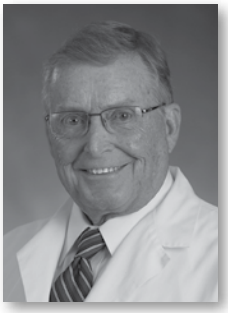
When we have the luxury of being able to talk with a patient directly, we ask questions to help understand what they consider an acceptable and/or unacceptable quality of life to them. If the patient is unable to participate in a conversation and has not completed advance directives, we rely on those around the bedside to provide the information. In addition to providing education about underlying disease, treatment options, burdens, and benefits, understanding the overall goals of living and acceptable quality of life is the key to helping patients and family members make decisions.

I have found that when a patient says, "I want you to do everything," they don't understand what that means. The unspoken part of that sentence in their minds can be "do everything and make me whole again."

I educate my patients that the most important advance directive to complete is designation of a power of attorney. I tell my patients that this is the person who speaks for you if you can't, so choose someone who will be strong enough to do it. I also tell them that with all the advances in medical treatments and technology, we don't know what options will be available in five years, so give directives related to acceptable quality of life and outcomes and not specific interventions.

Since 2016, Medicare has offered reimbursement for advance care planning services. Your coders can help ensure that your office is properly compensated for the time spent helping patients with these difficult questions. These can be ongoing conversations. There is no limit from Medicare on how often you have an advance care discussion with your patient, and there are no place of service limitations from Medicare, either. There are many resources available for both the practitioner and the layman online to begin these conversations. Having these difficult conversations at a non-urgent visit can be a gift you give your patients, and in turn, a gift those patients give their families.

Harry S. Truman: An American Hero | David A. Sorg, MD, FACE



In 1955, the Pfizer Pharmaceutical Co. continued its summer program of choosing a student from each medical school in the U.S. to promote their drugs. (I think there were about 70 schools at that time.) How it happened I don't recall, but I was chosen from Loyola University. My first flight on a large airliner took me to New York City, where I and students from across the country spent a week learning the Pfizer drugs (of which there were not many). We were divided into groups to detail those drugs to physicians in the larger cities.

I was assigned with four other young men to cities in the Midwest—St. Joseph and Kansas City, MO, Tulsa and Oklahoma City, OK, and Des Moines, IA among others. My peers and I carried our not so little black doctor bags filled with samples to the names and addresses given to us by the local drug representative in each city flying every few days from one to another.

When in Kansas City, one in our group wanted to try to meet President Truman, who had an office there before his library was built in Independence, MO. (At this time, Truman was just two years out of his presidency.) Contact was made and we received an appointment for the next day. The five of us were there at 9 a.m. Truman walked in and hailed us into his large office, where the usual photos and signatures were obtained. He then showed us a few of the awards and mementos he had received. I really don't remember much and I am sorry I didn't fully appreciate what a privilege this meeting was. The one award I do remember was a large medal on a long ribbon. I don't remember from whom he got it, but his comment I shall never forget. "Look at that damn thing. He hung that around my neck and it was so heavy it damn near pulled me over and hung halfway down to my balls". Harry was known for his colorful language, and he didn't disappoint.

In the many years since that time, I have learned a lot about President Harry S. Truman. He lived on a farm in his early years. Then finances caused the family to move to Independence with his grandmother. His vision was poor, requiring thick glasses, and prevented any activity in sports or anything physical. He was very bright and read voraciously. By the time he finished school (couldn't afford college), he had read all 3000+ volumes in the Independence library, several of them more than once. He was particularly enthralled by history and he remembered what he read, some of it rather esoteric.

In 1951, he was in a discussion with a biographer and they were talking about Alexander the Great. Truman said that Alexander died from drinking 33 quarts of wine. The biographer had never heard this. He called the Library of Congress and asked for their help in confirming it. A few days later, a returned call reported finding no link between Alexander and 33 quarts of wine. Another few days and the librarian again called. She hadn't given up so she checked in the rare book section. The librarian had found an obscure reference in a history of ancient Greeks and she confirmed the President was right after all. She informed the biographer, "And you know what? That book has been checked out only twice in the last 20 years, and the last time was by Senator Harry Truman in 1939. Truman more than once said "The only thing new is the history you don't know."

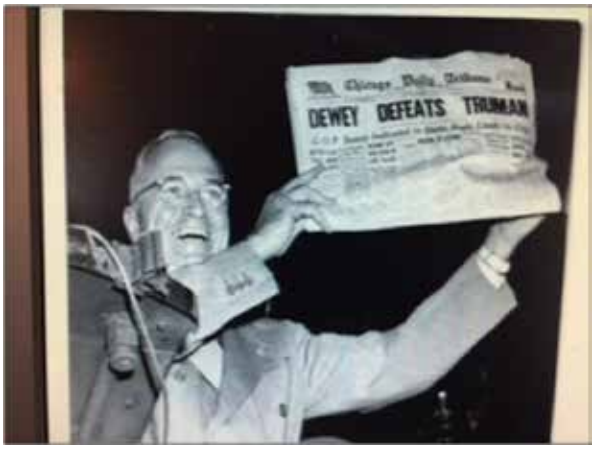
When the U.S. entered WWI, Truman wanted to join the Army but knew his poor vision would keep him out. He memorized the eye chart and was accepted. Truman was part of an artillery unit and ultimately became its captain. He treated his men with dignity and they all came to love him. Truman risked court martial twice by disobeying a command in order to do the right thing. Once he refused to keep marching his men up a hill when they were dead tired. On another occasion, he was ordered to fire his guns only in a certain quadrant but the German shells were coming from another direction. He ordered his men to return the fire. Truman would do anything for his boys. Many became lifelong friends. The Catholic chaplain in the unit once said "Harry Truman had integrity and much more than average intelligence, and there is no limit in a free society to what men with those attributes can attain".

After the war, Truman failed in business, but became a county judge and effected the building of what became known as the best roads in America, with no graft or corruption. He was later tapped by Tom Pendergast, the Kansas City mob boss, to run for the U.S. Senate, a race that he won. For a time in the Senate, he was accused of being a part of the mob, but soon his honesty became apparent. Truman chaired a committee investigating fraud in the production of weapons being built prior to WWII and ultimately saved the government billions of dollars.

Truman did not want the vice presidency nomination in 1944, as most everyone recognized that Franklin Roosevelt was gravely ill and would not survive another 4-year term. Roosevelt insisted. Truman was nominated and 3½ months later he became the 33rd President of the United States.

Truman was initially given a honeymoon period with 87% approval. Most approved of his decision to use the atomic bomb to end the war with Japan. But post-war woes of inflation, strikes, jobs for returning service men, concerns about Russia and others, eventually dropped his approval rating to 45%. In spite of this and being a proud man, he decided to run for President again even though he hated the job. He wanted to achieve the office on his own and not be seen as inheriting it as a Roosevelt pick.

Few gave him any chance of winning against Thomas Dewey, a famous prosecutor from New York. Truman travelled the country by train, "whistle stops" at any little community. He often brought out on the back of the train, his wife Bess (whom he dearly loved), and his daughter Margaret. He sometimes appeared during the night in his pajamas and robe, and crowds would greet him even at a late hour. Enough people loved his ordinariness, lack of pretension, honesty and no deception to re-elect him. See the famous picture of the Chicago Tribune assuming a Dewey victory. Truman loved it.



Harry Truman is routinely rated between our sixth and eighth greatest President. His accomplishments are really quite amazing! In the first four months of his presidency, he saw the founding of the United Nations, the fall of Berlin and the Nazi surrender, the fall of Japan following his decision to use the atomic bomb, the mass starvation in Europe, and the start of the cold war. No other President had faced as much in so short a period of time.

"You know that being an American is more than a matter of where your parents came from. It is a belief that all men are created equal and that everyone deserves an even break" ***Harry Truman***

Truman initiated the Marshall Plan to rebuild Europe, which stopped any communist influence there. He helped Turkey and Greece, thus preventing communism to take over. He initiated the Korean War to prevent the spread of communism in the entire peninsula. Truman was constantly aware of the very real threat of the Soviet Union.

Truman proposed universal health care, was adamant on civil rights (which caused the secession of the south, Dixiecrats, at the 1948 convention) and integrated the armed forces.

I write about this outstanding man mostly to extol his character. I could write so much more. What a privilege to have spent even a little time with him. He is indeed one of my heroes, a Hero for America.

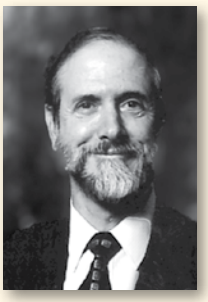
Truman Library, Independence, MO

Truman Office

Thomas Hart Benton Mural, Truman Library

In Memory

Aaron Borenstein, M.D.
December 25, 1945 – August 12, 2018



I was Aaron Borenstein's colleague and business partner from 1987-1999. Sadly, he passed away on August 12, 2018, in Medellin, Columbia, after challenges that were the consequence of a motor vehicle accident in 1999. That accident created a significant loss in our community as Dr. Borenstein was truly one of a kind. You will not know him if you have only practiced in Fort Wayne in this millennium but anyone who practiced medicine here prior to the year 2000 will undoubtedly have known him or known of him.

Aaron was an avid participant in life. He was a dedicated father to Solomon and Mila and husband to his wife Marion, whose effervescence was his perfect complement. He appreciated great food and was a huge supporter of the local arts community. I recall being in their home and marveling at the variety of art on the walls and that virtually every wall was covered with something remarkable. He relished in facilitating the success of others, particularly those with a unique and creative view of the world. Aaron was a lover of animals and I know that his choice to return to Columbia when he retired from clinical practice was to act upon a vow to "be a goat farmer", an intention he often threatened when he was frustrated by the changing face of medicine.

Dr. Borenstein was the consummate Plastic and Reconstructive surgeon; brilliant problem solver, artistically gifted, and absolutely dedicated to his patients and their care. He elevated the caliber of our specialty in this community. He was outspoken when anything compromised the care of his patients and simultaneously drove those around him to strive for excellence. I am confident that many in our medical community became better clinicians and stronger advocates because of his teaching and insistence. His surgical skills were precise and exemplary and his results were exceptional. I was proud to have him as a partner and I matured as a surgeon under his guidance.

When bigger than life people pass it seems impossible. Fortunately for us, he left a wonderful legacy of spectacular patient care and commitment to a community he loved.

Geoff Randolph, M.D.

Charles "Casey" Kroh, Sr. M.D.
December 24, 1949 – November 7, 2018

Casey was "the doctor's doctor," intelligent, soft spoken, and assuring. But to many of us, he was a dear friend. Casey, Jack Dyer, John Cowan and I gathered each Thursday for over 20 years to play tennis, followed by bridge in the Wildwood lounge. And for fourteen years, we enjoyed our friendship with a week of tennis at Barefoot Beach staying at the Cowans. Often, Casey and Jack would enjoy long discussions on issues of the day while lounging on the lanai. As a partner on the court, there was never an ill word said, no matter how poorly his partner played (even when his partner broke his racquet in frustration).

But although tennis and bridge were frequent pastimes, he always had time for his wife and sons. He often was on the sidelines coaching soccer, and was an ardent supporter of IU basketball, taking his boys along to get the IU experience.

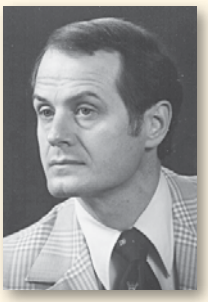
One of the attributes that will be remembered about Casey was his modesty. It was exemplified in a golf outing together. After a rather forgettable drive on my part, Casey stepped up to the ball and drove well over 225 yards right down the center of the fairway. I recall looking at him with astonishment. He simply said, "I played a little golf in high school."

Patients will remember Casey for his skill in the office and at the bedside. You never felt that he was in a hurry. When he was with you, it seemed that you were the most important person he would see that day. He was without doubt a very skilled and compassionate clinician. And his compassion persisted even while he battled Alzheimer's. On visits, he would place his hand on yours and clearly not want you to go. He was your friend as long as he could muster the thoughts to be just that.

Many in the medical community are left with fond memories of Casey. He was a superb physician, a great Dad and husband, and a dear friend to many. He will be missed.

Fred Rasp, M.D.

Thomas L. Herendeen, M.D.
June 18, 1936 – October 27, 2018



On Sunday, November 11, 2018, there was a celebration of life for Dr. Tom Herendeen. It was a wonderful gathering attended by many of his patients, nurses and friends in the medical community who shared their experiences and reminisced about times past.

Tom and his wife Sue came to Fort Wayne in 1968 joining Drs. Joe Jontz and Justin Arata in practice doing general and thoracic surgery. Tom later introduced both heart and cardiovascular surgery to our community.

Tom was a gifted surgeon who had many interests outside the practice of medicine. Both IU graduates, he and Sue supported Indiana University athletics and attended many of their games. He was an accomplished wood worker and sculptor whose works varied from totems, busts, reliefs and beautiful renditions of the human body.

He joined a group of retired physicians made up of several doctors who had done medical case review for Medical Professional Liability Co. They met for lunch weekly at the Acme Bar and shared cases, family stories, limericks, discussed politics, such ethereal subjects as cosmic forces in the universe and sports, especially IU, where Tom was expected to be "the man in the know".

A country boy at heart, Tom was also an avid fisherman, who traveled at great lengths to chase walleye, northern, steelhead and salmon. Tom's four children, eleven grandchildren and two great grandchildren were a source of great pride and he frequently shared their successes in academics and sports. Tom and Sue witnessed great strength and devotion as they faced his final life challenge.

We have lost a valuable friend and fellow physician and were blessed by his presence among us. Rest in peace, Tom.

Phil Tyndall, M.D.

John "JP" Smith, M.D.
July 24, 1945 – November 6, 2018

As family, friends, colleagues, and the community at large mourn the death of John P. "JP" Smith, M.D. on November 6, 2018, we, the former partners of Dr. Smith at Lake Avenue Physicians, want to honor him with our memories. Our physicians group later became First Care Family Physicians and eventually became the original members of Parkview Physicians Group.

John grew up on a dairy farm in Waterloo, IN and understood from a very young age the value of work, which had been engrained in him. This served him well as he excelled in school, and later at Purdue University. After graduation, he taught mathematics at several schools. His desire was to become a physician. He enrolled in IU School of Medicine, where he graduated in 1974. John then served a 1-year Family Practice internship at Ball Memorial Hospital. He subsequently came to Fort Wayne to join Drs. Al Haley, Robert Bahr and Richard Tielker at Lake Avenue Physicians.

Dr. Smith's practice grew rapidly as patients recognized his skill and professionalism, as well as his down-home manner and compassion in caring for them. John was often described as a doctor who 'listens more than he talks". This led his patients to feel that their input into his medical decision-making was important to Dr. Smith's patient care.

John valued friendship, fellowship and camaraderie. He was a great listener, always making one feel important even when our opinions didn't match up. He was not quick to offer advice, but one was compelled to listen to his opinions.

Dr. Smith was a valuable and important partner of Lake Avenue Physicians (later to include Drs. James Harris, E. Jon Brandenberger, and Jacqueline L. Akey), in leadership at the beginning of PHP, and President of the Medical Staff at Parkview Hospital.

We enjoyed our decades-long working relationship with JP, and even more our lasting friendship. There was a lot of work accomplished over the years, and innumerable times of levity and hard laughs. Some of us heard way too much "Boiler-up" between JP and Dr. Akey, but we had our quiet comeback, IU championships!

JP's faith in Christ grew through the years, which was an anchor-point for his last days. He will be greatly missed by his family, many friends, and those of us who were privileged to call him a colleague and partner.

Richard E. Tielker, M.D., Jacqueline L. Akey, M.D.E. and Jon Brandenberger, M.D.

January: Human Trafficking Awareness Month

January is Human Trafficking Awareness Month. Often referred to as modern day slavery, human trafficking is a complex issue. Many of us assume this only occurs in other countries. However, human trafficking occurs daily all around us in our state and city. While the victims may sometimes be kept behind locked doors, they are often hidden right in front of us at, for example, construction sites, restaurants, elder care centers, nail salons, agricultural fields, and hotels. Human traffickers generate hundreds of billions of dollars in profits by trapping millions of people in horrific situations around the world, including here in the U.S. Traffickers use violence, threats, deception, debt bondage, and other manipulative tactics to force people to engage in commercial sex or to provide labor or services against their will.

While there is no official estimate of the total number of human trafficking victims in the U.S. Polaris (**polarisproject.org**) estimates that the total number of victims nationally reaches into the hundreds of thousands when estimates of both adults and minors and sex trafficking and labor trafficking are aggregated. More than 40,000 total cases of human trafficking have been reported to the National Human Trafficking Hotline in the last 10 years with the number of cases that Polaris learns about in the U.S. increasing every year.

Risk Factors of Human Trafficking

There are numerous circumstances that can contribute to someone being trafficked. In general, trafficking victimization shares similar risks and consequences with other forms of interpersonal violence, including child maltreatment, domestic violence, and sexual assault. Some of the risk factors for trafficking include:

- Being a runaway or homeless
- Poverty
- System involvement
- Personal or family history of abuse, neglect, or addiction
- Personal or family history of untreated mental health issues
- Developmental disabilities
- Identifying as LGBTQ
- Being an immigrant or refugee

While awareness of risk factors is an important component of preventative efforts, the recognition of protective factors is equally as critical, factors such as: having a positive adult or mentor influence, access to stable housing, strong social supports, community engagement, self-regulation, self-efficacy, and positive self-esteem.

Locations of Potential Human Trafficking Cases in the U.S.

Traffickers thrive on the isolation of their victims, and grooming often begins with a trafficker pretending to care or love a vulnerable youth. Thus, local efforts to prevent human trafficking should involve active engagement to both reduce risk factors and increase protective factors. Research suggests that promoting safe, stable, nurturing relationships for youth is essential in a community's efforts to reduce abuse and exploitation. And while anti-trafficking work is complex and the challenges can be overwhelming, each of us can do something.

If you are interested in learning about local anti-trafficking efforts in your community or to request a training, contact:

Jeremy Greenlee, MA
Region 3 Coalition Coordinator
Indiana Trafficking Victim Assistance Program, Indiana Youth Services Association
Work Cell: 574.213.1502
jgreenlee@indysb.org

If anyone suspects human trafficking of a youth, they should call the **Indiana Child Abuse Hotline at 800-800-5556** and be sure to mention human trafficking.

If imminent harm is suspected, call 911.

You can also call the National Human Trafficking Hotline at **888-3737-888**
or **text Help or Info to 233733**
24 hours a day, seven days a week

Regional Mental Health Coalition
NORTHEAST INDIANA

Submitted on behalf of the Regional Mental Health Coalition of Northeast Indiana. Visit LookUpIndiana.org/Advocacy to learn more about the Regional Mental Health Coalition of Northeast Indiana and how you can get involved.

Fort Wayne Medical Education Program (FWMEP) Updates

Amy Dawson, M.D., MPH

Patient-centered Medical Home

The FWMEP Family Medicine Center is pleased to announce that we have received updated National Committee for Quality Assurance (NCQA) recognition for our Patient Centered Medical Home (PCMH) program in September, 2018. We first received PCMH recognition in 2013 aided by a generous increase in funding from Lutheran, Parkview and St. Joe hospitals. This increased funding allowed us to expand our staff offerings to include not only a behavioral health specialist, but also a clinical pharmacist, a social worker, and a diabetes educator.

The Family Medicine Center serves over 8,000 patients each year, predominantly low income households, with1200 Burmese and 800 patients with diabetes. As part of the safety net, we find that many of the patients we serve have extraordinarily complex medical, social, and/or psychological needs that require restructuring of our delivery of primary care to help support these needs.

Access

Patients need to be able to access medical care reducing barriers to treating acute conditions, managing chronic conditions and maintaining health. **"The care patients want and need when they want and need it."** In our clinic we have expanded evening hours, reserve 20-30% of appointments for same-day and/or new patients and offer a sliding scale fee for cash-paying patients based on income. Appointments are available for any type of visit whether acute or chronic, urgent or preventive. If a parent calls for a child's appointment and the child is due for a well-child exam, then we offer a well-child visit in addition to addressing the urgent issue. As a result of this practice, our well-child visit rates are very high and we have won the MD Wise Star Performer award!

Non-traditional Office Visits

We offer multidisciplinary office visits, group visits and shared medical appointments as well as a limited number of home visits by physicians and our social worker to care for complex patients. Our social worker also accompanies patients to apply for services including Medicaid, housing, and financial assistance.

Knowing and Managing Your Patients

Our comprehensive patient intake process includes developmental assessment of children, screening for social determinants of health, risky behaviors, need for advance care planning, mental health screening, language preferences and cultural needs. We address health maintenance items for patients during all visits. We then use this information to assess the health of our patient panel in areas of diabetes control, rate of preventive care visits, health screenings and appropriate use of medications and procedures. We also use population management reports to manage our patient panel as a whole.

Projects:

We are part of a current community improvement and research project led by Sarah GiaQuinta, MD, MPH to assess social determinants of health for children, link to 211 services and then track the 211 referrals provided.

We have also conducted research on disparity of blood pressure and diabetes control by age, race, ethnicity and language. These findings were presented at both national and international conferences and form the basis of our team-based care interventions.

Additionally, we participated in Agency for Healthcare Research and Quality (AHRQ) funded projects last year to implement the "Teach-Back" communication method with patients to improve their understanding of physician instructions and medication reconciliation involving the pharmacy team for complex medication lists.

Team-based Care expands the disciplines available to care for patients and sets expectations for how this team should function.

In our clinic, physicians can **co-schedule appointments** with the diabetes team, pharmacy services, behavioral health or social services for patients with complex needs.

Medicare Annual Wellness visits are provided with a team approach including: a behavioral health specialist to address cognitive screening, a social worker to address advance directives, a pharmacist for medication reconciliation and advice to optimize medications to prevent disease progression.

Burmese Diabetes Group visits in the Autumn Woods apartments were conducted by our diabetes team, explaining diabetes, the role of carbohydrates, glucose and insulin, cholesterol, and high blood pressure. Novel strategies were developed to help balance carbohydrate and protein intake. Large portions of rice and once-daily meals were improved by reducing rice and adding fish paste to reduce the blood glucose spike after the meal. For those that required insulin, they initially found that

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prescribing a single insulin pen with a combination of long and short acting insulin at the time of the large meal improved glucose control without danger of confusing the two types of insulin. Focus group feedback from the Burmese in the diabetes program showed the Burmese felt the team cared for them, took time to help them understand both the disease and their treatment, and made them a valued partner in their care. The first Burmese diabetic cohort saw the average A1C drop from 9.9 to 7.9 in just 3 months!

Adult weight loss and wellness group visits are offered every week, with three weeks of group education visits using the CDC's **diabetes prevention curriculum** and the fourth week a shared medical appointment where weight loss medications are used to assist weight loss. We currently have the only CDC-approved diabetes prevention program in northeast Indiana with 75 patients enrolled, averaging 25 attending each week.

Childhood Obesity Groups have been offered 4-8 weeks each year for the past 4 years, recently partnering with the Trine University physical therapy program. These offerings use the 5-2-1-0 approach to healthy childhood habits: 5 fruits and vegetables daily, 2 hours of screen time or less, 1 hour of physical activity or more and 0 sugary beverages. The findings have been presented internationally and published.

Care Coordination and Transitions of Care leave patients vulnerable to readmission or adverse outcome, so the patient-centered medical home specifically addresses this risk through increased communication and care coordination. Our clinical pharmacist rounds at the hospital twice a week to manage transitions of care for complex patients. Multidisciplinary transition of care appointments in the clinic are scheduled with the pharmacist and the physician, reducing hospital readmissions by 50%!

Care Management/Case Management

As an interdisciplinary team with the social worker, pharmacist and medical director, we meet at least monthly to discuss patients that are super-utilizers from our insurance reports or recommended by providers, patients and families. We create a care plan that often includes an interdisciplinary office visit with the social worker, pharmacist and physician to develop a comprehensive care plan for the patient that improves their health.

Our social worker also leads our monthly **Patient Advisory Panel**, which includes patients representative of the diversity of our clinic. Patient feedback has improved our communication with patients about clinic changes, providers, service offerings, helped us improve scheduling, check-in and parking.

Quality Improvement reporting in our clinic provides a positive feedback loop for change. We use relevant reporting for the measures that are important to us and our patients and then design clinic-wide programs to address these issues and measure our progress. My favorite patient remark was **"you guys did more for my diabetes in one visit than my last doctor had done for five years!"**

To prioritize quality improvement in the clinic, we involve a team of clinic leaders meeting weekly to design our PCMH strategies and meet with insurance company quality managers to review reports and examine our offerings. Once a program need is identified, a proposed solution is presented to the FMC committee meeting with representatives from every area of the clinic. Decisions reached there are disseminated in clinic huddles and all-clinic monthly meetings.

Notable activities and accomplishments include:

1. The chief resident of safety and quality directs the **"Good Catch"** program. This program allows physicians and staff to note events that did not result in harm, but need to be improved to lower risk of future harm. To date, there have been over 100 Good Catches on many disparate topics. The resident leads the committee through a root cause analysis, and clinic improvements are made and tracked for resolution of the identified issues
2. **Patient Satisfaction** is followed with standardized HCAHPs questionnaires
3. **Designed for the outpatient PCMH setting**. Our ratings for access, communication, office staff and provider rating are well above the national average.
4. The **Culture of Safety survey** is administered and compared with national data every 1-2 years to assure that we are continuously improving our culture of safety within our clinic.
5. A reduction in **high risk medication** prescribing for the elderly was accomplished through pharmacy review of medications and inviting patients in for a consultation with the pharmacist and physician resulting in a reduction of the use of Beers-list medications by 37%.
6. A clinic **workflow time study** revealed that patients spend a total of 31 minutes unused waiting time for 17 minutes of provider face-to-face time. Plans were put into place to reduce the waiting time and increase the provider time (physicians, social worker, pharmacy, diabetes education, behavioral health) that the patients experience. A new workflow time study will be done in the near future to assess improvement.

Indiana University School of Medicine – Fort Wayne

Gina Bailey, Assistant Director of Program Development

Indiana University School of Medicine-Fort Wayne (IUSM-FW) will be introducing two new initiatives at our campus: the establishment of a Student-Centered Educational Outreach Clinic (SOC) and a Scholarly Concentration in Aging Studies. Both of these initiatives are part of a statewide plan being implemented at all nine campuses.

The establishment of a SOC will provide free health care services to underserved individuals living in the Fort Wayne community. IUSM-FW medical students will provide these service in collaboration with students enrolled in IU Fort Wayne health related disciplines, under the guidance of physicians. The weekly clinic will complement existing community clinics and provide another avenue to help meet the needs of underserved patients in Fort Wayne. As the SOC will be student led, students will assist in managing every aspect of the clinic, from marketing to ordering supplies and scheduling student volunteers. We look forward to the opening of the clinic in the 2019-2020 academic year.

IUSM's Scholarly Concentration Program is designed to offer students elective opportunities in several medically related areas at each of nine campuses. As part of this initiative, faculty, including full-time, part-time and volunteer, will provide educational modules and research opportunities for students interested in a focused area of medicine. Most of the educational curriculum will be delivered through videoconference lectures and web-based modules to ensure accessibility of the materials to any interested student across the state. The IUSM-FW Aging Studies Concentration will help students gain an understanding of the challenges and growing opportunities in health care for our ever-expanding aging population using evidence-based medicine. Students will examine the unique challenges posed in diagnosing and managing elderly patients with single and multiple chronic conditions. They will have the opportunity to conduct translational research related to aging in various areas such as neurology, cardiology, public health and patient management. This initiative reinforces IUSM's commitment to education and research. IUSM-FW faculty and research staff are excited about the potential expansion of our research efforts in areas related to aging as part of this program. Students can choose to enroll in this program, which officially begins in August 2019.

IUSM-FW would like to extend an invitation to physicians and health care providers who are interested in learning more about or becoming involved in these programs to contact Gina Bailey at gibailey@iu.edu.

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.

Indiana University School of Medicine – Fort Wayne

Kyle Davis

Students at the Indiana School of Medicine-Fort Wayne (IUSM-FW) continued the tradition of hosting a Trunk-or-Treat fundraiser for a third year in a row to collect canned goods and funds for a local food bank. The fundraiser started two years ago when, then first year student, Ali Salameh, organized the first Halloween themed fundraiser and it has grown in effort since.

With multiple hurricane disasters occurring in 2017, last year's fundraiser focused on relief aid for the U.S. and Puerto Rico hurricane victims. This year, the project, headed by Kyle Davis (MS2) and Ali Salameh (MS3), returned its focus on our local community by collecting canned goods and monetary donations for the Community Harvest Food Bank in Fort Wayne.

Food insecurity is a reality for many people in America, including people in our own community. According to Feeding America, 14% of people in Allen County are without reliable access to a sufficient quantity of affordable, nutritious food. Although there are federal programs to help people access proper nutrition, not everyone struggling with hunger qualifies for these federal nutrition programs. Instead, many people in our community rely on charitable food assistance, which includes the great people at Community Harvest Food Bank.

This year's Trunk-or-Treat was held on October 29th on the fourth floor of the parking garage near the IUSM-FW building on the Purdue Fort Wayne (PFW) campus. There were over 30 creatively decorated trunks with medical students and PFW pre-med undergrads handing out candy.

Several medical students served on the planning committee and participated in this event including: Olivia Johnson, Anna Cole, James Sullivan, Grant Adams, Kori Ormachea, Ruben Prado, Jarrett Campbell, Angel Jones, Joyce Mannon, Seth Baker, Jean Crowley, Michaela Campbell, Stephanie Adjei, Juan Valdez, Jaymin Patel, Xyryl Pablo, Jacob Applegarth, Angela Pikus, Cam Duffner, Leah Amstutz, Grant VanNess, Steven Dawson, Alexia Parra, Andy Wang, Brandon Kiley, Sam Stegelmann, Jasmin Sanchez, and Bianca Blaettner. In addition to the trunk candy stations, the event offered 15 Halloween themed carnival games for kids to play, which Casey Miller (MS2) organized. In the end, during the two-hour event the medical students and volunteers raised over $300 and 295 pounds of dry goods for Community Harvest Food Bank.

IUSM-FW students are proud to sponsor this fun event that put smiles on the faces of over 100 kids in attendance to support the food bank.

The Trunk-or-Treat committee contributes much of the success of this event to our partnerships with the Fort Wayne Medical Society and its Alliance. Both organizations helped to promote the event through fliers and social media. The Fort Wayne Medical Society donated candy and trick-or-treat bags for the event. The Fort Wayne Medical Society Alliance, including Dawn Davis, Jennifer Bojrab, Maria Krach, Betty Canavati and Liz Hathaway, helped welcome the attendees, collected donations, and even captured pictures at the event! These organizations provide support to our program throughout the year, and we are grateful to join forces with them in this activity to help others in our community.

Fort Wayne Medical Society – Alliance | Betty Canavati, Co-President

Fort Wayne Medical Society
ALLIANCE
CONNECTING PHYSICIAN SPOUSES
...WITH CAUSES THAT MATTER

The FWMS Alliance has had a fantastic autumn with many social and educational events.

The **Annual Legislative Workshop,** which was co-sponsored by the FWMS and Alliance, was held on October 10th at Sycamore Hills Country Club. During the evening, attendees heard from nine state legislators about issues that they deem important. Physicians, spouses, residents and medical students were all given the opportunity to discuss with their local state legislators, issues and problems affecting their medical practices and give their input on proposed solutions.

The Alliance assisted the IU School of Medicine-FW with their 3rd Annual ***Trunk or Treat*** evening on Monday Oct. 29th in the parking garage across from the medical school. Admission fee and/or canned food items were collected for the Community Harvest Food Bank. Medical School Liaison, Dawn Davis, and several Alliance members participated in making this a very successful evening for more than 100 children. The FWMS donated funds to help underwrite the cost of the event.

Social Program Chair, Cammy Sutter, and her committee have done a great job of adding variety to Alliance member activities. In addition to monthly events, such as First Friday Fun, and knitting/book club meetings, Cammy planned the first ***Lunch & Learn*** luncheon on Oct. 24th at Baker Street restaurant. The topic was Fraud Prevention, which was presented by Detective Chrystopher O'Connor of the FWPD.

If you are new to Fort Wayne, or if you have lived here for years but have not attended one of our events, let me encourage you to come out and enjoy one of our programs. We love new faces and look forward to spending time with other spouses who want to make Fort Wayne the best place to live and practice medicine.

The FWMS Alliance is so thankful to each of our members who are willing to take the time and serve our community bringing together 'spouses who care, with programs that matter'.

Please visit our website at **www.alliancefw.org** for any questions or comments or Facebook 'Fort Wayne Medical Society Alliance'.

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Legislative Workshop

Trunk or Treat

Left to right: Jennifer Bojrab, Maria Krach, Medical School Liaison Dawn Davis, Liz Hathaway and Betty Canavati

Continued from page 29

The Membership Committee, co-chaired by Betty Canavati, Vivian Tran, and Preeti Jain, are still busy encouraging physician spouses to support the Alliance. We are the face of the medical society and want to contribute to the well-being of people in Fort Wayne.

MEMBERSHIP DUES OPTIONS

	Current	Retired
Fort Wayne	$ 45	$ 25
State	$ 35	$ 35
National	$ 65	$ 65
National Couple	$100	$100
Friend of the Alliance	$ 25	
Total Dues	**$145**	**$125**

Please send your checks to:
Liz Hathaway, Alliance Treasurer
12014 Thornapple Cove, Fort Wayne, IN 46845
Or pay online at AllianceFW.org

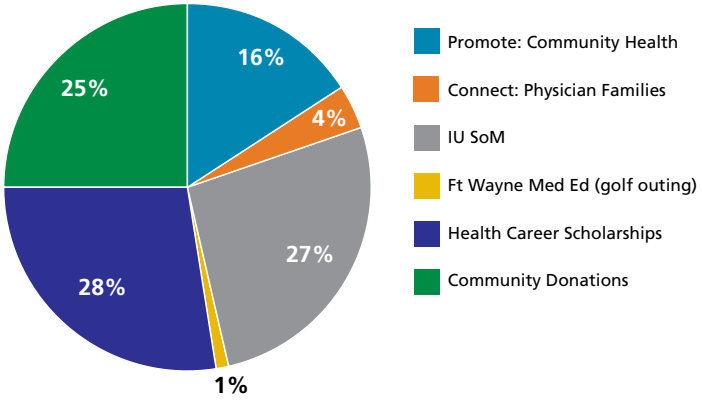
The Alliance Holiday Lunch and Bazaar Fundraiser was held on December 5th at Ceruti's Banquet & Event Center. This event is a holiday highlight for our members, their friends and families. There were more than 90 people participating in the luncheon and "Feed the Reindeer" gift baskets. This well-attended, fun event offered a chance for our members to celebrate the Holiday Season with friends and guests, while providing the opportunity to shop with more than 15 local vendors. All vendors graciously agree to donate at least 10% of their sales back to the Alliance. Friends who could not stay for lunch were welcome to come shop before or after the luncheon portion of the event.

The funds raised are used to help underwrite our Health Careers Scholarship program and community donations.

We would like to thank Jennifer Bojrab and her committee for planning this event. She did an amazing job of making it fun and successful!

We would like to thank all the people who contributed to the "Feed the Reindeer" gift baskets: Jennifer Bojrab, Betty Canavati, Crestwood Gallery/Best Boy products, Dawn Davis, IU School of Medicine, Preeti Jain, Melissa Somerville, and Vivian Tran. A special thank you goes to Sue Shilts, our graphic designer elf, for producing the invitations, table tents, and "Feed the Reindeer" tickets.

Alliance Spending Summary: 2018



You do not have to attend any meetings nor help with any community service projects to support the Alliance. **Your donations** are used to support our community service projects and scholarships. If you haven't paid your dues, you may do so on our web site at **Alliancefw.org**.

All local and state dues donations are tax deductible.

Upcoming Alliance Events

Jan. 9, 16, 23, 30	**Knitting/Craft Club**, 9:30 am, Mocha Lounge, 4635 E Dupont Road
Jan. 23	**Lunch & Learn**, 11:45 am – 1:15 pm Healthy Eating, Aboite Township Community Center, 11321 Aboite Center Rd
Jan. 24	**Book Club**, 7 pm The Joy Luck Club, by Amy Tan, Host: Liz Hathaway, 12014 Thornapple Cove
Feb. 1	**First Friday Fun**, Noon Lunch at Nawa, 126 W. Columbia St
Feb. 6, 13, 20, 27	**Knitting/Craft Club**, 9:30 am Mocha Lounge, 4635 E Dupont Road
Feb. 9	**Medical/Dental Mixer**, 6:30 pm Host: Kos and Mulo Lugakingira 12032 Kingsbridge Road
Feb. 19	**Book Club**, 7 pm, check website for further update
Mar. 2	**Doctor's Day**, 10-3 Science Central
Mar. 6, 13, 20, 27	**Knitting/Craft Club**, 9:30 am Mocha Lounge, 4635 E Dupont Road
Mar. 19	**Book Club**, 7 pm., check website for further update
Mar. 23	**Cinderella Dress Day**, 8 am-1 pm FW Convention Center
Apr. 1	**First Friday Fun**, check website for update

Alliance Holiday Luncheon and Bazaar Fundraiser

2018-19 Alliance Board

Feeding the Reindeer

Table decorations

Lucky winner

Shopping at the Holiday Bazaar

ISMA-A President Jaime Dinn and her guest

AMA-A President-Cami Pond, Preeti Jain, and Deanne Baker

Greeters: Cammy Sutter, Liz Hathaway and Jennifer Bojrab

Lutheran CEO Adds Cooking to the Continuum of Care

Paula Autry, Lutheran Hospital's CEO, and other members of the administrative team recently prepared a meal for families staying at Mad Anthonys Children's Hope House.

MACHH is located at 7922 W. Jefferson Blvd., on the Lutheran Hospital campus, and has provided hospital-based hospitality services to families displaced by medical emergencies since 2003.

In addition to keeping families near their critically ill or injured child, MACHH also provides a volunteer supported meal service known as "Home Cook Heroes." These volunteers prepare balanced and nutritious meals for MACHH families during their child's inpatient hospital stay. Paula and team will prepare a meal in MACHH's kitchen and then join the families for dinner.

"Our meal service program is one of the most important ways volunteers can impact our families. It is not simply preparing the meal, but sitting down with families to share that meal while learning more about the struggles they face. It helps reinforce the need for community during times of hardship, and it is so important to the health and well-being of our guests," said Andrew Gritzmaker, executive director of MACHH.

"We continue to see the impact that the Children's Hope House has on our patients and their families," said Autry. "The love and support they provide is a crucial component with regards to the healing process. We are grateful for their hospitality services and happy to support their mission by preparing a meal for their residents."

Mad Anthonys Children's Hope House is a non-profit hospitality house that provides shelter, meals, laundry facilities and a peaceful refuge for families with children who are critically ill or injured. The house opened in 2003, has 10 private bedrooms with private baths, a fully equipped kitchen, pantry, living room, TV lounge, computer room and meditation room.

Contact:

Andrew Gritzmaker, Executive Director	Phone: (260) 459-8550
Chris Dubes, President of the Board	Phone: (260) 423-9411

Dupont illuminated in pink for Breast Cancer Awareness Month

Patients, visitors and passers-by probably noticed a different nighttime hue at Dupont Hospital during October. That's because Dupont was illuminated in pink to observe Breast Cancer Awareness Month. Pink and white balloons were also visible around the campus.

Dupont Hospital and Lutheran Health Network encourage women to discuss the current recommendations for breast awareness with their personal physician.

Lutheran Hospital receives American College of Cardiology's highest recognition

The American College of Cardiology has recognized Lutheran Hospital for its demonstrated commitment to comprehensive, high-quality culture and cardiovascular care. Lutheran was recently awarded the HeartCARE Center National Distinction of Excellence based on meeting accreditation criteria, and through its ongoing performance registry reporting. Lutheran was one of the first seven hospitals in the country to achieve HeartCARE Center status, which is the ACC's highest recognition.

Hospitals and health systems that have earned an ACC HeartCARE Center designation have met a set of criteria including at least two earned CV accreditations offered by the ACC, a third earned CV accreditation offered by the ACC or participation in a National Cardiovascular Data Registry, and involvement in additional efforts designed to help hospitals and institutions close gaps in guideline-based care.

"Lutheran Hospital has demonstrated its commitment to providing northern Indiana with excellent heart care," said Phillip D. Levy, MD, FACC, chair of the ACC Accreditation Management Board. "ACC Accreditation Services is proud to award Lutheran with the HeartCARE Center designation."

With this new designation, hospitals and health systems can now showcase their elite status and publicly highlight their outstanding commitment to quality for their patients, providers and other stakeholders.

Our vision has always been to provide the most comprehensive cardiovascular care available for patients in northern Indiana," said Joyce Walz, RN, BSN, executive director of cardiac, ICU and neuroscience services, Lutheran Hospital. "This designation, and our desire to enhance our collaborative efforts with the American College of Cardiology even further, is a clear indication that Lutheran takes its role as a leader in heart health very seriously."

According to the ACC, hospitals receiving its HeartCARE Center designation have demonstrated their commitment to consistent, high-quality cardiovascular care through comprehensive process improvement, disease and procedure-specific accreditation, professional excellence, and community engagement. Based on its assessment, the ACC believes Lutheran has proven to be a forward-thinking institution with goals to advance the cause of sustainable quality improvement.

The ACC offers U.S. and international hospitals like Lutheran access to a comprehensive suite of cardiac accreditation services designed to optimize patient outcomes and improve hospital financial performance. These services are focused on all aspects of cardiac care.

St. Joe and Bluffton Regional nationally recognized for short-stay rehabilitation care

U.S. News & World Report has identified the transitional care unit at St. Joseph Hospital and the continuing care unit at Bluffton Regional Medical Center as high performing in its recent review of nursing homes.

New for 2018 was a category that looked at short-stay rehabilitation care. Both Lutheran Health Network locations earned top marks. They represent two of only 16 units in Indiana to achieve high performer status in the overall and short-stay categories. Only 16 percent of the short-stay locations nationwide achieved this level of recognition.

New downtown physical therapy and MRI location open on West Wayne Street

Optimum Performance Therapy, a department of The Orthopedic Hospital of Lutheran Health Network, invited the public to celebrate the opening of its new location at 219 W. Wayne St. in downtown Fort Wayne. To coincide with this year's "Be a Tourist in Your Own Hometown," an Ortho Hospital-sponsored event, games and tours were offered.

The 6,150-square-foot site, which is conveniently located adjacent to the new Fort Wayne Orthopedics clinic at 217 W. Wayne St., features one-to-one physical and occupational therapy, and a wide bore MRI.

Call 479-3040 to make an appointment or learn more about the services available at this location.

RediMed Huntington wraps up year long renovation

Those who haven't been in the RediMed urgent care clinic on Flaxmill Road recently may be in store for a pleasant surprise. That's because significant interior and exterior work to the facility located just off of U.S. 24 on Huntington's west side is now complete.

An overhaul of the entire building included all new flooring, lighting, casework and countertops, sinks, fixtures, insulation, and paint. The project at RediMed Huntington was one of eight clinic renovations to take place within the RediMed system.

Each renovation had improving the experience for patients and staff as a common goal.

"Updates to our Huntington clinic, as well as the recent implementation of our online check-in across the region, allow our clinical staff to work in a more efficient manner so patients can be seen quicker," said Matt Lehn, chief operating officer, RediMed / Business Health Services. "Equally important is our enhanced ability to provide quality care in an updated, more patient-friendly environment."

RediMed Huntington offers care for patients who need immediate, nonemergent medical attention for conditions that include cold and flu symptoms; sprains, strains and fractures; headaches; abdominal pain; cuts and lacerations; and allergies and rashes. Onsite X-rays and lab draws are available at all RediMed urgent care clinics. Physical therapy services are available at two RediMed locations including the Huntington clinic.

Parkview Huntington Hospital honored among 100 Great Community Hospitals for fourth year

Parkview Huntington Hospital (PHH) has been recognized by Becker's Hospital Review as one of the 100 Great Community Hospitals in 2018. The list of selected hospitals was announced by Becker's Healthcare in the July 28 issue of Becker's Hospital Review.

The 100 Great Community Hospitals list includes independent community hospitals as well as facilities affiliated with large health systems. Some hospitals serve expansive rural areas, while others care for small communities outside of large cities. Many of the hospitals have been recognized for their clinical and operational excellence and economic impact on the surrounding areas.

For the listing, a "community hospital" was considered to be a facility with 550 or fewer beds.

"We're proud to be a 36-bed hospital that is consistently outperforming much larger facilities across the country," said Juli Johnson, president, Parkview Huntington Hospital. "Focusing on innovation, the highest-quality care and a superior patient experience, our team is dedicated to providing an ever-wider range of treatment options and wellness resources close to home for Huntington County residents. For example, the current expansion of our Rehab and Wellness Center and the addition of a state-of-the-art wound clinic in the coming months will provide a real advantage for community members who might otherwise have had to travel for certain types of specialized care. It is so rewarding to receive this important recognition from a healthcare industry monitor like Becker's Hospital Review."

Hospitals were chosen for inclusion in the list by the Becker's editorial team based on a number of rankings and organizational ratings, including IBM Watson Health™ 100 Top Hospitals®, iVantage Health Analytics, and The Chartis Center for Rural Health's Top 100 Rural & Community Hospitals, as well as CareChex ratings, Leapfrog Group grades, Healthgrades awards and the Centers for Medicare & Medicaid Services star rating program, among other considerations, such as a hospital's reputation for leadership and innovation.

Among other recognitions, Parkview Huntington Hospital has received IBM Watson Health 100 Top Hospitals honors six times and for the past five consecutive years. The hospital has a five-star CMS rating, and has been named one of the Best Places to Work in Indiana for 2018 by the Indiana Chamber of Commerce.

Parkview Regional Medical Center receives national recognition from The Leapfrog Group for straight "A's" in patient safety

Parkview Regional Medical Center has received its 11th consecutive 'A' in The Leapfrog Group's Fall 2018 Hospital Safety Grade, released today. Leapfrog's Hospital Safety Grades are released each spring and fall, and assign an A, B, C, D or F grade to hospitals across the country based on how safe they are for patients.

"This recognition truly belongs to Parkview Health's quality and safety teams, as well as the caregivers in our hospital, who are making patient safety a priority in their work day in and day out," said Ben Miles, president, Parkview Regional Medical Center and Affiliates. "We take great pride in the level of care we offer our patients and their families, and this safety grade is a testament to that dedication."

Developed under the guidance of a National Expert Panel, the Leapfrog Hospital Safety Grade uses 28 measures of publicly available hospital safety data to assign grades to more than 2,600 U.S. hospitals. The Hospital Safety Grade's methodology is peer-reviewed and fully transparent, and the results are free to the public.

"Parkview Regional Medical Center's continued success in achieving an A rating is evidence that the organization places an emphasis on protecting patients from preventable medical errors, injuries and infections. We are inspired by Parkview's leadership on patient safety," said Leah Binder, president and CEO, The Leapfrog Group.

Parkview Physicians Group to open primary care clinic at The Summit

Parkview Physicians Group (PPG), in collaboration with The Summit, will soon bring a primary care clinic to a new area of Fort Wayne. The clinic will house two physicians and two advance practice providers, along with a support staff of about 20.

The 7,000 square foot clinic will house nine exam rooms and a procedure room, as well as e-visit exam rooms, lab services, concierge-style check-in areas and several other amenities designed to optimize the patient experience.

PPG joins a variety of socially-minded organizations on The Summit campus who are working together to help the community thrive, such as Healthier Moms and Babies, Big Brothers Big Sisters, Mental Health America of Northeast Indiana and The Literacy Alliance. Existing Parkview services at The Summit include Parkview Sports Medicine and Parkview Community Partners.

The clinic is expected to open in August 2019.

Parkview Hospital Randallia Outpatient Therapy wins Studer Group 2018 Excellence in Patient Care Award for Outpatient Services

Parkview Hospital Randallia Outpatient Therapy has been awarded a 2018 Excellence in Patient Care Award by Studer Group, a Huron solution. Specifically, the hospital is being recognized for demonstrating outstanding performance in outpatient (non-surgical) patient care in 2017. To be considered for an award in this category, an organization must rank in the 90th percentile or higher for overall outpatient services satisfaction as measured by patient satisfaction surveys.

"The outpatient therapy team at Parkview Hospital Randallia is so deserving of this recognition. It is their dedication to high quality care, and what that means for our patients and their outcomes, that sets them apart," says John Bowen, chief operating officer, Parkview Hospital Randallia.

Excellence in Patient Care Awards are presented annually to a select group of organizations from Huron and Studer Group's partner base. To be eligible for an award, an organization must demonstrate outstanding performance and achievement in areas such as patient care and employee and physician engagement.

"We are fortunate to work with the best of the best in healthcare and are so proud of all the organizations that are receiving awards for their outstanding results," says Debbie Ritchie, president, Studer Group. "It takes dedication from every individual to provide excellent care and this award should be celebrated by all those who work daily to make a difference. They are what's right in healthcare."

Parkview LaGrange Hospital and Parkview Noble Hospital welcome Ortho Northeast

Leadership at Parkview LaGrange Hospital and Parkview Noble Hospital and Ortho Northeast (ONE) have announced that the providers have partnered to provide orthopedic care in LaGrange & Noble Counties.

"Parkview Noble Hospital is excited to grow our long-standing relationship with ONE through this new orthopedic delivery model," said Gary Adkins, president, Parkview Noble Hospital, "Orthopedists from many different sub-specialties will provide care here in our community, offering the best specialized orthopedic care to each patient who utilizes the clinic, despite the orthopedic issue that brings them to us."

ONE physicians at Parkview Noble Hospital include Dr. James Danias and Dr. David A. Goertzen (TraumaONE), Dr. Brett F. Gemlick and Dr. David M. Conner (SportONE), and Dr. Micah W. Smith (SpineONE).

"This partnership will expand our existing relationship with ONE surgeons Dr. Jeffery Hartzell, who specializes in joint and sports injuries, and Dr. Ahmer Ghori who specializes in spinal pathology," said Jordi Disler, president, Parkview LaGrange Hospital. "Three additional orthopedic surgeons from ONE have recently joined the hospital's medical staff, allowing us to provide our community with a depth of orthopedic coverage that was previously unavailable."

The new ONE surgeons who have joined Parkview LaGrange Hospital's medical staff are Dr. Christopher N. Johnson (JointONE), Dr. Christopher LaSalle (HandONE) and Dr. Alan McGee (SpineONE).

The ONE physicians will rotate clinic and surgery hours weekly at each of the hospitals. Rachel Wilson, CNP (LaGrange) and Ruth Wilson, CNP (Kendallville), both of PPG–Orthopedics, will continue to provide full time services. The physicians will provide general orthopedic care for new patients and may refer patients to a specialist within the practice, should the patient's specific injury or condition require it.

ONE in LaGrange is located in Suite 201 of the Medical Office Plaza attached to Parkview LaGrange Hospital. Office hours are Mon.– Fri., 8 a.m. to 4:30 p.m. To schedule an appointment for orthopedic services in LaGrange, call 260-463-9160.

ONE in Noble County is located at Parkview Noble Hospital in Kendallville. Office hours are 8 a.m. to 5 p.m. For additional information or to schedule an appointment in Noble County, call 260-347-8430.

Cincinnati Children's Hospital and Parkview Health announce pediatric specialty care affiliation

Parkview Health announced today they are collaborating to expand pediatric care in cardiology, gastroenterology (GI) and general surgery to families in the Fort Wayne region.

The collaboration will include innovative telehealth consultations that will allow a family and their Parkview physician to conduct a video conference with a specialty physician at Cincinnati Children's, allowing physicians to work together on a child's care plan. This approach brings advanced care to the patient, reducing or even eliminating the need for travel to receive care. For patients who require inpatient care at Cincinnati Children's, a coordinated approach for referrals and local follow-up appointments will streamline care.

Additionally, Cincinnati Children's will provide training to Parkview physicians and clinical teams and share best practices to improve patient outcomes. Examples include protocol sharing, access to education, case reviews and diagnostics.

"This collaboration is centered around the patient and giving them access to a higher level of care," said Tom Miller, MD, physician leader, Parkview Women's & Children's Hospital. "We are now able to provide specialty care alongside the nation's No. 2 ranked children's hospital. Creating convenient access to skilled physicians at Cincinnati Children's who are leaders in their fields can make all the difference to a child battling illness."

"Parkview Health and Cincinnati Children's both share a deep commitment to changing the outcome for the children in the communities we serve," said Pramod Reddy, MD, physician leader for clinical affiliations, Cincinnati Children's Hospital Medical Center. "Together, through this collaboration, we will be able to help bring care close to home while being a trusted partner to serve those patients with complex care needs."

"Cardiology, GI and general surgery were identified as top priorities for pediatric specialty care in northeast Indiana, so that is where we began," Miller added. "We hope to expand our collaboration to additional specialties, programs and services in the future to meet the changing needs of patients in our region."

Cincinnati Children's and Parkview Health have been collaborating on pediatric trauma care for several years under the leadership of Richard Falcone, MD, director of trauma services, Cincinnati Children's Hospital Medical Center. This new affiliation builds upon and broadens the relationship between the two health systems.

About Cincinnati Children's Hospital Medical Center

Cincinnati Children's

Cincinnati Children's Hospital Medical Center ranks second in the nation among all Honor Roll hospitals in U.S. News and World Report's 2018-2019 Best Children's Hospitals ranking. In addition, Cincinnati Children's ranks first in the pediatric specialties of cancer and gastroenterology/GI surgery care, and among the top five pediatric hospitals in nine of 10 specialties. In fiscal year 2017, patients came to Cincinnati Children's from all 50 states and 58 countries. Founded in 1883, Cincinnati Children's vision is to be the leader in improving child health, through patient care, research and education.

Parkview Health EMS achieves accreditation as center of excellence

Parkview Health EMS has achieved a prominent distinction in 9-1-1 emergency communications by attaining International Academies of Emergency Dispatch® (IAED™) status as an Accredited Center of Excellence (ACE) for its use of the Medical Priority Dispatch System™ (MPDS®). The MPDS is a comprehensive system of providing care via phone, by a dispatcher, prior to first responders arriving to a scene. When appropriate, this system allows care to be delivered as soon as a 9-1-1 call is made, which may lead to improved outcomes. This distinction places Parkview EMS among the very highest-performing emergency dispatch centers in the world.

"It takes an entire team to achieve this accreditation," said Andrew Hoskins, manager, EMS communications/dispatch, Parkview Health. "I am so proud of the way our team came together to demonstrate our continued focus on putting patients first. The ACE distinction confirms our commitment to timely, high-quality care."

In order to achieve accreditation, dispatch centers must meet or exceed all of the IAED's rigorous Twenty Points of Accreditation, which requires participation from department leadership to individual emergency dispatchers, and pass a thorough on-site review. Areas that must be documented and/or demonstrated include individual certifications, continuous education, call auditing and compliance, response priorities and training to field EMS and other dispatch centers with whom Parkview works.

"There's a tremendous amount of work that goes into achieving ACE status," said Christof C. Chwojka, chair of accreditation, IAED. "We're certainly proud of Parkview EMS and its accomplishment."

There are currently 190 emergency dispatch centers in the world that hold the ACE distinction, among the 3,500 dispatch centers using the fire, police, medical and nurse triage protocols for safe and efficient response to a wide variety of emergency situations.

IAED | International Academies of Emergency Dispatch

Parkview Health named Most Wired® for fifth consecutive year

For the fifth year in a row, Parkview Health has been recognized as one of the College of Healthcare Information Management Executives (CHIME) HealthCare's Most Wired health systems. One of only five in the state, the recognition honors organizations that have established best practices and promote the strategic use of healthcare information technology to elevate care in their communities.

"The bar was raised this year for organizations hoping to be recognized among the Most Wired," said Ron Double, chief information officer, Parkview Health. "So to see that we were still ranked in the 92nd percentile among all participating organizations speaks volumes about the work Parkview's Information Services team has done to create a sustainable IT infrastructure, advance care delivery and implement security measures to protect our electronic assets."

Hospitals and health systems at the forefront of using healthcare IT to improve care delivery have maximized the benefits of foundational technologies and are embracing new technologies that support population management and value-based care. The most successful organizations not only adopt technology but apply it strategically to achieve great outcomes, according to survey results.

"Healthcare IT has the potential to revolutionize care around the world, but to meet that potential it must be used strategically," said Russell Branzell, president and CEO of CHIME. "The technology is important, but leadership and a strategic vision are equally important."

In CHIME's analysis of survey results, two key areas emerged in 2018: the use of foundational technologies such as integration, interoperability, security and disaster recovery; and the use of transformational technologies to support population health management, value-based care, patient engagement and telehealth. These foundational pieces need to be in place for an organization to leverage tools to effectively transform healthcare.

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