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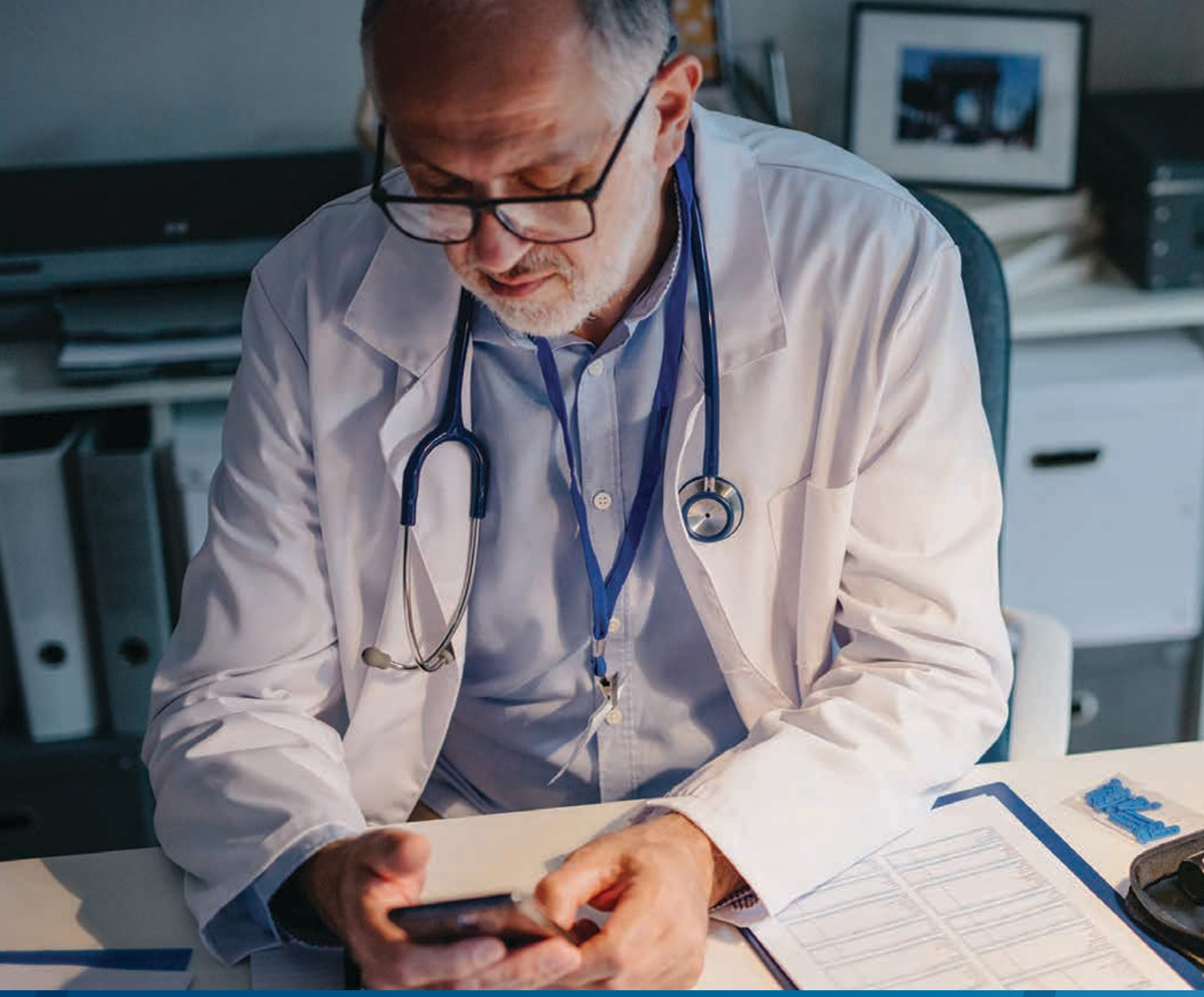

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FEATURES

DEPARTMENTS

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Metro Omaha Medical Society

COMING **EVENTS**

RETIRED PHYSICIANS: COFFEE & CONVERSATION

2ND WEDNESDAYS THROUGH APRIL

MOMS Boardroom
7906 Davenport St., Omaha

EARLY CAREER PHYSICIANS – CARE KITS & CONNECTIONS

THURSDAY, FEB. 6
6 – 7:30 P.M.

Heart Heroes
220 N. 89th St., Omaha

2025 NMA ADVOCACY BREAKFAST

THURSDAY, FEB. 6
7:30 – 9 A.M. BREAKFAST

NE State Bar Association Conference Room
635 S. 14th St., Ste 130, Lincoln

9 – 10:30 A.M. PHYSICIAN WHITE COATS IN ROTUNDA

Nebraska State Capitol
1445 K St., Lincoln

WOMEN IN MEDICINE NIGHT OUT AT FAT PUTTER

THURSDAY, FEB. 18
6 – 8 P.M.

The Fat Putter Mini Golf Lounge
111 N. 10th St., Omaha

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Metro Omaha Medical Society

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WHO WE ARE – AND WHAT WE SHOULD DO

AUDREY PAULMAN, M.D.
Editor
Physicians Bulletin

We call it progress. So many things once done by hand are now done by machine. Bread dough was kneaded, documents written and quilts sewn, all by hand. No more.

Most of it is good, perhaps inevitable. But what if it isn't good?

What if in pursuing standardization and automation, the personal touch is lost?

It is the personal touch in medicine that identifies us as physicians – uniquely marking us as healers that work to cure a patient from disease and ease their pain. The basic tool developed to use in this process is the history and physical exam.

Historically, the physical exam was taught early in medical school, in small groups, with students practicing on each other. The student doctors would examine their pretend patients, and then switch roles – before reverting back to being medical students.

Heart sounds were emphasized, with many repeating the lub-dub lub-dub sounds. Lub-dub must be differentiated from lub-dub-click or lub-slub-dub in order to determine the correct diagnosis. As students, we felt that memorizing this would help make us better doctors.

Fundoscopic examinations defined the top students from the masses, as if being able to focus on the retinal arteries determined the ability to buy an exotic car in the future.

Signs were learned. Babinski sign, Barlow's maneuver, Romberg test and Homan's sign were all carefully memorized. Degowin and Degowin was readily available to help with the nuances of the bedside clinical exam.

It all was so magical, and so important. It was the essence of being a physician.

And then, it changed.

Echocardiograms now image the heart, cameras examine retinas, and the Degowin and Degowin has been put back on the shelf.

Groups of people are now examined collectively, as part of population health. Screenings and preventative measures are performed at public events, health fairs, schools and grocery stores – far from the privacy and confidentiality allowed in a doctor's office.

Insurers do not universally support physical exams. The Medicare "Annual Wellness Visit" prescribes specific actions to physicians, including a history, measurements as done by a clinic tech, medication list, and advance care planning. Nowhere does the physician examine the patient. In fact, Medicare explicitly states that "the yearly wellness visit isn't a physical exam."

The United States Medical Licensing Examination has permanently eliminated the second licensing exam, the clinical skills exam. This test was developed to ensure that graduating physicians possess the necessary skills to provide patient care, including a physical exam.

What is no longer tested is not taught. What happens when we collectively all lose the ability to perform a physical examination?

In medical school, I learned about a classic study focusing on bonding. It impacts me still.

The researcher, Harry Harlow, allowed that infant primates could access one of two mother figures. One was a mother figure made of terry cloth. This mother provided no food. The second mother figure was made out of wire, with a bottle of milk attached.

The infants spent more time with the cloth mother, even though there was no milk.

The young primates would go to the wire mother figures only when hungry, and absolutely necessary. When frightened, worried or tired, they would go to the terry cloth mother. The terry cloth mother provided needed comfort.

What does this have to do with doctoring?

Everything.

Some doctors are covered with wire, and some with terry cloth.

Imagine if you were a child and cut your finger, and your mom wouldn't look at it. Imagine if you took your car in for a funny noise, and the mechanic didn't listen. Imagine the plumber began replacing pipe without first examining for the leak.

Imagine if you went to a physician with an ache or pain and you were not examined. Lab was ordered, along with imaging. You received an automated workup, ordered by a doctor covered in wire. I probably would choose a doctor covered in terry cloth – the one who cared enough to take a look and listen to me and help understand my pain.

Much of the work previously done by physicians has been outsourced to others on the health care team. There are care pathways and artificial intelligence. But still, the basic bond is the patient-physician relationship, and that should be a healing relationship.

Performing a physical exam is a privilege given to physicians. It is Mom placing a bandage and a mechanic listening to the noise. It is the laying on of hands to try to help the patient. It is a sign of compassion and respect.

We must not lose that ability.

It is who we are.

THE IMPACT OF PRIVATE EQUITY ON HEALTH CARE

AMY REYNOLDSON
Executive Vice President
Nebraska Medical Association

Private equity (PE) investment has surged across various sectors across the United States, including health care, over the past two decades. While this influx of capital has the potential to drive innovation and efficiency, it also raises questions about its long-term implications for patients, providers and the overall health care ecosystem.

Private equity firms target health care for its potential profitability and resilience to economic downturns. Sectors such as urgent care clinics, nursing homes, dental practices and specialty physician groups have been particularly attractive to PE investors. In 2022 alone, health care private equity deal volume reached over $90 billion globally, demonstrating the scale of investment.

Private equity firms typically acquire health care businesses with the intent of improving operations, expanding market share and increasing profitability before selling the asset – often within five to seven years. This model can result in streamlined operations and better access to resources but also introduces significant challenges.

There are potential benefits of PE in health care, including:

- **Operational Efficiency:** Private equity-backed firms often bring managerial expertise and economies of scale, which can improve operational efficiency. By centralizing administrative functions or negotiating better supply chain deals, PE owners can reduce costs for health care providers.
- **Access to Capital:** Health care organizations under PE ownership often gain access to substantial financial resources, enabling investment in advanced technologies, expanded services and improved facilities. This can enhance the quality of care and patient experience.
- **Expansion of Services:** Private equity can accelerate the growth of health care practices, expanding their geographic footprint or adding new specialties. Patients in underserved regions may benefit from increased access to care.

Despite its benefits, private equity involvement in health care has drawn criticism for prioritizing profits over patient care, including:

- **Cost Pressures:** Critics argue that private equity's focus on financial returns can lead to increased costs for patients. This may include higher billing rates, additional service charges or aggressive revenue-generation strategies.
- **Quality of Care:** To boost margins, PE-owned health care entities may reduce staffing levels, shorten appointment durations, or limit investments in patient care. For example, studies on private equity-owned nursing homes have linked such acquisitions to lower care quality and worse patient outcomes.
- **Short-Term Focus:** The typical PE investment horizon of five to seven years may incentivize decisions that favor short-term profitability over sustainable, long-term health care improvements. This approach can undermine the stability of health care institutions.
- **Impact on Providers:** Physicians and other health care workers often report dissatisfaction under private equity ownership. Increased pressure to meet financial targets and reduced autonomy in clinical decision-making are common grievances.

"Private equity investment in healthcare is likely a double-edged sword. On one hand, it has the potential to enhance efficiency, access, and innovation. On the other hand, its profit-driven model can create challenges for patients and providers alike."
— AMY REYNOLDSON

The growing influence of private equity in health care has prompted calls for increased regulation. Policymakers and advocacy groups argue for greater transparency in ownership structures, billing practices and the quality-of-care metrics for PE-owned entities. Striking a balance between fostering investment and protecting patients is essential to ensuring that private equity's role aligns with public health goals.

Private equity investment in healthcare is likely a double-edged sword. On one hand, it has the potential to enhance efficiency, access, and innovation. On the other hand, its profit-driven model can create challenges for patients and providers alike. As private equity continues to expand its footprint in Nebraska, the health care sector must navigate these complexities to ensure that financial gains do not come at the expense of patient well-being. Effective oversight and collaboration between stakeholders will be crucial in shaping a future where private equity can contribute positively to the health care landscape.

WELCOME TO THE NEW YEAR

CORRIGAN MCBRIDE, M.D.
President
Metro Omaha Medical Society

I am fortunate to serve as the president of the Metro Omaha Medical Society for 2025. I have been a general and bariatric surgeon at UNMC since 2002. When I started practicing, like many academic surgeons, I became engaged at the national level with my professional societies. When the Affordable Care Act was passed in 2010, neither bariatric surgery nor medicine was required to be in the essential benefits package. What did that mean? It meant that each state was able to decide if insurance policies offered in their state covered bariatric surgery or medicine. Nebraska, unfortunately, did not consider them essential.

I consider myself lucky because I genuinely love what I do for a living. My passion is Bariatric Surgery and Medicine. I get to help patients change their lives, and in the process cure or improve dozens of diseases. I look forward to my clinics when I see patients for their follow-up appointments. There is no better feeling then when patients tell me about the medications they no longer need or the CPAP machine they no longer use. I get to hear how patients' lives have changed in remarkable ways. Things that I think many people can take for granted. I love the stories about the things they couldn't do before but now can, such as ride on roller coasters or fly without the seatbelt extension or play on the floor with their kids and grandchildren.

The literature is clear that patients who have bariatric surgery live five years longer on average than those who do not through a decrease in major adverse cardiac events and have a decreased risk of being diagnosed or dying of cancer. I cry happy tears when I learn of the patient with PCOS who is now able to have a healthy baby after years of trying before surgery or the end stage organ failure patient who gets a heart, liver or kidney transplant.

"We've dedicated our careers to making our patients better, yet the constraints imposed by insurance companies, hospital policies, and government regulations often stand in the way. But as we know, just because something is difficult doesn't mean we should shy away from it. In fact, it's precisely in these moments of adversity where our roles as advocates become even more essential."

— CORRIGAN MCBRIDE, M.D.

The Nebraska government's decision that bariatric surgery and medicine was not essential care was an eye-opener for me about how important organizations like MOMS are. They help us to advocate for our patients to make sure our local government sees the bigger picture, but also sees these patients and the benefits that this care can provide. While I enjoyed my work nationally, some of these decisions are made locally and that is where we as physicians can really engage.

Involvement in MOMS helps us to be the voice for these patients. Events such as the Physician and Policymaker Meet & Greet help us make connections with government officials who make decisions regarding coverage. Last year when a bill went before the Nebraska Legislature that would have taxed obesity care, putting additional obstacles in my patients' paths, MOMS helped me make the connections with legislators to help them understand the consequences if this had been passed.

Bariatric is still not in the essential benefits package and several of the state's largest public and private employers do not have bariatric benefits in their health benefits plans. That is not stopping me. I will continue to meet with leaders to continue to advocate for change, so that all Nebraskans can receive the health care that they need to not only improve their longevity, but also to improve their quality of life.

We each decided to go to medical school for different reasons. We then chose a residency and a specialty. The types of patients that we treat vary and I hope each one of you has found the patient population that energizes and inspires you.

There are obstacles in all our clinical practices. Some are as blatant as the exclusion of medically necessary care, but others are more subtle. Coverage gaps, high co-pays, prior authorization hurdles, and policy limitations frequently leave patients without the care they need. When we see a patient struggling with these issues, it's easy to feel powerless. We've dedicated our careers to making our patients better, yet the constraints imposed by insurance companies, hospital policies, and government regulations often stand in the way. But as we know, just because something is difficult doesn't mean we should shy away from it. In fact, it's precisely in these moments of adversity where our roles as advocates become even more essential. I am grateful that I have found MOMS to be by my side as I advocate for our patients.

So, I ask each of you what patient population or disease inspires you, and how can MOMS and I help you advocate for the patients that are important to you?

RESPONDING TO CIVIL SUBPOENAS

DEAN MCCONNELL
Deputy General Counsel
Copic

Health care providers sometimes receive a subpoena to testify or to produce medical records, electronic information and other documents. Most often, the subpoena asks for copies of a patient's medical records. Other times, the range of documents can become quite complex and detailed, and may include requests for meta data of your EHR, credentialing files, personnel files, and even medical records of other patients who were treated for the same condition.

Deciding How to Respond: A health care provider may respond to a subpoena in the following ways:

1. Informally resolve the issue – If a subpoena is overly burdensome or complex, requests privileged or confidential information, or has scheduled testimony at a time when the provider is not available, the provider should consider contacting the attorney issuing the subpoena to see if the scope of the documents requested can be narrowed or the testimony rescheduled. If the provider is willing to work with the attorney and be reasonable, most attorneys will try to accommodate the provider.

2. Comply with the subpoena – If any necessary authorizations are obtained, no privileged documents are requested, and the subpoena is otherwise not objectionable, then a provider will usually comply with the subpoena and produce the responsive, non-privileged records requested and/or attend the deposition, hearing, or trial and give testimony. With respect to records requests, only the documents in your possession, custody and control are required to be produced. The subpoena must be satisfied within the time provided, unless an extension of time is granted by the attorney issuing the subpoena (get it in writing or in an email) or by the court.

3. Object to the subpoena – Most states allow a non-party to object to responding to a subpoena for good cause by sending a letter or email to the attorney issuing the subpoena. If an objection is made, the provider usually does not have to give testimony or produce requested records that are the subject of the objection until the court resolves the issue. However, non-objectionable records should be produced in a timely manner, and the provider should appear for any hearing or testimony but refrain from disclosing privileged information unless ordered by the court. Usually, an objection must be made within the time allowed to respond to the subpoena. The most common objection is that the records requested or the testimony to be given contains privileged information. Note: Not all courts allow objections, it may be necessary in your state to file a motion to quash or a motion for protective order to avoid the duty to respond within the time allowed.

4. Move to quash or modify the subpoena – If the provider is not able to reach an informal resolution with the issuing attorney, you may need to move to quash or modify a subpoena seeking documents or testimony. Common grounds asserted to support the motion include that the subpoena requires disclosure of privileged information, does not allow a reasonable time for compliance, requires compliance beyond geographical limits set by rule, creates an undue burden on the provider, requires disclosure of trade secrets or other confidential business information, or was improperly served or is technically defective. You will generally want to retain an attorney to assist you with this motion.

5. Move for a Protective Order – A motion for protective order may be used if a subpoena caused undue annoyance, embarrassment, oppression, burden, or expense. Upon good cause shown, the court may order precluding the requested discovery, allowing the discovery on specified terms and conditions, limiting the scope of the subpoena, requiring the requesting party to pay expenses, upholding privileges, or sealing the court files to protect confidentiality or trade secrets.

NEBRASKA (Neb. Rev. St. § 25-1223, et seq.)

- Subpoena Requirements: Separate subpoena for records allowed. Must be served by person who is not a party and is at least 21 years old. Copy of subpoena rule must be provided.
- Witness Fee: Witness fees for trial subpoenas, but not discovery subpoenas.
- Who Must Be Served: Records and deposition subpoenas may be served personally or by registered or certified mail.
- Time of Service: 10 days before compliance for records subpoena. Must give other parties 10 days' notice before service of subpoena, reasonable time for compliance for testimony.
- Objections: Within 10 days after service.
- Place of Service: Anywhere in state.
- Place of Testimony: County where the witness resides or was served for deposition.
- Asserting Privilege: If withhold documents for privilege, must state privilege applicable.

The information provided herein does not, and is not intended to, constitute legal, medical, or other professional advice; instead, this information is for general informational purposes only. The specifics of each state's laws and the specifics of each circumstance may impact its accuracy and applicability; therefore, the information should not be relied upon for medical, legal, or financial decisions and you should consult an appropriate professional for specific advice that pertains to your situation.

GETTING PEOPLE TOGETHER AGAIN

They figured it was time.

Hana Niebur, M.D., and Lauren Nelson, M.D., recently helped plan conferences for their medical organizations – and opted to bring participants together. Good call, they said.

“There was no pushback. Lots of enthusiasm because opportunities to come together have been limited,” said Dr. Niebur, who helped organize the Nebraska Asthma Conference, held in November at UNO.

Said Dr. Nelson: “We needed that interpersonal connection.” Dr. Nelson, who serves as governor of the American College of Physicians’ Nebraska Chapter, helped plan the chapter’s annual scientific meeting, which was held in October on Creighton’s campus.

Drs. Niebur and Nelson discussed the reasons behind the push for in-person conferences, the lessons they learned and what they enjoyed most. They also discussed what they might – or might not – do differently.

Dr. Nelson called her chapter’s scientific meeting a success, although participation wasn’t what organizers had hoped. “I love the event. I love attending. I enjoy visiting and connecting. We just have to get other people there.”

Attendance numbers in 2024, she said, topped numbers from the two previous years – “but we can do better.”

Last year’s session offered in-person and virtual options for participants and was held in Nebraska City with the location seen as more of an event and as a way to boost statewide attendance. The organizing committee decided to bring the meeting back to Omaha, Dr. Nelson said, to focus more on attendees from the metro area and dropped the virtual option for participation.

“Adding the virtual option was a lot of work for a minimal return,” she said.

The organizing committee scheduled the meeting on a Saturday when the Nebraska football team wasn’t playing. “The choice meant that potential participants didn’t have to decide between watching the Huskers and attending,” Dr. Nelson said, but the planning committee discovered “everyone else schedules on bye weeks.”

CONT. PAGE 16

The **Niebur** File

Hometown
Grand Island, Nebraska

Undergraduate Degree
St. Louis University in biology and music

Medical Degree
University of Nebraska Medical Center

Residency
Advocate Christ Medical Center and Children's Hospital in Oak Lawn, Illinois, in pediatrics

Fellowship
University of South Florida Health and All Children's Hospital in St. Petersburg, Florida, in allergy and immunology

Specialty
Allergy and immunology

Title
Medical Director

Location
Children's Nebraska Specialty Pediatric Center, which is part of the Asthma Center of Excellence

Hobbies
Chasing after her children

Family
Husband, Platt Niebur; three children, Penni, Rose and Sam

Why She Joined MOMS
"I joined to be part of the physician community in Omaha."

FROM PAGE 15

Organizers discovered that the COVID hangover of people not wanting to gather in person had diminished. They also realized that people are more possessive of their free time. "It's hard to ask anyone when they work five days a week – or more – to spend an entire Saturday to sit in a conference room."

Their challenge for future sessions: to give the chapter's members increased reasons – beyond receiving CMEs – to attend. Dr. Nelson noted the chapter's membership is broad – from hospitalists, to primary care physicians, residents to specialists. Finding a topic – along with a keynote speaker – that appeals to the chapter's wide audience can be challenging.

Delivering a session with that kind of content appeal begins with forming a planning committee with wide representation. "We must have all voices represented to offer options for a broad group of people. I think we do a good job, but we must be cognizant of this."

Dr. Nelson's shared other insights from the session-planning process:

- Creighton was a strong choice as a session site. The cost was reasonable and the chapter used Creighton's catering service.
- The planning committee is sure to incorporate well-being activities into the session. Sensory-grounding tools – Dr. Nelson described them as "fidget type things" — are placed on all tables.
- Participants are provided materials that allow them to doodle throughout the session. "I doodled plenty," she said.
- Doctor's Dilemma – a Jeopardy-type contest – is a session regular and favorite.

The first Nebraska Asthma Conference offered in-person and virtual options for attendees – and organizers were pleased with the response: More than 100 people attended in person and the online option drew nearly another 200 participants.

"All were very enthusiastic and thought it was a great conference," Dr. Niebur said.

Dr. Niebur and Mitzi Cardona, Ed.D., Children's Nebraska asthma program coordinator, served on the core planning committee of four. "After COVID," Dr. Cardona said, "many conferences were online. Participants started expressing it was time to come back together."

The conference received financial support from a memorial fund of longtime member Fred Kiechel, M.D. "The conference was a tribute to Dr. Kiechel," Dr. Niebur said.

The planning committee began its work in February, taking an audience-centric approach. Asthma guidelines had changed in the past few years, and planning committee members focused on what information attendees would find most beneficial.

The planning committee scheduled in November – to come before the holidays and the flu season. UNO's Weitz Community Engagement Center was a logical choice for a location, given its emphasis on supporting non-profit organizations, Dr. Cardona said. The conference used UNO's catering service for meals and snacks.

The committee's focus then turned to marketing the conference, ensuring the logistics of conducting a hybrid conference were handled and securing education credit.

"There was no pushback. Lots of enthusiasm because opportunities to come together have been limited."

— HANA NIEBUR, M.D.

Presented by Children's Nebraska and sponsored by the Nebraska Asthma Coalition, the conference provided no-cost registration, food and snacks, and educational credit.

The planning committee relied on such organizations as MOMS and the Nebraska Medical Association to spread the word among its members.

Some initial technical difficulties – with Zoom for virtual attendees – presented early on conference day. "Our team and the folks at UNO were able to address the problems – and most people didn't even notice," Dr. Niebur said.

Drs. Niebur and Cardona said the hybrid approach for the conference proved to be the correct one." The point of education is to reach everyone equally. Even though it is wonderful to meet everyone in person, the hybrid model allows us to have a greater reach," Dr. Niebur said.

Added Dr. Cardona: "We just received an email from a Hastings attendee: 'Thanks for doing it hybrid. I might not have been able to make it in-person.'"

Lauren Nelson, M.D.

The **Nelson** File

Hometown
New Orleans, Louisiana

Undergraduate Degree
University of New Orleans in biology

Medical Degree
Northwestern University's Feinberg School of Medicine in Chicago

Residency
University of Nebraska Medical Center in internal medicine

Specialty
Internal medicine

Location
Boys Town National Research Hospital's Internal Medicine Clinic

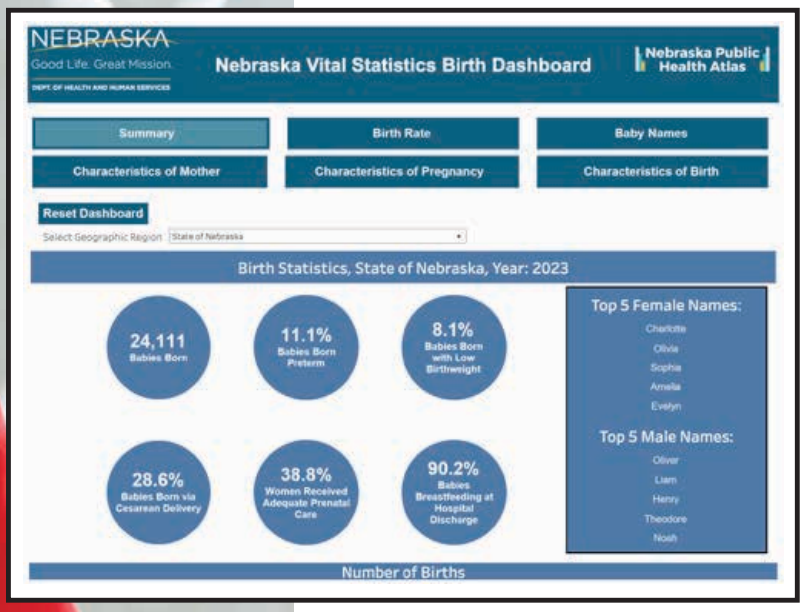
Hobbies
Gardening, yoga and attending her children's activities

Family
Husband, Eric Nelson, M.D.; two sons, Elliot and Peter, and a daughter, Frances

Why She Joined MOMS
"To connect with physicians from different specialties and because of MOMS' effort to bring together physicians from throughout Omaha."

AN ENTRY TO NEBRASKA'S VITAL BIRTH STATISTICS DASHBOARD

Ann Anderson-Berry, M.D., Ph.D.



Consider this story an invitation from Ann Anderson-Berry, M.D., Ph.D., to explore the Nebraska Vital Statistics Birth Dashboard.

"This dashboard is a huge win for Nebraska," she said. "It's a huge win for individuals who want to assess trends and care delivery in Nebraska. It's a huge win for individuals and organizations, such as myself and the perinatal collaborative, because we can more precisely target our interventions."

Dr. Anderson serves as medical director for the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC, which formed in 2014 to bring focus to maternal and child health outcomes in the state. With state funding in hand, the NPQIC collaborated with the Nebraska Department of Health and Human Services to ensure the Nebraska Vital Statistics Birth Dashboard was a priority and included critical information for Nebraska providers.

The dashboard, launched in September, includes de-identified aggregate birth data between the years 2005-2023 for Nebraska resident births. It allows results to be presented across six overarching sections, including an overall summary, birth rates, baby names, characteristics of the mother (age, race/ethnicity, education, and marital status), characteristics of pregnancy (parity, plurality, smoking status, pre-pregnancy BMI, hypertension, diabetes, previous preterm delivery, adequacy of prenatal care, and trimester of prenatal care), and characteristics of birth (birth weight, breastfeeding at discharge, delivery method, delivery payment source, and gestational age).

Dashboard results are presented by demographic (age, race/ethnicity, education and marital status) and geographic (state, local health department and urban/rural) categories. Users can combine multiple years of data, examine trends over time, and explore data in charts, tables and maps.

All this information can have a profound impact on care interventions, Dr. Anderson said. "You can only do work if you have the data to understand what the current situation is. And then, you can use that data to see if your interventions work – so you can either continue those interventions or you can pivot if they're not working and find something that works better."

Ten years prior, Dr. Anderson said, Nebraska didn't have a vehicle to gather and then share this data. Clinicians could gather data from individual care institutions, the Nebraska Hospital Association and, if they were willing to wait several years, the Centers for Disease Controls. Seeking data from hospitals in Nebraska's smaller communities that delivered much fewer infants was time-

consuming and a burden to those institutions, she said.

Conversations with the Department of Health and Human Services led to a greater understanding about the type of data needed for clinicians to develop improved interventions for pediatric care, Dr. Anderson said.

Discussion followed about what type of data was needed and who should have access to it. These conversations came, Dr. Anderson said, during a time when opinions about access to data were evolving.

"We have been working with the state over the course of many years and, frankly, getting a bit more vocal about what we needed in order to be effective," said Anderson, who serves as vice-chair for research in UNMC's Department of Pediatrics and vice president for Research for Children's Nebraska. "The state responded this year with this dashboard – and so we are thrilled."

Dr. Anderson offered an area of need for birth statistics: Mothers – during their pregnancies, during childbirth and during the first year after – are dying at the highest rates ever. "We need to see what the key drivers of those maternal and neonatal complications are. And unless we have real time data, we can't change practice and we can't change policy.

"You can use this information from the dashboard to not only change how a hospital, a physician or a community approaches perinatal health delivery, but you can also look at it and say 'What do we need to do at a state policy level?'"

Take maternal smoking, for example. Nebraska, when compared to other states, ranks high in its rate for maternal smoking. "We know that smoking in and of itself increases the risk of pre-term delivery. It also increases the risk of having a low birth weight infant.

"Guess which babies do the worst after delivery? Preterm infants and low-birth weight infants. They also stay in the hospital for an extended period of time and have a much higher rate of sudden infant death syndrome."

Statistics provided through the dashboard can help clinicians determine which expecting mothers are smoking or vaping. "Then, we can work with the state health department to think about what interventions we can target geared toward pregnant women."

Available data also helps health officials determine which counties have higher rates of maternal smoking. "Where do we need to target education? Where do we need to target those interventions? Do we need to work with providers to think about prescribing medication so they can help pregnant women stop smoking?

"There are a lot of things we can do based on precise data. Current information will direct us to target interventions and allow us to assess those interventions quickly with real time data."

Back to her invitation. Dr. Anderson suggested her peers spend a few minutes to see what the dashboard can do and the data it provides. "I think that would be an incredibly useful and engaging exercise. It wouldn't take more than 5 minutes to get a feel for the type of data that is accessible. It will also help them understand what their perinatal collaborative is doing."

A bonus, she said, is those who take a dashboard test drive will learn which baby names are most popular in Nebraska.

"We like to connect people one-on-one. How do you do that? With names. You always want to see where your name falls on the list. You want to see where the names of your children fall on the list."

Providing this list, she said, also provides a human side to the vital statistics birth dashboard. "Behind every premature delivery, there is a name."

To access the dashboard, go to https://dhhs.ne.gov/Pages/Vital-Statistics-Birth-Dashboard.aspx

The **Anderson-Berry** File

Hometown
Casper, Wyoming

Undergraduate Degree
University of Wyoming in zoology and physiology

Medical Degree
Creighton University School of Medicine

Residency
Creighton University/ University of Nebraska Joint Program in pediatrics

Fellowship
University of Utah School of Medicine in Salt Lake City in neonatology

Doctoral Degree
University of Nebraska Medical Center medical nutrition

Titles
Professor of pediatrics, chair of pediatric research

Institution
UNMC

Titles
Vice president for research

Institution
Children's Nebraska

Hobbies
Hiking, spending time in the mountains of Wyoming and gardening

Family
Husband, Tom Berry, D.D.S.; and two daughters, Elizabeth and Katherine

Why She Joined MOMS
"It's a great way to meet and collaborate with other medical professionals across the metro area who are willing to use their influence to improve patient care."

"For me, the walk was also a spiritual journey."
— KRIS MCVEA, M.D.

DR. KRIS MCVEA'S MONTH-LONG 'PAUSE' WALKING THE CAMINO

Kris McVea, M.D., stepped out of a hostel in Saint-Jean-Pied-de-Port, France, on June 24 and began a month-long, 500-mile journey.

That first day walking the Camino de Santiago, she recalled, could only be described as remarkable. "You climb over the Pyrenees mountains into Spain. It's just beautiful."

But she found herself having difficulty disengaging from her recent challenges so she could focus on her journey. Rather than admiring her surroundings, she found herself distracted: Did I make arrangements for dinner that evening? Will I have wi-fi? Should I check my email?

"Everything was buzzing around and I had to bring it back." She forced herself to pause. "Look at what's around you. This is beautiful. Be present. Just be present."

And so she was. After the first two days, Dr. McVea said, she never questioned her reasons for walking the Camino and never considered turning back. She also never questioned her approach to walking the Camino, also known as the Way of St. James.

"There are different ways to do the Camino," she said. "There's no judgment for people who would do it other ways – but I wanted to do it the traditional way."

The traditional way means she carried her clothes and everything else in her backpack. She stayed entirely in hostels, rather than opting for hotels and the conveniences they afford. Those who take the traditional approach are known along the route as "Pilgrims." They are easily identified by a shell they display on their backpacks. "It's leading a very simple life. I was relieved of all but very necessary possessions. Relieved of any planning. Just walking for the day."

Dr. McVea's story of walking the Camino de Santiago starts with a backstory. Her reasons for walking the Camino were personal.

Her story starts with how COVID disrupted her life, personally and professionally, as medical director at OneWorld Community Health Centers. Just as COVID was finally in the past, she said, her husband was diagnosed with cancer. He died a year later. "I started 2024 thinking this year is for healing. This is the year I am going to be able to move forward."

She met with her spiritual director and regularly put down her thoughts – her grief and her sadness – on paper.

One month into 2024, her son, Patrick, was diagnosed with cancer. "He moved in with me and we began the journey of chemotherapy together."

During their hours spent together while Patrick received his infusions, mother and son talked about how they would celebrate when he had beaten cancer. Where would they go? They decided it could be anywhere in the world.

Dr. McVea's son is a foodie and suggested Donostia, Spain – which boasts eight Michelin-starred restaurants. While her son inventoried the restaurants they would visit, Dr. McVea explored whether she could add a journey of her own at the end of her trip with her son.

She had long wanted to walk the Camino – even watched the film, "The Way," which starred Martin Sheen. This was bucket list material. Was she ready for this journey? she asked herself.

The timing was optimal, as she had stepped away from OneWorld but had yet to start as medical director at All Care Health Center in Council Bluffs. The physical aspect of walking the Camino didn't faze her. But could she take this journey on her own?

She realized she could – and did. She discovered that Donostia was just 60 miles from Saint-Jean-Pied-de-Port, known as a starting point of the Camino de Santiago. She would remain after their trip and make the walk that ends at the Cathedral of Santiago de Compostela in Galicia in northwestern Spain, where tradition holds that the remains of St. James the Apostle are buried.

"The second day I was walking, I felt a sense that my anxiety was gone. I felt this lightness – that a weight was lifted from me. I didn't have to be responsible for anything or anyone."

So, she walked – averaging 15 miles per day, often starting before sunrise and never taking a day off. She carried one set of clothes, two pair of socks, a jacket and a few other essentials – and quickly discarded items that she originally felt were important, but learned she could do without. Shampoo. Sleeping bag. Her hair dryer. "I had this idea that I was going to do my hair each day." She also carried less food and just one bottle of water. She quickly learned that the Camino – as people had promised – would provide.

CONT. PAGE 22

Pilgrims often gathered for dinner after a day's walk.


Dr. McVea enjoying watermelon.

"Look at what's around you. This is beautiful. Be present. Just be present."

— KRIS MCVEA, M.D.


A seashell affixed to walkers backpacks indicates they are pilgrims on the Camino.

FROM PAGE 21

Dr. McVea quickly learned to sleep in a room full of pilgrims – men and women in one large room lined with bunk beds. Their snoring, movement and breathing became part of the nightly routine. "To me, it sounded like the ocean. I never had a problem sleeping."

She typically finished her day's walk by early afternoon. She would do her laundry, relax, join other walkers for dinner, and turn in. Up by sunrise and repeat.

Along the way, she often passed Catholic churches where parishioners would hold Mass for Pilgrims walking the Camino. "They would do a blessing for us. For me, the walk was also a spiritual journey."

Each day, Dr. McVea spent some time walking in solitude – some days just a few hours, others the entire day's journey. She spent some of this time grieving.

She also learned to listen more intently. "The sounds of nature around me. I became very tuned in to the different bird sounds." And the smells she encountered. She saw a type of yellow bush that provided a fragrance of lilacs or possibly honeysuckle. The smell of wheat always caught her attention as she walked through fields. "I'd be walking early through a small town and I could smell a baker making bread."


Dr. McVea (with white backpack) and companions approach a small town.

Stamp marks represent checkpoints Dr. McVea passed through off the Camino.

She recalled one day stepping inside a small grocery store and noticed a watermelon. The store owner chopped it up for her and she sat outside on a bench and enjoyed the melon. "I was so grateful. It wasn't any kind of special watermelon. I was just grateful for the taste."

Other memories remain close: A plum tree that she picked a few from. Flowers growing in the middle of the trail. Fields of sunflowers. And the morning she started at 4 a.m. and walked in complete darkness. "You could see the colors of the Milky Way."

She also connected with Pilgrims from throughout the world – Japan, Germany, Italy, France and Ireland. "You found a way to communicate when you didn't speak the same language. You couldn't tell if people were rich or poor – all those superficial things had been stripped away."

On the night after arriving in the Cathedral of Santiago de Compostela in Galicia, Dr. McVea and her walking companions ate dinner together. "Someone asked me, 'What do you do for a living anyway?' No one had asked me that before – and that was really cool."

Enjoying people solely for who they were, she said, was the way of the Camino.

The Camino trail was formed by 1,000 years of pilgrim feet walking the path.

The **McVea** File

Hometown
Omaha, Nebraska

Undergraduate Degree
Stanford University in American studies

Medical Degree
University of Nebraska Medical Center

Residency
University of North Carolina at Chapel Hill in internal medicine and pediatrics

Fellowship
University of North Carolina School of Public Health in primary care research

Master's Degree
University of North Carolina School of Public Health in epidemiology

Title
Chief Medical Officer

Organization
All Care Health Center in Council Bluffs

Hobbies
Writing poetry, hiking and her involvement with Ixim: Spirit of Solidarity – a ministry that cultivates relationships of friendship, faith and solidarity between the Archdiocese of Omaha and the Diocese of Huehuetenango, Guatemala

Family
Three sons, Patrick, Andrew and Jackson

Why She Joined MOMS
"I appreciate MOMS' support of physicians and their advocacy for underserved populations."

IT'S ALL ABOUT FAMILY WHEN RECRUITING TO OMAHA

Ties bind – as the saying goes – especially when it comes to recruiting physicians to Omaha.

C. Christian Schlaepfer, M.D., knows that when recruiting a physician to Omaha, having a family tie to the Midwest – even better to Omaha – is a strong selling point. That connection, he said, can be with the physician being recruited or his or her spouse.

"When we've lost people to other cities," Dr. Schlaepfer said, "it often comes down to he or she liked the job, but someone else said 'No' to it."

So not only do Dr. Schlaepfer and his colleagues at Radiology Consultants promote the value of living in the Midwest, they also are sure to share that sentiment with the candidate's family.

Dr. Schlaepfer said he can speak from experience about the value of living in the Midwest. A California native, Dr. Schlaepfer grew tired of being stuck in traffic. "It takes an hour to get anywhere in California."

Plus, he said, the public schools in California were underfunded and, as a father of two, that was disconcerting. During his undergraduate and medical school days, he said, he had met – and liked – students from California who were studying in Nebraska and had spoken highly of their experience. He also valued his time as a radiology resident at Creighton.

So, when he learned of an opening in Omaha, he said, he jumped – and hasn't looked back since. One reason, he said, is his commute time: "You can live where you want and pretty much be any place you want to go in 30 minutes."

Dr. Schlaepfer told the story of a recent recruiting success for Radiology Consultants. They learned through social media that a radiologist whose father practiced at CHI Health in Omaha was looking to relocate. Dr. Schlaepfer and his colleagues asked the physician's parents whether they thought their son would be

"Omaha is becoming an increasingly trendy place to live with plenty of outdoor and entertainment options and a rich cultural scene. Rent in Omaha makes up only 18.28% of the median earnings for full-time workers – one of the best rates in the US – meaning that your earnings can go further."
— C. CHRISTIAN SCHLAEPFER M.D.

open to returning to Omaha. "They said they would be thrilled."

So was the recruit.

Dr. Schlaepfer said Radiology Consultants has an inside advantage, as it oversees the residency program at Creighton University School of Medicine. "The ones who seem happy to be in Omaha, we see how we can keep them."

Dr. Schlaepfer said he can quickly – and genuinely – list the virtues of living in the Midwest to physician recruits – beyond the ease of getting from one place to another without spending a large portion of one's day. Then, there's:

- Being in the Midwest means quicker commute times to both coasts – when compared to going coast to coast. Eppley Airfield, which is under construction, will only get better.
- Per capita, Omaha sports quality restaurants.
- And a large number of golf courses.
- Omaha may not feature a major league team, but it makes up for this omission with minor league and college teams.
- Omaha sports a great music scene with Hollard Performing Arts Center, Steelhouse and CHI Arena drawing quality acts.

"You have to look at things differently," he said. "We have good schools here and lots to do."

If Dr. Schlaepfer hasn't provided enough ammunition to sell Omaha, the Omaha Chamber of Commerce shares its lists of ranking the community has earned, starting with Forbes.com, which anointed Omaha as the top city to move to in 2024.

In anointing Omaha to the top shelf of places to move to in 2024, Forbes.com shared with its readers:

"Omaha has a reasonable median monthly housing cost of $1,188 and its residents have a median family income of $69,198. We loved that the city enjoys 117 sunny days a year and has an impressive 98% employment rate, emphasizing the city's strong job market and abundant opportunities for those who value career advancement.

"As far as safety is concerned, Omaha has a fairly low crime rate with only 40 out of 1,000 residents being impacted, showing the city's commitment to keeping homes safe and secure."

Omaha's trophy case of "bests" features the Forbes ranking as its centerpiece. Other rankings of note:

-The ninth best city for young professionals in 2024, according to pheabs.com. "Omaha is becoming an increasingly trendy place to live with plenty of outdoor and entertainment options and a rich cultural scene. Rent in Omaha makes up only 18.28% of the median earnings for full-time workers – one of the best rates in the US – meaning that your earnings can go further."

-The No. 5 best large city for new college grads, according to checkr.com. "By one measure, the fastest-growing economy among the nation's largest counties isn't in Texas, Florida or any of the other usual big dogs. It's Douglas County, Nebraska."

The **Schlaepfer** File

Hometown
Fullerton, California

Undergraduate Degree
University of California Irvine in biology and psychology

Medical Degree
University of California Los Angeles

Residency
Creighton University School of Medicine in radiology

Fellowship
Northwestern University in Chicago in neuroradiology

Specialty
Neuroradiology/ Interventiona

Location
Radiology Consultants

Academic Appointment
Assistant clinical professor of radiology, Creighton

Hobbies
Cooking, gardening and running

Family
Wife, Sarah Haddad; one son and one daughter

Why He Joined MOMS
"I joined for the continued communication and connections in medicine."

MOMS **EVENTS RECAP**

RETIRED PHYSICIANS GATHER FOR COFFEE AND CONVERSATION

The MOMS retired physicians group met for its monthly Coffee & Conversations event at MOMS on Dec. 11. These meetings will continue monthly on the second Wednesday at 10 a.m. in the MOMS Boardroom at 7906 Davenport St. through April.

Photo (from left): Drs. Herman Greenwald, Paul Coleman, Brett Kettelhut, Robert Beer, Paul Paulman, John Walburn, Peter Whitted and former MOMS executive director Sandy Johnson.

MOMS PHYSICIAN WRITING GROUP STARTS SECOND COHORT

A group of member physicians, led by Nebraska's State Poet, Matt Mason, met to begin the second cohort of a writing group with meets seven times over the next few months to discuss each other's writing and give feedback.

NEW MEMBERS

THOMAS BLOUNT, M.D.
Children's Nebraska – Cardiology
Pediatric Cardiology

ATTILA CSORDAS, M.D.
Radiologic Center Inc.
Interventional-Integrated Radiology

MICHAEL DASILVA, M.D.
Eye Consultants
Ophthalmology

LINA ELSAYED, M.D.*
Clarkson Family Medicine
Family Medicine

LINDSEY MCALARNEN, M.D.
UNMC – Gynecological Oncology
Gynecological Oncology

DANIEL SCHLESSINGER, M.D.
Schlessinger MD
Dermatology

DANIEL WELCH, M.D.
Radiologic Center Inc.
Diagnostic Radiology

**Resident or Fellow*

BOYS TOWN National Research Hospital

EDUCATIONAL OPPORTUNITIES TO FOCUS ON IMPROVING CLINICAL PRACTICE

Boys Town National Research Hospital is offering two conferences designed to enhance one's clinical practice and research knowledge.

The Pediatric Audiology Translational Research (PAT) Conference, set for May 30-31 at Boys Town National Headquarters, honors the legacy of Pat Stelmachowicz, Ph.D., a pioneer in pediatric hearing research at Boys Town. The event will feature 11 sessions led by leading translational researchers who will share evidence-based practices and strategies for audiology care across all pediatric ages and abilities. CEU credits will be available with details available soon. Poster submissions are welcome, with abstracts due by March 7. Visit boystownhospital.org/PAT to submit an abstract.

On April 4, the Boys Town Behavioral Health Conference: Help & Healing Across the Continuum of Care will be held at the Boys Town Education Center. This one-day event will cover critical mental health topics relevant to clinical practice, research, crisis intervention, interdisciplinary care and the challenges of providing care in the age of social media. Registration details and speaker announcements will be available in January.

For more information, visit boystownhospital.org/classes-and-events.

CHI Health

DR. GERJEVIC LEADS PELVIC HEALTH CENTER

CHI Health recently welcomed Kristen Gerjevic, M.D., as the new medical director of its Pelvic Health Center. This initiative represents a significant shift toward a more comprehensive and patient-centered approach to pelvic health for men and women. Dr. Gerjevic, with her experience as division chief of urogynecology at CHI Health, brings knowledge and a clear vision to this role.

Recognizing the complexities associated with pelvic health conditions, Dr. Gerjevic champions a multidisciplinary approach. This holistic model integrates various specialties including colorectal surgery, urology, urogynecology, physical therapy, behavioral health to address the diverse needs of patients.

The Pelvic Health Center's structure is designed for accessibility. Using asynchronous communication capability via Epic software, and complex case reviews via Zoom, providers are able to collaborate on complex patients and problem solve together with minimal disruption to their individual practices, even in remote areas. Additionally, a multidisciplinary conference is held annually in partnership with Creighton University, providing learning and connection opportunities among providers of all relevant specialties.

Looking ahead, Dr. Gerjevic plans to expand access to care through community outreach programs and research in pelvic health. Her focus on patient-centered outcomes, aligning with best practices and high-quality evidence based care, ensures that treatment success is measured by the tangible improvements in patients' lives.

ADVANCED PEDIATRIC HEART FAILURE & TRANSPLANT PROGRAM RECEIVES CMS APPROVAL

The Advanced Pediatric Heart Failure & Transplant Program at Children's Nebraska received full approval from the Centers for Medicare and Medicaid Services in November 2024, is active in the United Network for Organ Sharing system, and is actively listing patients for heart transplantation.

In addition, durable mechanical circulatory support in the form of ventricular assist devices is now offered for the first time as part of the program, which is housed in Children's Criss Heart Center. Led by surgical director Camille Hancock Friesen, M.D., and medical director Jason Cole, M.D., the program provides comprehensive care for children with heart failure, serving patient families across the region and beyond.

Children's multidisciplinary team includes specialists from various pediatric fields, including cardiology, cardiothoracic surgery, cardiac critical care, cardiac anesthesiology, nutrition, child life, social work, pharmacy and nurses, with consultations available from other specialties. Care is provided in Children's 32-bed, acuity-adaptable Cardiac Care Unit (CCU) in the state-of-the-art Hubbard Center for Children, where heart patients receive continuous, specialized monitoring and treatment.

The reopening of the Advanced Pediatric Heart Failure & Transplant Program marks a significant milestone for the Criss Heart Center, allowing Children's to offer the most advanced pediatric cardiac care available anywhere in the world.

WOMEN IN MEDICINE AND SCIENCE SYMPOSIUM FOCUSES ON ENCOURAGING PHYSICIAN LEADERS

Creighton University and CHI Health in November co-hosted Women in Medicine and Science (WIMS) Symposium at CHI Health Creighton University Medical Center – Bergan Mercy. The day featured Nicole Piemonte, Ph.D., associate dean of faculty leadership at Creighton University; and Ronael Eckman, M.D., vice president of medical affairs at Yavapai Regional Medical Center; and a panel of female surgical and procedural physicians who offered their perspective and encouragement as physician leaders.

"All women and allies of women" were invited to attend the day dedicated to supporting women in medicine and science through "shared mentoring, networking opportunities and the development of essential management and leadership skills to advance careers and support leadership roles." said Delto, M.D., chair of WIMS.

Speaker topics included compassion fatigue, the power of storytelling and values-based leadership. The panel discussed the challenges that women face in their fields, emphasizing the importance of identifying these obstacles, addressing biases and developing actionable strategies to navigate them and support others.

The panel's topics addressed one of the core goals of WIMS, which is to acknowledge the challenges and opportunities of women in medicine and science and seeks to create a strong support system to enhance mental well-being as they balance the demands of their professional and personal lives.

STOFER NAMED VICE PRESIDENT OF INTEGRATED SERVICES

Shanna Stofer, Pharm.D., has been named the new vice president of integrated services for Methodist Health System. Prior to this appointment, Dr. Stofer served as vice president of ancillary and professional services at Methodist Jennie Edmundson Hospital in 2021.

"Shanna will do an excellent job in this role," said Josie Abboud, executive vice president for Methodist Health System. "Her approachable leadership style and experience working collaboratively with teams will serve us well as she leads the Integrated Services division of Methodist Health System, supporting strategic goals across all Methodist affiliates."

In her new role, Dr. Stofer will oversee patient transportation, environmental services, food services, plant engineering and operations, maintenance, grounds, mail/courier services, safety, security, emergency preparedness, sustainability, construction collaboration, call center, and PBX/Dial MD.

"I'm very excited to join the strong Integrated Services leadership team and help continue the great work initiated by Bill Vobejda and so many others," Dr. Stofer said. "I look forward to the work we'll do to accomplish strategic goals across Methodist Health System."

Prior to joining the Jennie Edmundson staff in 2021, Dr. Stofer was a key player in the opening of the Kearney Regional Medical Center (KRMC) in Kearney. She also served as director of pharmacy for Lincoln Surgical Hospital from 2003 to 2009 before serving in a similar role at Community Memorial Hospital in Syracuse.

Dr. Stofer earned her doctorate of pharmacy from the University of Nebraska Medical Center and a master's degree of health care administration from Bellevue University. She is a member of the American College of Healthcare Executives and the American Society of Health-System Pharmacists.

Nebraska Medicine
SERIOUS MEDICINE. EXTRAORDINARY CARE.

INNOVATION DESIGN UNIT WILL BE PROVING GROUND FOR PROJECT HEALTH

When patients first set foot in the Innovation Design Unit (IDU), they might think they've entered the future. The ultramodern appearance will likely be the first thing they notice the moment they exit the elevator. But the state-of-the-art patient care unit located on the sixth floor of University Tower at Nebraska Medical Center is about much more than looks. With a $40 million investment, the IDU represents a step forward in redefining health care delivery.

Spanning 20,000 square feet for patient care and an additional 4,500 square feet for the Bridge Innovation Program, the IDU will serve as a hub for designing, testing and validating advanced care models, innovative technology and facility designs. This 17-room unit is staffed by about 40 inpatient care providers and eight to ten Bridge program staff.

The unit is the first phase of Project Health, a new $2.19 billion health care facility that will serve as a clinical learning center to train the next generation of health care providers and conduct research, and will be the primary hospital for Nebraska Medicine.

The IDU is poised to shape the future of health care delivery, creating a blueprint for sustainability, efficiency, and patient-centered excellence. "This is where we will discover the care models for Project Health," said Michael Ash, M.D., Nebraska Medicine president and chief operating officer. "When we started envisioning Project Health, we realized we needed a space where we could develop and refine ways to further improve the quality and safety of health care. This will be a space where we can challenge the norms. The things that work best will be shared with the rest of the organization and become staples of care when Project Health becomes reality."

University of Nebraska Medical Center

DR. ROMBERGER MOVES INTO ADVISORY ROLE

Debra Romberger, M.D., chair of UNMC's Department of Internal Medicine since 2015, stepped away from that role in January. She now serves in a special advisory role in the dean's office.

Dr. Romberger, who served as the first woman chair of the internal medicine department, said she appreciated her time as chair, as well as the colleagues who supported her during her UNMC career.

"It has been my greatest joy to have this job as chair, and that's because of all the great people that I work with — staff, faculty, trainees, all of our folks," she said. "It's been a privilege to work with them. I can't say enough good things about the people of the UNMC Department of Internal Medicine."

Bradley Britigan, M.D. College of Medicine dean, said he is excited to work with Dr. Romberger in her new role. Mark Rupp, M.D., will serve as interim department chair.

Dr. Romberger arrived at UNMC in 1988 as a research fellow in the lab of Stephen Rennard, M.D., before joining the faculty two years later. She steps away from her departmental leadership role with a sense of accomplishment, citing not only the creation of two new divisions — allergy and immunology and hospital medicine — but of leadership roles designed to support faculty and students and increase mentorship in the department.

"I'm looking to the next chair to take the department to a new level," Dr. Romberger said. "Our educational programs are historically strong, and we need to make sure that continues. Our research has been growing, and more growth is needed. Of course, clinical care is absolutely essential to what we do and partnering well with Nebraska Medicine will remain important."

APPLICATION FOR MEMBERSHIP

Metro Omaha Medical Society

NMA Nebraska Medical Association

This application serves as my request for membership in the Metro Omaha Medical Society (MOMS) and the Nebraska Medical Association (NMA). I understand that my membership will not be activated until this application is approved by the MOMS Membership Committee and I have submitted my membership dues.

PERSONAL INFORMATION

Last Name:_____ First Name:_____Middle Initial:_____

Birthdate:_____Gender: ☐ Male ☐ 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: (*M.D., D.O., M.B.B.S, etc.*)_____

Residency Location:_____Inclusive Dates:_____

Fellowship Location:_____Inclusive Dates:_____

Primary Specialty:_____

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

_____ _____

Signature *Date*

FAX APPLICATION TO:
402-393-3216

MAIL APPLICATION TO:
Metro Omaha Medical Society
7906 Davenport Street
Omaha, NE 68114

APPLY ONLINE:
www.omahamedical.com

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Metropolitan Omaha Medical Society
7906 Davenport Street
Omaha, NE 68114

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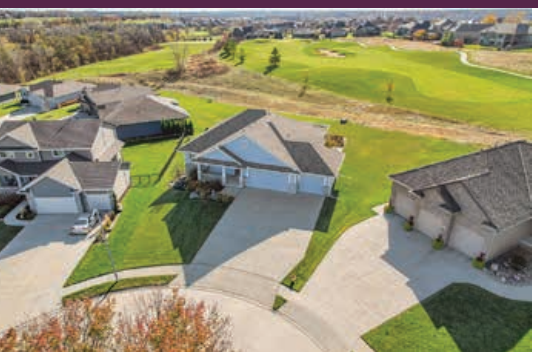

12307 REYNOLDS CIRCLE | $600,000

Cozy front porch, stone accents, and cul-de-sac location. Zero-entry home (front and garage), ADA interior doors, and wide hallways. Two suite bedrooms on the main floor with walk-in closets, tile showers (zero entry), heated tile floors, and primary bedroom has soaker tub and double vanity. Open design with hardwood floors, extra large windows, new interior paint (2024), and designer lighting. Modern kitchen with painted cabinets (soft close), granite counters, tile backsplash, and white appliances. Just off the garage is the powder bath with faux finish walls and the laundry room with sink plus washer/dryer (included). Lower level is 75% finished with in-floor heating, drywall, lighting, doors, wood stairs, and window treatments (needs trim and flooring). Lower level includes bedrooms 3 and 4 (walk-in closets), huge family room, partially finished 3/4 bath (all fixtures to stay in home). Stunning views, large patio with pergola, and professional landscaping. Impressive property!

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KAREN JENNINGS

Realtor/Real Estate Agent
OMAHA MAGAZINE'S Best of Omaha 2025 Winner
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