

Physicians Bulletin

November/December 2015 • USA \$1.95

Placing an Emphasis on Community:

MOMS 2016 President
David Ingvaldstad, M.D.

Two Takes

On Medical Marijuana

Direct Primary Care:

A New Approach to Patient Care

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History was made in 1866...

- Passage of 14th Amendment (Civil Rights)
- Cincinnati Baseball club (Red Stockings) formed
- Outlaw Jesse James robbed his first bank in Liberty, MO
- First U.S. nickels minted, replacing the half-dime
- Metric system became a legal measurement in U.S.
- First hospital-based ambulance went into service

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Marvin Bitner, M.D.
Editor
Physicians Bulletin

Bring on More Hassles

THIS EDITORIAL IS AN argument why medicine needs more bureaucratic hassles. Let me explain.

This view resulted from a lecture I heard on vaccine hesitancy. The less polite term is “the anti-vaxxers.” Public health scholar Saad Omer built a lecture around an approach that emphasized the three pillars on which contemporary medical practice rests: basic science, clinical research and bureaucratic hassles.

He drew on a seminal paper in psychology by Amos Tversky and Daniel Kahneman. They described the availability heuristic. They argued that if something can be easily recalled, it will influence a person’s thinking. This is recognized in medicine as a cause of diagnostic errors. Sometimes I, as a physician, will encounter a clinical problem, quickly recall a possible diagnostic explanation – yet fail to consider a more obscure diagnosis that may merit consideration.

How does the availability heuristic apply to vaccine hesitancy? As a boy, I was told repeatedly about the girl down the street who had been paralyzed by polio and who required operation after operation. Near my father’s workplace was the dwelling of a man confined to an iron lung. Say “polio vaccine” to me – and I’d recall these tragic stories. How could I hesitate to get polio vaccine? Say “polio vaccine” to someone born in this millennium – and you’d be lucky if he or she had any idea what polio is. On the other hand, they may have heard an anti-vaxxer rail against vaccine side-effects. Result of the availability heuristic in the 21st Century: Say “vaccine” and thoughts of adverse effects spring to mind.

That led to Dr. Omer’s approach to vaccine hesitancy: talk about the disease.

Dr. Omer also took lessons from works in behavioral economics like Richard Thaler and Cass Sunstein’s “Nudge: Improving Decisions about Health, Wealth, and Happiness.” Make it easy for a patient to accept a vaccine. Don’t say: “Let’s discuss the risks, benefits, and alternatives of vaccine.” Say: “You’re due for your vaccine. Let’s give it right now. OK?”

His advice to facilitate vaccination (and not to facilitate refusal) has some immediate lessons for the Nebraska Medical Association. Should the NMA lobby the Legislature to narrow the list of exemptions parents can use to avoid giving their children vaccinations required for school? Dr. Omer cited research that says: “No.” Tightened requirements generate evasive responses, such as home schooling a child to avoid the requirements.

Here’s what’s critical: the mode of administration of exemptions. Don’t make it easy to use an exemption (download a form, sign it, and hand it to the child) but hard to comply with vaccination requirements (multiple visits to health-care providers). That’s why I’ve now come out in favor of more bureaucratic hassles: Does the parent want the child exempted from the vaccine requirement? Require the parent to bring the child to a health-care provider, obtain documentation of the discussion and informed refusal, and—to top things off—require such a documented visit to renew the exemption every year!

Let’s have our NMA lobbyists encourage more and more bureaucratic hassles! ☺

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Debra Essex, M.D.
President
Metro Omaha Medical Society

Thank You for a Great Year

WHERE DID THE LAST two years go? I can remember taking the position of president of MOMS as if it were yesterday. Time is fleeting. It seems the older I get, the faster time goes, but enough of that. I started in January of 2014 trying to figure out how we could increase our membership. What could we do that would attract more members? How could we give back to the community in ways that we haven't done before?

Many committees have taken off over the past several years. The Public Health Committee is strong and working on access issues in our community. The Foundation is very active and looking for interesting ways to collaborate with community partners. Over the past two years, we have funded programs for the Omaha Street School and a program for single parents at Metropolitan Community College. This year will be funding a medical exhibit at the Children's Museum, initially to be featured and then to become part of their permanent collection.

The Women in Medicine group is very busy with many activities that have sparked creativity and the Retired Physicians have been busy with interesting speakers. We had a great Medical Legal Dinner this year with a focus on human trafficking that was very thought-provoking. Who knew we had such issues in the Heartland? We have had two trap shooting events, well-attended and enjoyed by all, and two Habitat for Humanity builds. Our builds will continue in the future as we give back with our hands in ways we have not done in the past. If you have not been able to participate in the past, I encourage you to set this day aside and help MOMS help Habitat for Humanity. Brush up your skills and enjoy your colleagues in a different setting. I am always impressed with the jobs they give up to do. We have installed windows, built garages, wrapped a house and landscaped. There is something

for everyone and you don't have to have any particular skills.

The MOMS Senator breakfasts have been well-attended. This is a great way to get to know not only the senators and candidates for the Unicameral, but also hear about the issues that the Unicameral will be dealing with in the coming year. If you haven't been to one, you should come. The senators and candidates listen to what we have to say and we need to be proactive in legislative issues.

The Young Physicians group has been delving into connecting with other young professionals in Omaha and residents. They held a seminar on debt management and have scheduled a re-match with young lawyers for a trivia contest.

This year we have our Community Internship Program and the Leadership Institute. Everywhere I go, persons who have been involved in the Community Internship Program tell me how this impressed them and how much they learned. "Hats off" to the physicians who year after year volunteer to have our community interns follow them to see what happens in a physician's office.

What I really want to say is "thank you" for making my presidency so enjoyable. We have explored new horizons as well as some very comfortable venues. We have some new favorites and some new ideas for the future. Next year is Metro Omaha Medical Society's 150th anniversary. We started in 1866 as the Omaha Clinical Society and have come a long way. Next year we will have many celebrations to mark the anniversary. We will partner with USA Swimming Foundation to host the "Building Champions for Rio" 5K run in Omaha on July 3. In conjunction with the USA Olympic swim trials, MOMS will co-sponsor this run in celebration of our anniversary. Get out your running shoes, I'll see you there. 🏊

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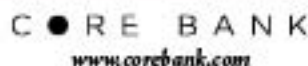
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*Dale Mahiman
Executive Vice President
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Follow Dr. Tom's Example

FOUR SCORE AND SEVEN years ago our fathers brought forth on this continent a new nation, conceived in liberty, and dedicated to the proposition that all men are created equal." This great speech closed with the famous line "and that government of the people, by the people, for the people, shall not perish from the earth." President Abraham Lincoln spoke these words on Nov. 19, 1863.

I refer to this famous speech as we now are in the midst of the campaign season(s) on a national level and just starting out on a local level. The next 12 months will feel like 87 long years listening to all the rhetoric. As Americans, our sincerest hope is that our elected officials remember the phrase "government of the people, by the people and for the people."

Engaging our membership in this process has been a priority for the Nebraska Medical Association for a number of years, and we repeatedly urge physicians to become involved at the local, state and national levels. Our successes have been offset by our disappointments, but all the while we still continue the effort understanding this is a marathon and not a sprint. Sometimes it's difficult and incredibly frustrating, but never forgetting the goal of patient care, it remains our primary focus.

In addition to deciding the 45th president of the United States of America, the 2016 election


will also change the face of the Nebraska Legislature once again due to term limits for 12 senators. While our state elections won't be nearly as entertaining as our national elections, losing the speaker and six committee chairs has become routine with term limits, and opportunities for new senators present themselves more quickly than in the past. As a result, our efforts to learn all we can about the possible replacements becomes more necessary and earlier than in previous years.

As of the date of this writing, we are fortunate to have two Lincoln physicians running for one of the term-limited seats. The one downside to this is they both happen to represent the same legislative district, so short of some Chicago-style elections, only one could be elected. Both of the candidates, Dale Michels, M.D., and Les Spry, M.D., are long-time Lincoln-area physicians and former NMA presidents. Both would be excellent additions to the Legislature, not only for medicine, but also for all Nebraskans. At our annual membership meeting a few years ago, our PAC Chair Todd Hlavaty, M.D., of North Platte, challenged the members present to increase their activism and consider running for a political position. Little did he realize we would have two great physicians running against each other.

On Oct. 6, 2015, the NMA, MOMS and all who knew him, lost a great friend and advocate

with the passing of Tom Tonniges, M.D. More than three years earlier, Dr. Tom spoke with me about his interest and desire to run for the term-limited seat of then State Sen. Pete Pirsch in District 4 in west Omaha. Before he could pursue that goal, Dr. Tom began his fight against ALS. I remain convinced that, if given the chance, he would have ran a spirited campaign and would have served as a great representative for all Nebraskans, old and young alike. Had the team that surrounded him throughout his illness been the same team that would have supported him in office, I remain convinced he would have been a difference maker. Dr. Tom believed that everyone was created equal, and he would have directed us back to a government of the people, by the people and for the people. With his passing, we all lost a great friend and advocate.

Why wait for the next election to "make American great again," let's all work at that every day. Our fellow Americans in President Lincoln's days were in much worse shape than we are today. Let's remember that and take advantage of the opportunities that have been made for us by those that came before us.

"Advocating for Physicians and the Health of all Nebraskans" started with the NMA in 1868, and continues today, but only with an engaged membership committed to make positive change and steer the course ahead of us. 

Maximizing Your 401(k) Plan Design's Deferral Opportunity



*Adam Cockrell
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EACH YEAR, MANY RETIREMENT plan sponsors are required to issue refunds to highly compensated participants due to a failure of the IRS nondiscrimination testing rules applicable to 401(k) retirement plans. If this is happening with your plan and you and your partners would like to see if additional deferrals are possible, now is the time to take a look at plan design options.

The IRS plan qualification rules currently require all prototype and volume submitter plans to be amended and restated no later than April 30, 2016. This upcoming April 30, 2016, deadline for the amendment and restatement of prototype and volume submitter plans provides not only the opportunity for plan sponsors to update their plans in accordance with legal requirements, but also to consider possible changes to their plan's design provisions. The following sets forth some plan design considerations aimed towards maximization of deferrals by highly-compensated employees for plan sponsors as they finalize the amendment and restatement process.

Automatic Enrollment and Escalation: Automatic enrollment is becoming a popular trend in the 401(k) industry. Through automatic enrollment, new or current plan participants may be treated as having enrolled at an established contribution percentage. The participant must be provided a notice describing the terms of the automatic enrollment feature and offered the option to change the automatic enrollment percentage or elect no contribution at all. If the automatic enrollment feature is designed to be an "Eligible Automatic Contribution Arrangement," participants may be offered the option to withdraw the amounts automatically

deferred from their pay within the first 90 days after the date of the first contribution. In addition, a plan may include a "Qualified Automatic Contribution Arrangement" or "QACA" and, in doing so, avoid the 401(k) nondiscrimination testing provided certain requirements are met. This form of automatic enrollment requires an initial 3% automatic deferral rate, and automatic escalation of the default rate for each of the following three years.

Traditional Safe-Harbor Plans: Another trend in the retirement plan world is the continued growth in popularity of safe-harbor 401(k) plans. Safe-harbor 401(k) plans offer employers a free pass on the nondiscrimination requirements. This simply means that business owners and highly compensated employees can contribute up to the maximum contribution dollar limit (\$18,000 for 2015 and \$24,000 for participants over age 50 under a plan's "catch-up" provision) without the threat of having the amount of contribution limited to a lesser amount or returned to them. The trade-off is that eligible non-highly compensated employees must receive either a fully vested employer contribution of 3 percent of their compensation or a fully vested matching contribution not less than 100% of the first 3 percent they contribute plus 50 percent of the next 2 percent they contribute. Safe-harbor plans are very popular and any employer that has problems with the non-discrimination tests should seriously consider a safe-harbor 401(k) plan design.

Cross-Tested Safe-Harbor Plans: A twist to the traditional safe-harbor plan discussed

above is the concept of a cross-tested safe-harbor profit sharing plan. This plan design permits an employer to contribute a much higher percentage of plan contributions to owners and other highly compensated employees than what is normally allowed by adding a cross-tested profit-sharing feature to a traditional safe-harbor plan design. This strategy requires a traditional safe-harbor contribution be provided to all eligible employees of the organization (as described above) and then allows for a more generous ratio of profit sharing contributions to be made to highly compensated employees versus non-highly compensated employees (up to the IRS annual contribution limits of the lesser of 25 percent of compensation or \$53,000 for 2015). These ratios can be based on numerous factors such as age, compensation, service, etc. These cross-tested safe-harbor profit sharing plans are gaining popularity in professional practice groups as they allow owners to maximize their deferral contributions and avoid the IRS nondiscrimination testing rules that often times require refunds be issued to such highly-compensated employee and owner groups.

These considerations may not work for every plan and are not intended to be an exhaustive list of changes a plan sponsor may consider during this amendment and restatement process but rather are a list of items a plan sponsor may wish to consider if concerns are growing about the ability of highly-compensated employees and owners to maximize deferral amounts on an annual basis. If you are interested in exploring these concepts further, you should seek input from your legal and tax advisors. [i](#)

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Can You Practice Medicine and Manage a Practice?



Tara Wisdom
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WHETHER YOU PRACTICE ALONE, or in a group, seeing patients and billing for those visits isn't a guarantee for success. You also need to manage continuous improvement in scheduling, operational efficiency and the revenue cycle to assure profitability and sustain your practice.

When we see patients day-to-day, we take for granted the availability of staff in place. Money coming in the door. Bills being paid. So, in order to stay on top of business management responsibilities that allow you to see patients every day in an efficient manner, make sure you take the time and have a good understanding of each of these critical areas for managing your practice.

Staff: Assuming you have the right staff performing the right jobs and they are here to stay, you still need to ensure productivity and morale remains high. This means appropriate scheduling and payroll and benefits management. Payroll and benefits must be monitored and adjusted as needed. It is also imperative to show your employees in detail the cost of their salaries and all benefits paid by the practice at least yearly during an annual review.

Communication: Make sure to create a continuous communication cycle. Due to the fast pace of a physician's office, formal communication between doctors, management and staff often is neglected or postponed. Animosity can develop between management and staff because of inaccurate assumptions.

Management must take ownership of this responsibility and strive to communicate with staff. Key issues such as turnover, additional hiring of personnel to support practice functions, and new processes needing implementation should be communicated timely. Staff meetings with specific agenda items and formal memos documenting new policies and decisions seem to work well for physician offices.

Managing Accounts Receivable (AR): The nature of health care is serve now, reimburse later. This means we need to be diligent in verifying we have all the appropriate information necessary to submit an insurance claim correctly in order to get paid at expected rates within two weeks. Managing the process of data collection from patients, verification of information, correctly transmitting data to payers, and monitoring the results can mean the difference between putting money in the bank or operating a bleeding clinic.

Normal accounts receivable for a full-time family physician should average approximately 100 percent to 120 percent of monthly charges, with half of this amount being under 30 to 40 days old. Practices with a 500 percent ratio of AR to charges, the majority represent accounts one to five years old where staff never adjusted off bad debts. In that situation the AR metric is not useful. High AR rates can also be a symptom of delayed claim submission, dirty claims, excessive fee schedules and a host of other issues that require investigating. Make sure the front desk

is doing a good job collecting money at time of patient check out. If you collect it, it doesn't become a receivable.

Expenses: Many practices already monitor expenses on a global basis, but expenses should be tracked by category as well. By quickly identifying a surge in medical supply costs you identify the impact of unneeded vaccine expenses. This approach can also help to detect an embezzlement scheme where an employee sets up a phantom supply company and issues checks to himself or herself. Reviewing the financials and invoices when signing checks takes just 15 to 20 minutes a month and will lead to a financially healthier practice. When you find outlier data, follow through on diagnosis and treatment of the problem until it is validated or corrected.

Customer Service: The most important management responsibility is customer service. The patients' satisfaction with their ability to get an appointment, to be seen in a timely manner, to be treated by staff respectfully and with appreciation, to be billed fairly and in a timely manner, and, of course, to have their need for the appointments fulfilled, is really what management is all about. 📞



Christina J. Insinger
Insurance and Investment Specialist
Renaissance Financial Corporation

Risk Management- and Its Many Forms

WHAT IS RISK MANAGEMENT? By the Webster Dictionary definition, it is a two-step process: the first determining what risk exists, and the second determining the best way to handle these risks in the most efficient way possible to meet your objective. Proper risk management implies control of possible future events, and it is being proactive rather than reactive. Determining the probability of an event and how it might impact you.

Risk management occurs in everyone's life in some form or another. Identifying for yourself what areas of risk you have to manage usually involves needing assistance from an individual who specializes in that particular area. From a very young age, we are all exposed to risks. Determining how to manage these risks may have been decided by advice from parents, family members and friends. We find that many physicians do not realize all their risks and do not have the time to manage the risks they are exposed to. Patients come to physicians to assist in managing their medical risks. Providing excellent clinical care, good record keeping, and developing a good relationship with the patient may reduce potential risks that could lead to a lawsuit. Training and educating your staff will also contribute to reducing any malpractice risk.

There are other personal liability risks besides dealing with a malpractice claim. Evaluating the risk of not having proper coverage to protect you and your family (should it be determined that you are at fault for injuries caused by an auto accident or someone being injured while


on your property) is something that we do not always identify. Sometimes we are too trusting thinking that no one will sue even if they are injured because there was no intent to cause harm. Making the decision to protect yourself and your family with liability coverage is managing this risk with the help of the insurance company. One overlooked area is when a family has a young driver. Increasing your coverage through a personal liability umbrella is highly recommended.

In the past, managing our health risk was really left up to the type of health insurance coverage that was provided by our employer or purchased personally through an individual policy. Today, everyone is having to manage his or her own health insurance risk. To decide to have health insurance or not. The amount of deductible depends on how much a person can self-insure in case medical care is needed. It has become more of a choice to manage this risk with the help of the insurance company than it was in the past.

One of the biggest risks to manage is regarding disability insurance. First, most assume their employer is going to have the best quality plan for you, and you do not need any additional coverage. Often physicians do not realize the gap in coverage they have by only having group insurance, which is taxable. Reviewing the group plan regarding language of the contract is also very important to know the risk of having only group coverage and whether to supplement your coverage with an individual plan. Having coverage that bridges the gap with an individual

policy is very important. Being advised as to what carrier provides the best coverage should be sought through a trusted adviser who has the expertise in this area.

One thing we all know is that we will die someday. Knowing when this will occur, when the right time to buy life insurance, and the amount to protect your family, can be considered unknown risks. We are all "risks" to an insurance company. Depending on your health, you will be classified in a certain rating classification. Life insurance companies have different risk classifications to help manage their risks with providing coverage. Choosing to only have group life insurance is a risk you would be assuming by thinking you will always be employed by the same employer, and that the coverage amount is sufficient for your individual needs. Converting from group is very expensive and sometimes does not provide the best coverage, but some people may not have a choice. So it would be recommended to make sure and take the coverage through the employer if you cannot purchase life insurance personally. Purchasing life insurance personally will allow portability of your plan should you change employers, retire, or become disabled.

In summary, risk management comes in many forms and occurs daily in our lives. It sometimes takes one of the above situations to occur in order for us to realize the risks we are exposed to on a daily basis. Hopefully this isn't the case and you are able to evaluate the risks associated with your field, and address these risks with the help of a knowledgeable, trusted adviser. 



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MOMS Foundation Annual Match Program



Omaha Children's Museum 40th Anniversary ImagiNation Exhibit - Hospital/Medical Clinic



Photos from a similar previous exhibit

Each year the Metro Omaha Medical Society Foundation selects a local non-profit and asks members to join in supporting that cause. The MOMS Foundation matches the first \$5,000 in donations and our overall goal is to raise a total of \$15,000 to create a hospital/medical display as part of the Omaha Children's Museum's 40th Anniversary ImagiNation exhibit.

The ImagiNation exhibit will feature an interactive, hands-on medical section that is developed with the input of physician members of the Metro Omaha Medical Society. It will be part of a larger show that will highlight popular exhibits throughout the 40 year history of the Omaha Children's Museum. The contribution of the Metro Omaha Medical Society Foundation and its physicians will be added as part of the museum's permanent collection. This is also a great opportunity to tie into the Metro Omaha Medical Society's 150th Anniversary and highlight how medicine has evolved over the years by showing what medical equipment has evolved over the years.

This exhibit is expected to be visited by 150,000 people throughout the duration of the exhibit from October 2016 to April 2017.

Dear MOMS Member,

We are excited to partner with Metro Omaha Medical Society to create an exhibit piece that is hands-on, engaging and of course, fun. Partnerships with organizations such as yours allow children to role play as a doctor, nurse, or patient which then can spark a conversation between children and families about a possible future career in the medical field. Role-playing also helps children gain a better understanding of what they can expect when they visit their own physician's office.

*Thank you for your support,
Michelle Chartrand
Omaha Children's Museum
Director of Advancement*



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The Metro Omaha Medical Society Foundation is a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. All contributions are 100% Tax-Deductible.

Please make your contribution by January 22, 2016.

A check will be presented at the MOMS Annual Meeting & Inaugural Dinner January 28, 2016.

**Also seeking volunteers
to help plan the exhibit**

*If you are interested in volunteering,
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Medical Society at 402-393-1415 or
email laura@omahamedical.com*

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Each issue also features human interest pieces, including architect/designer/builder profiles, hot products, maintenance columns, room spotlights, landscaping columns, neighborhood profiles, home transformations, home happenings, mortgage columns, new business stories, green design features, and much, much more.

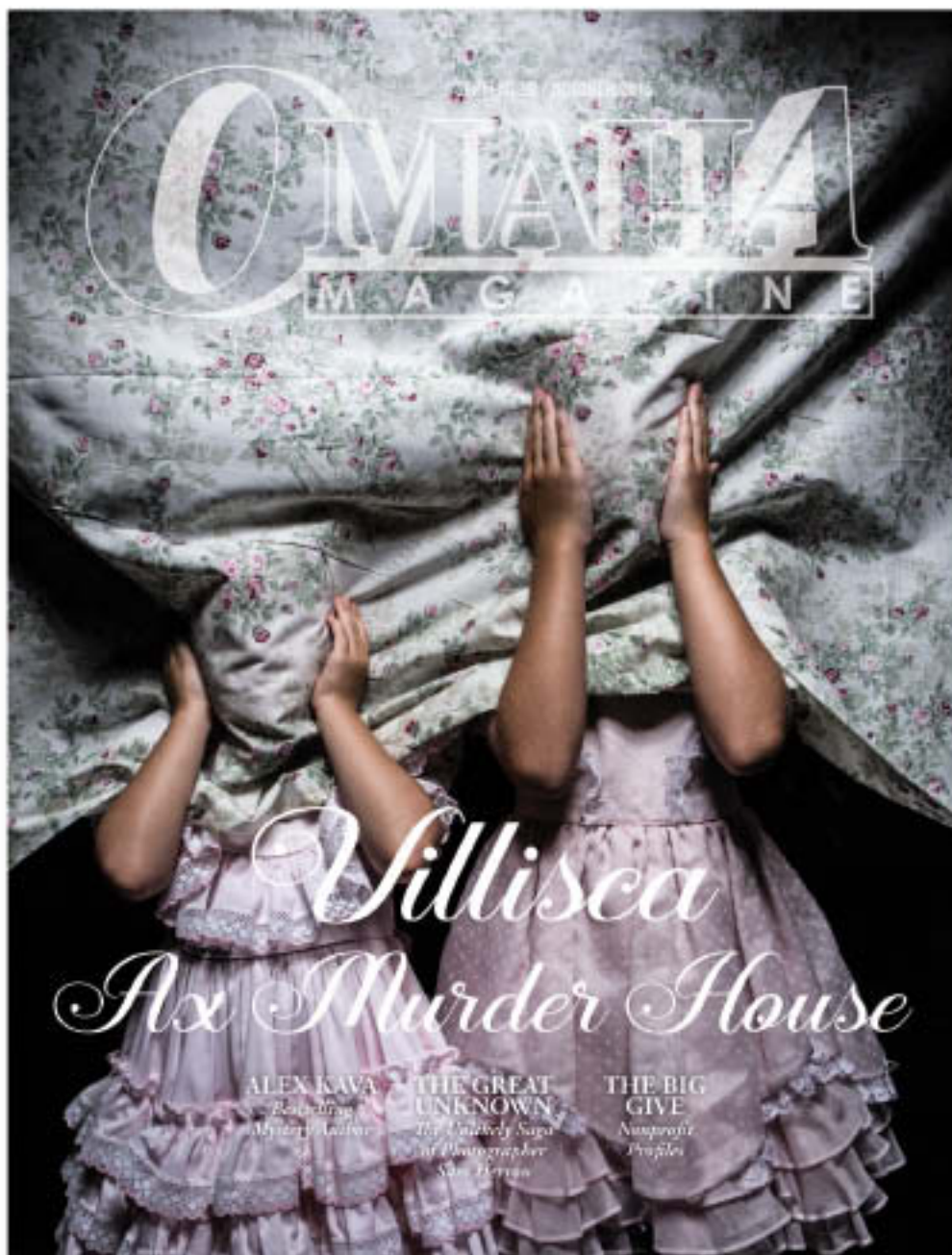


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POINT / COUNTERPOINT:

LEGISLATIVE BILL 643 – the Cannabis Compassion and Care Act – remains alive in the Nebraska Legislature. Introduced earlier this year by State Sen. Tommy Garrett of Bellevue and carried over to the 2016 session, the legislation would make medical marijuana legal in Nebraska. Thirteen state senators have added their names to the bill, which models legislation enacted in Minnesota. The Physicians Bulletin asked two MOMS members with opposing viewpoints – John Massey, M.D., and Ed Truemper, M.D. – to give us their perspective on the issue.



The Massey File

Hometown:
Lincoln

Bachelor's Degree:
University of Nebraska-
Lincoln in Chemistry

Medical Degree:
University of Nebraska
School of Medicine

Residency:
UNMC in anesthesiology

Specialty:
Interventional pain medicine

Group:
Nebraska Spine and Pain Center

Family:
Wife, Julie; daughters, Katie
and Libby; son, Ben

Hobbies:
Making pizzas in his
backyard pizza oven

Why I Joined MOMS:
"I believe in medicine
and getting involved."

Dr. Massey:

Why are you against the use of medical marijuana in Nebraska?

My reason for this is we have a lot of trouble with medications of abuse that have known therapeutic benefits and still have a difficult time knowing how to prescribe appropriately rather than inappropriately. With medical marijuana, there is no good proof of therapeutic benefit, so we are worried that it will add to the prescription drug abuse problem.

What caused you to take this stance?

In my work in pain medicine, I am running into people who are trying to get benefits from prescription drugs and they are finding themselves being harmed from those medicines without knowing it. I worry that medical marijuana has the high potential to be the next problem drug in our field.

What stands out among the studies you have reviewed regarding medical marijuana and its use?

Something that stood out to me in Colorado, where marijuana has been legalized, greater than 50 percent of the traffic accidents in the state occur where one individual or more has THC in their blood system. That indicates we are seeing negative consequences from the use of marijuana.

What would you say to the parent who wants to alleviate his (or her) child's suffering through medical marijuana?

I would say one of two things: If it's for seizures, there are approved outlets and studies where that kind of research is going on – and that might be available. But if it was for another reason – such as alleviating pain or anxiety, or headaches or nausea – I would be strongly opposed because young adolescent brains exposed to substances that alter the chemistry of their brains may have long-term effects that we don't understand.

Do some people who support the use of medical marijuana actually have an ulterior motive for this support?

You always hear of people who are highly interested in recreation marijuana because they like how it makes them feel and they are looking for a medical reason to take it. To me, medical marijuana is seen as a solution. They want to use it and they are searching for a legitimate reason to do so. They're just trying to justify it so that they can utilize it. It's just not medical. It's like a hammer in search of a nail. Take medicine out of it. With the possible exception of pediatric seizures, it doesn't have a good role as an actual medical treatment.

Is this more than a medical issue?

Absolutely. I think it is well understood by most clinicians that talking about medical marijuana is allowing the camel's nose under the tent. So people who are actually for recreational marijuana pretend to be for medical marijuana to get recreational use approved as well.

What would cause you to change your stance?

There is a very small percentage of medical marijuana that might be useful for some types of refractory seizures. If research shows that medical marijuana is useful with those very challenging seizures, that would change my opinion. We're talking about a very unique strain of marijuana, which has a different level of THC. It is not the kind of marijuana that would get a person high.

Is more – and what kind of – research needed?

Actual medications need to go through the FDA's very rigorous process, and proponents of medical marijuana are citing very poor studies that show a benefit, much like herbal medicines or nutrition-store "infomercials." If we are going to treat medical marijuana as a drug, it would need to go through that same kind of rigorous process or it would circumvent the safety that the FDA provides patients in the United States.

Do you see any benefits if Nebraska were to allow its use?

I believe that the negative effects would far outweigh the benefits.

Two Takes On Medical Marijuana

Dr. Truemper:

Why do you support the use of medical marijuana in Nebraska?

I support the initiation of programs of medical marijuana in Nebraska for two reasons. The first is that our patients and their families are demanding it. There are many anecdotal examples of symptom relief – symptoms that are life-limiting. The second is the federal government has spent decades inhibiting research into both marijuana and its bioactive compounds, and that has inhibited us from understanding the true potential of this valuable and readily available agent.

How did you come to this decision?

I have been following the medical marijuana issue for a long time. The University of Mississippi and DEA operates the only actually legal cannabis-growing facility in the U.S. When I was in college, I understood they were studying the plant. Over the years, it became increasingly apparent to me that they were more concerned about the abuse potential than the medical potential. As it happens, citizens don't always wait for our government to figure out if something can help them or not. So many of our patients have been to the point where they aren't getting success from their current medical regimen and they are reaching out for something that can get them relief. With social media, people are able to research alternative therapies.

Is there a research study on which you are basing your support?

I am basing it on a number of sources. First, there is increasingly large volume of anecdotal reports on its utility in a large variety of neurologic conditions. Second, there are two drugs derived from marijuana constituents that are approved by the FDA. So we went from a plant that had no therapeutic benefit to now two by-products that have therapeutic benefit. Third, there are a number of other derivatives in front of the FDA for approval that have been found to have therapeutic benefit. Fourth, if we don't regulate and monitor the medical use of marijuana, our patients are going to use it anyway. The medical community will largely be left out of the discussion. Last,

20-plus states have already approved marijuana for medicinal use with variable success. Let's learn from their successes.

Is this more than a medical issue?

It's always been more than a medical issue; the government made it more. It's been a political issue since the 1930s when – I'll call it the 'Hemp Act of 1937' – largely banned hemp production in the United States. It was heavily regulated by the Department of Treasury. It's a Class 1 Agent under the DEA, which means it has no therapeutic potential. It is put in the same league as heroin and cocaine with almost no benefit research being performed. Since 1999, only 11 NIH studies have been funded – and they're investigating abuse potential.


Is there a negative outcome if Nebraska were to approve its medical use?

As with any medicinal agent with hallucinogenic or addictive potential, there is the risk for abuse. We already have serious problems with other prescribed agents, such as opiates. Physicians must have an unfettered dialogue with patients who use marijuana for therapeutic benefit and seek to ensure that the patients are getting relief and not endangering themselves.

What are the consequences if we don't approve its medical use in Nebraska?

We're going to have hundreds, if not thousands, of people in Nebraska who are going to be using the products for self-medication. They're going to get marijuana from illegal sources. It will not be regulated. The money funnels through criminal enterprises. We will not be creating a dialog between patients and their caregivers.

How would the use of medical marijuana affect the way physicians treat their patients?

It would open dialog to discuss why patients feel they need such as product. Also, it would enable physicians to look at what the potential therapeutic benefits might be. I see the potential to improve our ability to understand the medical conditions and actually come up with a better alternative to marijuana. 



The Truemper File

Hometown:
Omaha

Undergraduate Degree:
University of Mississippi
in biology

Master's Degree:
University of Mississippi
in microbiology

Medical Degree:
University of Mississippi
School of Medicine

Residency:
Oklahoma Children's Hospital
in Oklahoma City in pediatrics

Fellowship:
Texas Children's Hospital
in Houston in pediatric
critical care medicine

Specialty:
Pediatric critical care medicine

Hobbies:
Gardening, writing
and photography

Why I Joined MOMS:
"I joined for the professional
associations and to aid the
health and welfare of the
people of Nebraska."



Direct Primary Care: A New Approach to Patient Care

THREE-HUNDRED FORTY-EIGHT PATIENTS and counting.

Joseph Sheppard, D.O., has his eye on 600 patients – his goal for his year-old clinic in Neosho, Missouri, where he provides direct primary care. “When I came to this area to practice medicine,” he said, “no one had heard of this type of care.”

Now some do, he said, but his work to grow his business continues.

Dr. Sheppard and Josh Umbehr, M.D., who has provided direct primary care for his patients in Wichita, Kansas, for the past five years, discussed the opportunities and challenges they have faced while introducing this type of health care to their communities. This discussion was prompted by State Sen. Merv Riepe’s plan to introduce legislation that would enable contracting for direct primary care in Nebraska.

“Fee-for-service health care in Nebraska is just not working,” Riepe said. “We need creative solutions to allow value-based health care for Nebraskans.”

Direct primary care practices offer patients with comprehensive primary services, including regular checkups, in exchange for a flat, recurring monthly fee. Patients still need catastrophic health care coverage for such things as hospitalization and surgeries.

Riepe said allowing physicians to provide direct primary care in Nebraska may keep them practicing longer. He noted that physicians practicing direct primary care would have no insurance and billing work, which results in lower overhead. “Physicians who might otherwise walk away from their professional careers due to the existing requirements of the ACA, ICD-10s and piles of insurance papers may now find new satisfaction and extend their practice for a number of years.”

Drs. Sheppard and Umbehr explained how their clinics operate, including what they charge their patients. Dr. Umbehr said his clinic charges \$10 per month for patients 0 to 18, \$50 for those 20-44, \$75 for those 45 to 64 and \$100 for anyone 65 and older. Discounts are available to groups of five or more. Dr. Sheppard charges \$60 monthly for adult patients and \$25 for those 18 and under. Medications are sold at wholesale prices; billing for laboratory test typically are under \$5. For example, Dr. Sheppard said, he charges \$3.85 for an A1C.

First the opportunities: Dr. Umbehr said he sought a new business model five years ago when he finished his residency. Five years later, his practice – Atlas M.D. – has four physicians and is soon to add a fifth. Because physicians who provide direct primary care don't have to bill insurance companies, they need less assistance. Dr. Umbehr's clinic employs two nurses – who provide care and administrative support.

With reduced administrative requirements, Dr. Sheppard said, he can schedule an hour for each initial clinic visit and 30 minutes for follow-up visits. Dr. Umbehr said he and his partners conduct home visits and provide their patients with their cell phone numbers. Dr. Sheppard said he doesn't guarantee home visits so he can guarantee same-day visits and on-time visits.

This approach to care, they said, allows them to provide personalized care that doesn't feel rushed and doesn't involve them spending more time inputting data than talking with their patients.

"You are creating a true medical note," Dr. Sheppard said.

Financially, providing direct primary care can be financial rewarding, Dr. Umbehr said. Physicians who join his clinic can expect to earn \$200,000 annually, he said. Dr. Sheppard said his clinic revenue the past several months has averaged about \$18,000, with his take-home about \$10,000.

Now, the challenges: People often are skeptical

when introduced to something new, Drs. Umbehr and Sheppard said. Dr. Umbehr said he took the approach: Patients may not fully understand the benefits of direct primary care until they receive it. Dr. Sheppard said he knew he would need to spend time educating Neosho residents about direct primary care to be successful.

"You have to work harder and do things doctors traditional don't do – going to business fairs. This is me running a business."

Dr. Sheppard said he moonlighted during his first year running his clinic to begin paying off his medical school debt. He said he earned about \$40,000 his first year. "It's like any start-up. It's high-risk. A lot of doctors who have tried, failed. You have to have a bit of an entrepreneurial spirit and you can make this work."

While less staff is required in a direct primary care clinic, hiring a nurse who is willing to handle other responsibilities, including administrative, is critical, Dr. Sheppard said.

To learn more about Dr. Umbehr's clinic, visit <http://atlas.md/wichita>; Dr. Sheppard's clinic, visit www.freemarketphysician.com

"PATIENTS MAY NOT FULLY UNDERSTAND THE BENEFITS OF DIRECT PRIMARY CARE UNTIL THEY RECEIVE IT. DR. SHEPPARD SAID HE KNEW HE WOULD NEED TO SPEND TIME EDUCATING... RESIDENTS ABOUT DIRECT PRIMARY CARE TO BE SUCCESSFUL."



Dr. Joseph Sheppard, D.O.



Dr. Josh Umbehr, M.D.



Collaborating to Address Continuance of Care

Communication Gap

DEB TOMEK, M.D., HAD heard these questions before.

As medical director of Children's Physicians, Dr. Tomek said, her colleagues and families often ask her for referral advice: Does she know a specialist who takes referrals of older children? To whom would she send her pediatric patient to in this situation or that?

Basically, Dr. Tomek said, pediatricians often aren't sure to whom they should refer their patients as they began the transition to adult care. The challenge becomes more noticeable with teen patients with adult diseases who need to see a specialist, she added.

Just as Dr. Tomek found herself in this communication gap that existed in continuance of care, so did fellow pediatricians Tina Scott-Mordhorst, M.D., and Cristina Fernandez, M.D. The three physicians, members of the MOMS' Public Health Committee, brought forth their concerns for discussion resulting in a plan to address the issue.

"It's the perfect type of issue for MOMS to tackle," said Carol Wang, MOMS executive director. "By addressing this concern brought forth by physicians, we can provide them with resources and, ultimately, better care for their patients."

"It's one of the reasons I joined MOMS," Dr. Tomek added, "to improve the health of our community and to make a difference in it."

Dr. Tomek said several committee members asked why pediatricians weren't sure where to refer their patients. Dr. Tomek explained that physicians no longer "mingle" with their peers where they practice as much as they once did. Participation in interdisciplinary committees and activities by outpatient physicians does not occur at health institutions as before, she said.

"These activities promoted collaboration," she said. Instead, she said, health care has become more segregated – call it the "silo" effect – among disciplines and specialties.

Public Health Committee members decided the best way to find out what specialists are accepting younger patients – and at what age – was to ask them.

Whitney Clausen, MOMS special projects coordinator, said the committee created a survey, which was sent via email to specialists throughout the Omaha area. MOMS also reached out to clinic managers and asked them to disseminate the survey. The survey asked respondents whether they were accepting new patients and, if so, at what age.

The survey drew 88 responses from physicians representing the following seven specialties: cardiology, endocrinology, gastroenterology, internal medicine, neurology, pulmonology and rheumatology. Among the respondents, 82 physicians indicated they were taking new patients. Clausen, who said she expects the list to grow, shared some of the results:

- Within each of the seven specialties represented by survey responses, at least one or more specialists were identified as currently accepting patients under the age of 19


- Fifty-five of the responding specialists stated they accept patients under the age of 18, some as young as 14, with others even younger on a case-by-case basis

- Nine neurologists returned their surveys. One participant will see patients, based on age, on a case-by-case basis, but will see patients as young as 5 years old; another would see 11-year-olds suffering from headaches. Two would see 12-year-olds suffering from headaches, otherwise age 16 for all other cases. Four begin seeing patients at age 16, and another at age 19.

- Of the 19 pulmonologists who responded, eight indicated they would see patients beginning at age 14; four others would begin seeing patients at age 16; and seven others would see patients at age 18.

Clausen said MOMS will make the results available city-wide and Public Health Committee members are exploring how to regularly update the results.

Members of the Public Health Committee see great potential in this survey and in the possibilities ahead.

Said David Filipi, M.D., committee chairman: "We want to bring pediatricians and other physicians together so they can develop relationships and protocols for transitioning care from one to the other. Forging relationships and opening doors of communication among doctors – that's what MOMS is all about." 



The Tomek File

Birthplace:

Council Bluffs, Iowa

Bachelor's Degree:

University of Iowa in engineering

Medical Degree:

University of Nebraska
School of Medicine

Residency:

Gelinger Medical Center
in Danville, Pennsylvania,
in general pediatrics

Fellowship:

University of Nebraska
Medical Center in general
academic pediatrics

Specialty:

General pediatrics

Position:

Medical director, Children's
Physicians; and medical adviser,
Building Healthy Futures

Family:

Spouse, Chuck Tomek, M.D.,
and four children

Hobbies:

Cycling and singing, and
watching baseball

Why I Joined MOMS:

"I wanted to join a group of
physicians who wanted to make
a difference in our community."

CONTINUANCE OF CARE PHYSICIAN NETWORKING EVENT

Tuesday, Jan. 19

6:00 – 7:30 PM

MidTown Crossing Club Room, 9th floor

Physician members and non-members alike are invited to a networking event hosted in an effort to bring local primary care and specialists together for the purpose of strengthening their referral networks.

Hors d'oeuvres and beverages will be provided.

Please RSVP to Whitney Clausen at
wclausen@omahamedical.com or call (402) 393-1415.



David Ingvaldsen, M.D. and wife Ashley Ingvaldsen, M.D. with their children.

Placing an Emphasis on Community:

MOMS 2016 President David Ingvaldstad, M.D.

DON'T BE SURPRISED WHEN David Ingvaldstad, M.D., repeatedly talks about the importance of physicians becoming more involved in their community during his term as MOMS president.

Dr. Ingvaldstad said he hopes to build on the emphasis placed on physician advocacy by his predecessor, Debra Esser, M.D. He cited the involvement MOMS physicians have had with the Omaha Street School and Habitat for Humanity. Those projects will continue, he said, which others – that have a vent toward health and fitness – will be added.

"On a grand scale, this is how medicine is shifting – preventative care," he said. "How can we as physicians be more involved in our community?"

Physician advocacy, Dr. Ingvaldstad said, can mean testifying in the Legislature when health-related issues such as motorcycle helmets, smoking and childhood obesity are before lawmakers. And it can mean promoting programs that impact society, he added.

Dr. Ingvaldstad recently discussed what sparked his interest in medicine and involvement in MOMS, and provided a glimpse of what he expects during his term as MOMS president.

His involvement in MOMS: As a new physician in Omaha, Dr. Ingvaldstad saw his peers – those whom he considered to be his mentors – get involved in their medical societies. "I wanted to emulate what they did." His first experience came when he served as a board member for the Nebraska Academy of Eye Physicians and Surgeons and later as its president. The experience was rewarding as the academy became involved with scope of practice issues with state

government. He credits former MOMS president, Peter Whitted, M.D., for encouraging his involvement in MOMS. "It's our duty to be concerned about and advocate for the health of our community."

His interest in medicine: Credit his father, James Ingvaldstad, M.D., an obstetrician and gynecologist.

He remembers, as a child, his father picking him up from sports practice and taking him along when he went on rounds. "I'd sit at the nurses' station and talk with the nurses." He also noticed his father's dedication to his profession and his patients. But his father didn't stop there – he volunteered in his community

and was involved in his church. I saw dedication to his practice and community as a whole."

His interests outside medicine: He runs. He plays the cello. Both interests started when he was young

continued on page 30 ▶

"IT'S OUR DUTY TO BE CONCERNED ABOUT AND ADVOCATE FOR OUR HEALTH COMMUNITY."



The Ingvaldstad File

Hometown:

Sioux Falls, South Dakota

Bachelor's Degree:

University of New Hampshire in ecology and evolutionary biology

Medical Degree:

Medical College of Georgia

Residency:

University of Missouri-Kansas City in ophthalmology

Fellowship:

University of Nebraska College of Medicine in vitreoretinal disease and surgery

Specialty:

Medical and surgical treatment of the vitreous and retina, diabetic eye disease, and cataracts

Location:

Midwest Eye Care

Family:

Wife, Ashley (a psychiatrist); son and two daughters

Hobbies:

Running and playing the cello

Why I Joined MOMS:

"I joined MOMS as an outlet to allow me to advocate for patients and my profession – something outside of day-to-day practice."



◀ continued from page 29

Dr. Ingvaldstad recently rekindled his love of playing the cello and hopes to pass the torch onto his son.

and both were temporarily shelved when his medical studies, starting a family and building a practice had his attention. Only recently, he said, did he return to those passions. He ran cross-country and track in high school and was on his college crew team for two years. Then, he decided to run marathons and qualified for – and ran in – the Boston Marathon in the mid-1990s. Twenty years later, he's back running with a passion and recently ran a marathon in Duluth, Minnesota, where his time was 1:49 under the qualifying time for the Boston Marathon. His time, although under the qualifying mark, still fell just short to earn him entry into the race. He first played the violin and an elementary school student

but switched to the cello – playing into college. He recently began taking lessons with the hopes of playing for a community orchestra someday. For now, he just wants to hold his own with his son, Jackson, who recently began taking violin lessons. "If I am going to help him, I need to make sure I can still play."

Both pursuits, he said, help him follow a former professor's advice to leave his work behind at the end of the day and focus on life away from medicine. Running and playing his cello help him do just that, he said.

"You really can't focus on anything else when you're playing the cello." 🎻

What's in a Name? INGVOLDSTAD

First, it's Norwegian. His great-great-grandfather, Peter Olson, immigrated to the United States from Norway in the mid-1860s and eventually settled in Decorah, Iowa. He discovered the community already had another Peter Olson and he was always getting his namesake's mail. So he changed his last name to Involdstad, the name of his farm in Norway. His name, Dr. Ingvaldstad said, often is mispronounced. For the record, it's Ing (rhymes with "ring")-vold (rhymes with "gold")-stad (rhymes with "dad").

The last syllable, he said, is most often mispronounced to rhyme with "mod," most likely the more traditional Norwegian pronunciation. "Some people just call me 'Dr. I,'" he said, "which is appropriate because of what I do."



CPT CODING SEMINAR

THURSDAY, DEC. 17, 2016

12:30 - 4:30 PM

ITT TECHNICAL INSTITUTE

Information and registration forms available
online at www.omahamedical.com

NETWORKING EVENT:

TUESDAY, JANUARY 19, 2016

6:00 - 7:30 PM

MIDTOWN CROSSING CLUB ROOM

This event is designed to allow physicians to
interact and expand their referral networks.

MOMS ANNUAL MEETING

THURSDAY, JAN. 28, 2016

HAPPY HOLLOW COUNTRY CLUB

Join us as we celebrate the 150th Anniversary
of the Metro Omaha Medical Society
and inaugurate 2016 President David
Ingvoldstad, M.D. Mark your calendar
and watch for more information.

**EARLY CAREER PHYSICIANS
& YOUNG ATTORNEYS
TRIVIA NIGHT**

THURSDAY, FEBRUARY 11, 2016

6:00 - 7:30 PM

MIDTOWN CROSSING CLUB ROOM

Join your peers and pit your wits against
members of the Omaha Bar Association
Young Attorneys Group. Battle to see
who has the upperhand in all matters of
trivia. Food and beverage provided.

MEDICAL LEGAL DINNER

TUESDAY, MARCH 15, 2016

OMAHA MARRIOTT REGENCY

Join your peers and members of the Omaha
Bar Association for dinner with a featured
speaker from the Douglas County Crime
Scene Investigation Division (CSI).

*Call (402) 393-1415 or email
Laura@OmahaMedical.com for
more information or to RSVP
for any of these events.*

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WOMEN IN MEDICINE

THE MOMS WOMEN IN Medicine group attended a lecture with author and Pulitzer Prize winner Sheri Fink, M.D., at the Joslyn Art Museum in late September. Dr. Fink wrote "Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital" – a New York Times bestseller and winner of the National Book Critics Circle Award for nonfiction, the Ridenhour Book Prize, the J. Anthony Lukas Book Prize and the Los Angeles Times Book Prize.

The event was hosted in partnership with the Creighton University Center for Health Policy and Ethics.

Among those attending the VIP Reception and book signing were, from left, Drs. Lindsay Northam, Peggy Tomes (guest of Dr. Prestridge), Laurel Prestridge, author Sheri Fink, Emily Kean, Jane Bailey, Lanette Guthmann and Jill Reel. 



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**Melissa Darling, MD**

Medical Degree:
University of Texas Medical School Houston

Residency:
Texas Tech University Health Science Center

Specialty:
Dermatology

Fellowship in Dermatopathology:
University of Virginia

Office:
Midwest Dermatology Clinic, PC

MELISSA DIAMANTIS DARLING, M.D., was born and raised in Omaha. Although she's the newest member of the Midwest Dermatology team, Dr. Darling came into medicine at an early age, thanks to having a father who has practiced cardiology in Omaha for the last several decades.

Dr. Darling is board certified by the American Board of Dermatology. Post residency, Dr. Darling participated as a Fellow in Dermatopathology at the University of Virginia. Working alongside two recognized experts in the field, Dr. Darling credits this subspecialty training for honing her

diagnostic skills and ability to diagnose skin cancers, tumors, rashes and other skin conditions.

Dr. Darling is married and she and her husband are parents to a daughter. Interestingly, her sister is also a dermatologist who practices on the East Coast. It is unforeseen if they will ever practice in the same city, but they do enjoy attending meetings together!

Dr. Darling is currently welcoming new patients to her new Midwest Dermatology practice offices in Omaha at the Midtown, Lakeside and Oakview locations and in Bellevue. ☺

NEW MEMBERS

Thomas Dworak, M.D.
Radiology

Andrew Gelbman, D.O.
Radiology

**Arun Mathagondapally, M.D.,
FAAFP, MSPH, MBA**
Family Medicine (Chief Medical Officer
of Aetna Better Health of Nebraska)

Erin Talaska, M.D.
Obstetrics and Gynecology

IN memoriam

Edward "Ted" Holyoke, M.D.
Jan. 5, 1943 – Oct. 25, 2015

Stanley Mountford, M.D.
May 21, 1932 – Oct. 13, 2015

David Rosenberg, M.D.
Jan. 23, 1935 – Oct. 5, 2015

Thomas Tonniges, M.D.
March 10, 1949 – Oct. 6, 2015

Sebastian Zarbano, M.D.
Mar. 15, 1924 – Nov. 1, 2015

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Grant to plan behavioral health services

CHI HEALTH HAS BEEN awarded a \$194,000 grant to support the development of a network of community and clinical initiatives inclusive of preventive outreach, education and resources that will help individuals who have, or are at risk of having, mental illness and substance use issues. This second-year project-planning grant is provided by the Mission and Ministry Fund of Catholic Health Initiatives.

Since it was established in 1996 with guidance from the health system's founding congregations, the Mission and Ministry Fund has awarded 452 grants totaling more than \$63 million to programs throughout the world.

"Finding new and innovative ways to improve the health of communities has always been the mission that guides CHI," said Kevin Lofton, president and chief executive officer of Catholic Health Initiatives. "We're very proud of the collaborative work that CHI Health is doing in the communities it serves."

The work being done by CHI Health to plan for its communities' mental health needs, which includes the expansion of telepsychiatric services, has the attributes Catholic Health Initiatives seeks when awarding Mission and Ministry Fund grants: It meets an identified community need, is innovative, is able to be replicated and promotes collaboration with other organizations.

"The prevalence of mental illness in our communities shows that there is a need for creative and innovative strategies to help support finding additional solutions," said Sheree Keely, vice president of behavioral health services for CHI Health. "We need these types of partnerships as we move into population health management. CHI is visionary in looking at how to develop and support these types of initiatives." 

Teamwork Is Key In Pulmonary Hypertension Clinic


THEY HAVE GROWN ACCUSTOMED to collaborating over the last year, a pediatric heart specialist and pediatric lung specialist working closely together in a crucial space where cardiac and pulmonary care intersect.

Scott Fletcher, M.D., medical director, Cardiovascular MRI and Exercise, and Paul Sammut, M.D., clinical service chief, Pediatric Pulmonology, partnered in early 2013 to launch the Pulmonary Hypertension Clinic at Children's Hospital & Medical Center.

"Dr. Sammut and I visit the patients together. Families hear us speak one after another. I'm listening to Dr. Sammut and Dr. Sammut is listening to me as the family is listening to both of us," says Dr. Fletcher. "We speak with a more common voice, and our care is much more coordinated than it would be if there was one cardiologist seeing patients independently and one pulmonologist seeing patients independently. Teamwork is critical."

Progressive and potentially fatal, pulmonary hypertension (PH) is a type of high blood pressure that can affect the arteries in the lungs and the right side of the heart. Difficult to diagnose, the path begins with an echocardiogram, an ultrasound-based test that can estimate pressure in the heart's right ventricle. Once PH is suspected, the gold standard is cardiac catheterization – a thin, flexible tube inserted into the heart through blood vessels – to directly measure pressure in the pulmonary arteries.

The Pulmonary Hypertension Clinic team includes a pulmonology nurse and a cardiology nurse. The premise is straight-forward: collaborative expert care, intense follow-up and the use of advanced medications to enhance outcomes for a complex class of patients.

For physician-to-physician consults, referrals, admissions and transport service, contact the Physicians' Priority Line at 855-850-5437 for a 24-hour link to pediatric specialists. 

NAPBE recognizes cancer center for high-quality breast care

METHODIST ESTABROOK CANCER CENTER Breast Care Center has been granted a three-year accreditation designation by the National Accreditation Program for Breast Centers (NAPBC), a program administered by the American College of Surgeons.


Methodist was the first in Nebraska to be accredited in 2009 and was re-accredited for the first time in 2012.

Accreditation by the NAPBC is only given to those centers that have voluntarily committed to provide the highest level of quality breast care and that undergo a rigorous evaluation process and review of their performance.

"To be the first in Nebraska to earn the NAPBC endorsement back in 2009 and again in 2012, speaks to the excellent scope of care we provide at our Breast Care Center," said Patty Bauer, service executive for Methodist Estabrook Cancer Center. "Our physicians and entire medical team take great pride in this recognition and know it's relevance in the fight against breast disease."

During the survey process, the center must demonstrate compliance with standards established by the NAPBC for treating women who are diagnosed with the full spectrum of breast disease. The standards include proficiency in the areas of: center leadership, clinical management, research, community outreach, professional education, and quality improvement.

A breast center that achieves NAPBC accreditation has demonstrated a firm commitment to offer its patients every significant advantage in their battle against breast disease.

The NAPBC is a consortium of professional organizations dedicated to the improvement of the quality of care and monitoring of outcomes of patients with diseases of the breast. This mission is pursued through standard-setting, scientific validation, and patient and professional education. Its board membership includes professionals from 20 national organizations that reflect the full spectrum of breast care. 



Student enrollment sets record for 15th straight year


STUDENT ENROLLMENT AT UNMC set another record high for the 15th straight year with 3,790 students enrolled for the 2015-16 school year, an increase of 94 students or 2.5 percent over last year's record of 3,696.

"The momentum in our enrollment reflects the interest Nebraskans have in serving their fellow citizens in this dynamic profession," said Dele Davies, M.D., vice chancellor for academic affairs and dean of graduate studies. "Our programs continue to attract the best and brightest and the expansion of our quality nursing and allied health programs with the opening of our facility in Kearney will help address rural health care workforce shortages we are working hard to fill."

Some enrollment highlights are:

College of Medicine: There are 132 new medical students entering their first year of medical school, bringing the total enrollment to 503, which includes 35 enrolled in the M.D./Ph.D. Scholars Program. The new students, 83 percent of whom are Nebraska residents, were selected from a total of 1,838 applicants, one of the largest applicant pools in the last 21 years.

College of Public Health: Enrollment in the College of Public Health this fall is 181, which includes 154 students seeking master's degrees, and 27 certificate and non-degree students in professional programs. This represents an almost 8 percent increase in enrollment over fall 2014. Enrollment in the College of Public Health's campus and online programs continues to grow as students accept the challenge of making Nebraska the healthiest state in the union and a global model.

Graduate Studies: Enrollment in doctoral and master's programs in graduate studies is 479. The Graduate College of the University of Nebraska is a system-wide college with programs administered on each of the four University of Nebraska campuses. As part of the system-wide Graduate College, the Graduate Studies programs at UNMC offer advanced instruction leading to master's and doctoral degrees in health-related areas. 



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Application for Membership



This application serves as my request for membership in the Metro Omaha Medical Society (MOMS) and the Nebraska Medical Association (NMA). I hereby consent and authorize MOMS to use my application information that has been provided to the MOMS credentialing program, referred to as the Nebraska Credentials Verification Organization (NCVO), in order to complete the MOMS membership process.

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Birthdate: _____ Gender: Male or Female
 Clinic/Group: _____
 Office Address: _____ Zip: _____
 Office Phone: _____ Office Fax: _____ Email: _____
 Office Manager: _____ Office Mgr. Email: _____
 Home Address: _____ Zip: _____
 Home Phone: _____ Name of Spouse: _____
 Preferred Mailing Address:
 Annual Dues Invoice: Office Home Other: _____
 Event Notices & Bulletin Magazine: Office Home Other: _____

Educational and Professional Information

Medical School Graduated From: _____
 Medical School Graduation Date: _____ Official Medical Degree: (MD, DO, MBBS, etc.) _____
 Residency Location: _____ Inclusive Dates: _____
 Fellowship Location: _____ Inclusive Dates: _____
 Primary Specialty: _____

Membership Eligibility Questions

YES **NO** *(If you answer "Yes" to any of these questions, please attach a letter giving full details for each.)*

Have you ever been convicted of a fraud or felony?

Have you ever been the subject of any disciplinary action by any medical society, hospital medical staff or a State Board of Medical Examiners?

Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? *(Including revocation, suspension, limitation, probation or any other imposed sanctions or conditions.)*

Have judgments been made or settlements required in professional liability cases against you?

I certify that the information provided in this application is accurate and complete to the best of my knowledge.

Signature

Date

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