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MEDICINE



Concierge Medicine

**Direct Primary Care
Gains Momentum**

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Collaboration and Leadership



Howard Axe, MD, was installed as the 164th President of the Chicago Medical Society in ceremonies on June 12. See page 22 for coverage.

AS PRACTICING physicians, we care for patients on a daily basis. As a primary care physician, I regularly collaborate with my specialist colleagues to diagnose and treat my patients' varied ailments. By phone, on the hospital unit, or consult report, we work together to form a treatment plan that best suits patients and their problems. Often, I find face-to-face conversation the best way to exchange ideas and share input.

This experience also plays out as the Chicago Medical Society increases efforts to reach out, collaborate, and build relationships. Listening to what our members told us over the past year, we consulted and formed a plan for better engaging and serving physicians in Cook County. Highlights include:

- Our Governing Council's modified format welcomes physicians from academic institutions and other groups, so we can hear how to best meet the needs of diverse groups, while stimulating their participation. The Society recognizes that academic doctors have different needs than employed physicians, whose needs are different than those of independent physicians practicing in small groups.
- On the District level, we are creating meaningful programs and services.
- Our reinvigorated committee structure allows more opinions to be heard and policy formulated that reflects our organization's diversity.
- In building broad-based coalitions with those who share our interests, we can more effectively institute meaningful change in the healthcare system. Our advancement from supporter to partner in the "Building a Healthier Chicago" initiative demonstrates our expanded role in the public health sector.
- Our role in an Institute of Medicine of Chicago forum highlighted the activities and positions of our Society. Thomas M. Anderson, Immediate Past President, represented you.
- In a Chicago Public Schools program, Anne Szpindor, MD, and I educated physical education teachers on asthma and diabetes.
- The Society teamed with the American Bar Association's Health Law Section to hold an educational conference. Yes, I was also skeptical initially, but have come to appreciate the value such a working relationship can provide to both organizations.
- Our Mini-internship Program continues to pair a legislator with a practicing physician to see firsthand how medical care is delivered. Through this program we are promoting Chicago's 22 Primary Stroke Centers (PSC). The PSCs offer the full spectrum of services to those suspected of suffering a stroke.

Productive partnerships are increasingly vital as our country's healthcare landscape evolves, along with the way care is provided. These relationships will require our members' active participation, and our finding common ground. Listening and valuing the contributions and approaches of others are both critical to providing patient-centered, high-value care to patients and their families. I urge you to join these efforts. You will find membership professionally and personally rewarding, as we channel our energies in a positive direction.

Please send me your comments and suggestions for strengthening your Society.

A handwritten signature in black ink, appearing to be "H. Axe", written over a horizontal line.

Howard Axe, MD

President, Chicago Medical Society

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From Hippocrates to HIPAA

More security mandates than ever **by Alex Cohn, CISSP, and Abel Kho MD, MS**

YOU MAY NOT think you learned about privacy and security in medical school, but you did. It's right there in the Hippocratic Oath: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account must be spread abroad, I will keep to myself, holding such things shameful to be spoken about."

The principles captured by the Hippocratic Oath still apply, but how we maintain the privacy of our patients' records in a digital age continues to evolve. Understanding new technologies and complex federal regulations requires significant time and effort outside the scope of our practice of medicine.

Did we mention the regulations? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set federal standards for the protection of individually identifiable health information. A privacy and security risk assessment is a required component for achieving meaningful use of an electronic health record (EHR) if you're participating in the Medicare or Medicaid EHR Incentive Program. The Health

Information Technology

for Economic and Clinical Health (HITECH) Act of 2009 further requires that breaches of protected health information affecting more than 500 individuals be publicly posted. Indeed, there are more privacy and security mandates for physicians to keep track of than ever before.

Audits will Increase Next Year

A recent search of the Department of Health and Human Services Website yields more than 400 recorded breaches by hospitals and clinics. In Arizona, a cardiac surgery practice was fined \$100,000 and required to implement a corrective action plan for such a breach. Over the past year, the professional services firm KPMG conducted 100 random audits of eligible providers to assess their adherence to the federal privacy and security standards. The number of audits is expected to increase in 2013.

This all may sound burdensome, but we all know it's for the best. And with a few key steps, you can

ensure protection for yourself, your practice and your patients:


First, consider some simple security measures. Make sure you are using strong passwords that are longer than eight characters; contain no dictionary words; and include a mix of letters, numbers and special characters. Never share your username or password with anyone, even your staff. Install anti-virus software on all of your desktops, laptops, tablets and servers. Install a firewall between your practice and the Internet, to keep prying eyes out of your data. Encrypt all of your laptops and mobile devices that contain patient data. Ensure you have appropriate physical locks in place and fire protection for your medical records.

Start with Security Risk Analysis

Perform a security risk analysis. These measures are a good start for protecting your data; however, to fully protect your practice as well as comply with federal regulations like HIPAA, you will need to perform a security risk analysis. This is a formal process that starts with a detailed inventory of your practice, including all staff, hardware and systems that deal with patient data. Next, you will put together a comprehensive list of all the threats and vulnerabilities to the staff, hardware, and systems you just identified. Then you evaluate each of these threats and vulnerabilities to determine their level of risk. Once you have determined that risk, you're ready to make a list of controls to mitigate those risks and sum up the analysis.

Above all, create a record of what you've done. Just as you record information on patients as part of the medico-legal record, be sure to keep documentation (receipts, policies, assessment results) for any possible future audit, however unlikely at this time.

If this all sounds a bit too far afield, seek professional assistance. As Chicago's federally funded resource for health IT assistance, we have helped train seven local information systems consulting firms to conduct formal privacy and security risk assessments. We have a complete set of tools and checklists, as well as a list of trained IT consultants, available to help guide you. For recorded Webinars and additional information, visit us at: www.chitrec.org/library/privacyandsecurity.

Dr. Kho is an internist and co-executive director of the Chicago Health IT Regional Extension Center (www.chitrec.org). CHITREC is federally funded to directly assist providers in Chicago achieve meaningful use of electronic health records. Alex Cohn is CHITREC's privacy and security officer. 

"Above all, create a record of what you've done. Just as you record information on patients as part of the medico-legal record, be sure to keep documentation (receipts, policies, assessment results) for any possible future audit, however unlikely at this time."



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Direct Primary Care Gains Momentum



Concierge medicine at an affordable cost **By Bruce Japsen**

For the daily cost of a “Grande” Starbucks latte, more primary care doctors like Anthony Auriemma, MD, say they are pretty confident they can provide their patients high-quality medical care at an affordable price and ultimately save the healthcare system a lot of money.

The 35-year-old family physician practices in the western suburbs of Chicago and is part of a growing number of doctors who are offering what they hope is a more affordable approach to concierge medicine known as direct primary care.

Unlike concierge care for wealthy people, which sparked a 2005 investigation by Congress’ investigative arm, the Government Accountability Office, the new direct primary care approach generally runs between \$50 and \$100 a month with lower prices for children.

Those prices are in contrast to what worried some lawmakers who saw patients losing access to medical care if they could not afford membership fees of \$5,000 to \$15,000 a year or more that

were outlined in the GAO report.

Doctors say they can still care for most primary care needs and do it without the interference of an insurance company, for as little as \$50 a month in many cases.

“The nice thing about this model is that I know my patients because I have 400 to 600 patients, whereas in the typical primary care model, a doctor has 2,000 to 3,000 patients,” Dr. Auriemma said.

“It’s trying to put customer service into medicine, which has been missing.”

Unlike the concierge practices that gained a lot of attention a decade ago, direct primary care practices say they provide more than just convenience, but a way to keep costs low because they keep patients from unnecessary and expensive trips to the hospital emergency room. They do this by giving patients an over-the-phone diagnosis that may only require a prescription or treating the ailment in the clinic when possible and avoiding an unnecessary referral.

For \$125 a month, Dr. Auriemma provides all the primary care a patient needs through unlimited office visits as well as round-the-clock mobile phone access and e-mail consultations. Dr. Auriemma said he is able to offer a lower priced, \$50-a-month option and provide the same service though patients’ insurance, which would be billed for traditional primary care services including tests and visits.

If patients need more specialized care or hospitalizations, they generally purchase a high-deductible plan, Dr. Auriemma and direct primary care advocates say.

The direct primary care approach is catching a wave of attention across the country, drawing major investors and convincing state policymakers to change rules to allow the concept to flourish.

Several companies have launched across the country to back doctors who want to join direct primary care practices, drawing some large Wall Street investors or big names like online retailer Amazon founder Jeff Bezos, who has helped back the expansion of Seattle-based Qliance.

Supporters say the easier access to a physician and the ability to call or e-mail any time with questions or advice potentially keeps a patient out of the more expensive hospital setting or away from an unnecessary and expensive emergency room visit.

“Currently, in most primary care practices, there is no reward for seeing a patient on time, listening to their needs, curing their ills, or cultivating compassion and trust,” said Dr. Garrison Bliss, Executive Vice President of Medical Affairs at Qliance, a direct primary care practice that charges \$59 a month for services that include same-day or next-day appointments, unlimited visits and 24-hour access to a physician via e-mail or telephone.

“With direct primary care these elements become central to the overall success of a practice, because if patients are unhappy they can go elsewhere.”

Bliss is also a co-founder of the Direct Primary Care Coalition, which was formed in part to promote the healthcare model and to convince members of Congress that it could be a solution—or at least help rein in federal health spending, particularly for the more than 48 million Americans covered by Medicare.

Though direct primary care practices involve only a fraction of practicing physicians today, they are growing. The coalition estimates there are direct primary care practices in two dozen states that are treating more than 100,000 patients.

Direct primary care practices say they are beginning to interest more employers in their concept, which will allow them to charge fees lower than \$60 if they get a higher volume of patients. Qliance, for example, charges someone who pays out-of-pocket such as an uninsured person, a monthly membership fee of between \$49 and \$89, depending on age. An older person with more needs might pay more.

Employers are drawn in by pitches from the practices that say administrative overhead and bureaucracy adds 20% or more to costs by some estimates.

Washington State’s largest employee union plan this year offered a direct primary care option from Qliance that lowered employee-only premiums for the United Food & Commercial Workers Local 21 to \$5 a week from \$9 a week.

The union said it purchased Qliance after first conducting a pilot program with the direct primary practice to see if it worked and would, indeed, lower costs.

“Through our pilot program, we were able to see how Qliance can bring down overall healthcare expenditures and keep our members healthier,” Diane Zahn, Secretary of the South Health & Wellness Trust, and Secretary-Treasurer of UFCW Local 21, said at the time the broader relationship was announced last November.

But not all areas of the country are as welcoming of direct primary care, and Illinois may need the blessing of the state insurance director before broader usage of direct primary care can happen here.

In most states, insurance directors at first glance consider certain direct primary care practices as prepaid health plans, which means they would require millions of dollars in capitalization.

“If I am paying a provider a fixed

monthly amount to receive unlimited physician visits, I believe that our law would call that pre-paid health or capitated care,” said David Grant, Deputy Director of the Health Products Division for the Illinois Department of Insurance.

“Provider groups would be found to be bearing risk and would need to be appropriately licensed.”

States have, however, been making changes to their insurance rules to allow more direct primary care, saying this care is different than “capitated” HMO-style care because it doesn’t restrict care to a network and it provides unlimited access without co-payments.

Washington State legislation was passed in recent years to allow more direct primary care practices to operate free of such insurance rules. Several other states, including California, have worked with insurance directors to allow for more direct primary care or are working on legislation to allow it.

“We have to educate on what direct primary care practices are,” said Jay Keese, principal with Capitol Advocates, a Washington lobbying firm that is representing the Direct Primary Care Coalition.

On the federal level, Keese and the Coalition have helped lead a legislative effort that so far has bipartisan support in Congress. It was introduced by Rep. Bill Cassidy, a Louisiana Republican, and U.S. Rep Jay Inslee, a Democrat. (Inslee resigned his seat earlier this year to focus on his campaign for Washington governor.)

A U.S. House bill introduced late last year would create pilot programs for Medicare beneficiaries as well as people enrolled in both Medicare and state Medicaid programs who are known as “dual eligibles.”

Under the proposed Direct MD Care Act, monthly fees could not exceed \$100 for Medicare beneficiaries. Without the law, doctors who contract directly with patients say they cannot treat Medicare patients because doctors cannot bill for services Medicare already pays doctors for.

The Act says that direct primary care medical homes in the pilot projects will provide Medicare patients and dual-eligible patients with the following: preventive care; wellness counseling; primary care that is coordinated with specialized and hospital care; urgent care services; office appointments seven days a week, email and telephone consultations; and 24-hour access to urgent care consultations by telephone any day of the week.

Supporters say the legislation’s emphasis on lower-cost primary care is key, particularly when members of Congress are under pressure to control spending.

“This kind of care should be a centerpiece of healthcare policy, not only because it will be a nice thing for doctors and patients, but also because it dramatically reduces overall healthcare costs in the private sector by keeping people healthier, thereby reducing ER visits, hospitalization days, surgeries and specialist visits by remarkable numbers,” Dr. Bliss said.


“If passed, this bill would enable the Centers for Medicare and Medicaid Services to measure the downstream cost-savings and health benefits of providing Medicare and Medicaid beneficiaries with unrestricted access to direct primary care, and could significantly reduce the cost of caring for America’s sickest and poorest population by providing easy access to high-quality primary care.”

Though the developers of direct primary care practices say their model saves money and they have their own internal data showing that, supporters and skeptics alike acknowledge the Medicare pilot projects would also test whether money can be saved in the government program.

Physicians like Dr. Auriemma believe the potential for savings is an achievable goal.

“If you can communicate regularly with patients with diabetes, you can save money on doctor visits, hospital visits, or adverse events from medications,” Dr. Auriemma said.

“The average patient sees the doctor about three times a year but for people who have diabetes, hypertension or other chronic conditions, telephone follow-up will help them and also save money. If we can improve cost efficiencies and outcomes, there is no reason not to give it a try.”

Bruce Japsen is an independent Chicago healthcare journalist and a contributor to the New York Times and writer for the Times’ Prescriptions healthcare business and policy news blog. He was healthcare business reporter at the Chicago Tribune for 13 years and is a regular television analyst for WTTW’s Chicago Tonight, CBS’ WBBM radio 780-AM and 105.9 FM and WLS-News and Talk, 890-AM. He teaches healthcare writing at Loyola University Chicago and has taught in the University of Chicago’s Graham School of General Studies medical editing and publishing certificate program. He can be reached at brucejapsen@gmail.com. 

Stroke in Women

Second leading cause of death by Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

ON AVERAGE, every 40 seconds someone in the U.S. has a stroke, the nation's leading cause of disability and the fourth leading cause of death. In women, stroke is the second leading cause of death, with 425,000 women suffering from stroke each year, 55,000 more than men. Not only is the overall stroke rate higher for women than for men, women are more likely to have more disability and poorer outcomes than men.

Women's Symptoms More Atypical

What are the possible reasons to explain this observation? One study showed that women may experience longer delay from arrival to emergency rooms to the time they are evaluated for stroke symptoms. The delay may be due to possible gender differences in the reporting of acute stroke symptoms. In a study of 1,189 admissions that ended with a confirmed stroke diagnosis in the emergency room, traditional stroke symptoms of postural imbalance (men 20% vs. 15% in women) and hemiparesis (men 24% vs. 19% in women) were more likely to be the presenting symptoms for men than for women. In addition, women were more likely to present with symptoms that were more atypical for stroke, including pain, and

change in cognition or level of consciousness.


Another possible reason centers around the type of medical treatment given after the diagnosis of stroke is made. Studies have shown that once a diagnosis of stroke has been made, the type of treatment given to women and men differ. In fact, the gender differences in management of stroke appear to be similar to the well-documented gender differences noted in the treatment of cardiac disease; where women are less likely to receive major diagnostic and therapeutic procedures. Differences may also exist in medical treatment for stroke prevention. Men with stroke are more likely to have significant co-morbidities, such as higher rates of ischemia, heart disease, and diabetes compared to women, who have higher rates of hypertension and atrial fibrillation. This cardiovascular medical history profile noted in men may result in more aggressive preventative treatment in men than in women.

Carotid Disease More Common in Men

Aspirin and warfarin are equally effective medications for stroke prevention in men and women. Carotid endarterectomy (CEA) is another important treatment for the primary and secondary prevention of stroke in patients with significant carotid stenosis. Although carotid disease is more common in men than women, some studies have shown a higher rate of post-operative complications in women, such as post-operative stroke. Other studies have found no differences in morbidity and mortality. Commonly cited complication rates in women have been old age at time of presentation for CEA, presence of hypertension, and smaller size carotid arteries.

Hypertension More Common in Women

In stroke and heart disease, the commonly recognized risk factors of smoking, elevated cholesterol, a previous stroke, and large artery atherosclerotic disease, hold true for both men and women. Workup following new stroke should be similar in both sexes. Hypertension and elevated cholesterol are more common in women as they age. Typically, cholesterol levels will increase at the age of 45, presumably due to the onset of menopause. For women who are pre-menopausal, the stroke rate is low except when associated with hormonal contraception. Pregnancy does not appear to increase stroke rates significantly until the last trimester, although pregnancy can complicate pre-existing cerebrovascular disease. Specific differences, though, have been found in some risk factors for women that may predispose them to stroke. One study found that women with stroke had an elevated tissue plasminogen activator antigen, which was an independent risk factor for stroke in non-diabetic women ages 15 to 44 years-old. Other studies have shown that a significant proportion of young women have elevated homocysteine serum levels, an independent risk factor for stroke and vascular disease. Serum homocysteine levels were decreased in women who took daily multivitamins with B6, B12, and folate. Last, oral hormone replacement used by menopausal women may increase the stroke rate.

Dr. Aggarwal is a cognitive neurologist at Rush University Medical Center, and the clinical core co-leader of the NIA-funded Rush Alzheimer's Disease Research Center. Dr. Prabhakaran is a stroke neurologist, and head of the section of cerebrovascular diseases and neuro-critical care at Rush. 

Primary Stroke Centers

THE CHICAGO AREA is now home to 22 Primary Stroke Centers that provide state-of-the-art clinical care 24/7 to prevent stroke, minimize disability in stroke survivors, and ensure the best possible outcomes for patients following a stroke. Please refer to this listing of PSCs.

Adventist Hinsdale Hospital	Center
Advocate Christ Medical Center	Mount Sinai Hospital Medical
Advocate Good Samaritan	Center
Hospital	NorthShore University
Advocate Illinois Masonic	HealthSystem
Medical Center	Northwestern Memorial
Advocate Lutheran General	Hospital
Hospital	Our Lady of the Resurrection
Advocate South Suburban	Medical Center
Hospital	Resurrection Medical Center
Advocate Trinity Hospital	Rush University Medical Center
Alexian Brothers Medical	Saint Alexius Medical Center
Center	Saint Francis Hospital
Ingalls Memorial Hospital	Saint Joseph Hospital
John H. Stroger, Jr., Hospital of	Saints Mary and Elizabeth
Cook County	Medical Center
Little Company of Mary	University of Chicago Medical
Hospital	Center
Loyola University Medical	University of Illinois Medical
Center	Center at Chicago
MacNeal Hospital	West Suburban Medical Center
Mercy Hospital and Medical	Westlake Hospital

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CMS Joins Leadership of Building a Healthier Chicago

There is no cost to becoming a stakeholder **by James M. Galloway, MD**

“We seek dedicated individuals who are willing to commit their expertise to improve the health of Chicago residents.”

WE ARE proud to welcome the Chicago Medical Society to Building a Healthier Chicago's (BHC) executive leadership team. Since 1850, your renowned organization has led important public health initiatives in the city, mobilizing thousands of dedicated physicians to combat disease and poor sanitary conditions, among other threats.

The Society's participation on the leadership team will help BHC further align and synergize coalition efforts throughout our communities. Team members also include the U.S. Department of Health and Human Services (Region V), Chicago Department of Public Health, and the Institute of Medicine of Chicago.

BHC was initiated four years ago to work with hundreds of local and national stakeholders, uniting and supporting organizations, businesses, and non-profits around the goals of prevention and healthy living. Our synergies and relationships continue to grow stronger, larger, and more effective.

Team efforts are focused primarily in three general areas:

- Improvements in healthy eating
- Increased physical activity levels
- The prevention, detection, and control high blood pressure

We work with community organizations, academics, healthcare and governmental bodies, promoting a wide range of events, interventions, policy and system changes, and partnerships so every individual can access information, resources, and support for a healthy lifestyle.



**BUILDING A
HEALTHIER
CHICAGO**

Not only that, BHC promotes and tracks the adoption of selected programs, practices, policies, and supportive environments throughout worksites, schools, healthcare organizations, faith-based organizations, parks and neighborhoods of Chicago.

There is no cost to become a BHC stakeholder. We facilitate joint projects among our stakeholders, information sharing and collaborative learning, and training, building a comprehensive network of programs and services.

Now is the time to join our growing network. We seek dedicated individuals who are willing to commit their time, energy, expertise, and resources to effectively improve the health of Chicago residents through this meaningful collaborative approach. Working together, we can provide Chicagoans healthy alternatives where they live, learn, work, eat, play, and pray.

Learn more about Building a Healthier Chicago by going to: www.HealthierChicago.org.

Dr. Galloway is Assistant U.S. Surgeon General and Acting Regional Director, Regional Health Administrator, Region V (Illinois, Indiana, Minnesota, Ohio, Wisconsin). In addition, he is also adjunct professor of medicine at Northwestern University's Feinberg School of Medicine in the departments of cardiology and preventive medicine. He can be reached at: James.Galloway@hhs.gov.

First Surgeon General had Local Roots

CHICAGO IS HOME of the first U.S. Surgeon General, John Maynard Woodworth. A graduate of the Chicago Medical College in 1862, Dr. Woodworth became a demonstrator in anatomy at the College in 1866. He was also appointed as Surgeon of the Soldier's Home of Chicago and Sanitary Inspector of the Chicago Board of Health in that same year. In 1871, Dr. Woodworth was appointed as the first Supervising Surgeon of the Marine Hospital Service, based in Washington, DC. The title was changed in later years to Surgeon General.

HEALTHY CHICAGO PRIORITIES



Tobacco Use



Obesity Prevention



HIV Prevention



Adolescent Health



Cancer Disparities



Heart Disease



Access to Health Care



Healthy Mothers



Comm. Disease



Healthy Homes



Violence Prevention



Public Health

Chicago's Top 12 Public Health Priorities

Healthy Chicago's 12 discrete priority areas for action.

Responding to challenges since 1835 by **Bechara Choucair, MD**

BEGINNING with the 1835 cholera outbreak, the Chicago Department of Public Health (CDPH) has responded to health challenges impacting our residents and city. In keeping with that mission, the CDPH launched the city's first public health agenda, Healthy Chicago, last year. This action plan outlines the city's top 12 public health priorities, with more than 193 strategies to achieve measureable targets over the next five years. Each priority area focuses on creating new policies to improve public health; delivering new programs and services; and leading educational and public awareness campaigns. These combined efforts will lead to a healthier

city for residents in every neighborhood.

Working with community partners, we are already creating more smoke-free places to reduce residents' exposure to second-hand smoke; designating hospitals as "Baby Friendly" to encourage new moms to breastfeed; and introducing mobile produce carts that give residents access to fresh fruit and vegetables as one strategy to lower obesity in our city.

Improvements in our city's health require more than a response from local health departments and lawmakers. Physicians are encouraged to get involved.

Please view our full agenda online at www.cityofchicago.org/health and give us your feedback on key strategies

to transform the health of our city. Suggestions should also come from faith-based organizations, educational institutions, community groups and individuals.

Chicago Medical Society members can follow the progress of Healthy Chicago by downloading monthly updates from the CDPH website or by signing up to receive email updates at <http://tinyurl.com/6pu9d96>. You can also find us on Facebook (ChicagoPublicHealth) and Twitter @ChiPublicHealth.

Dr. Choucair is Commissioner of the Chicago Department of Public Health. Please contact him at choucair@cityofchicago.org or @choucair on Twitter. 

The View from Our Office

“Million Hearts” national initiative needs you **by James M. Galloway, MD**

“We, as physicians, can help prevent one million heart attacks by 2017,” says Dr. James Galloway, Assistant U.S. Surgeon General and Regional Health Administrator, Region V, U.S. Public Health Service.

A S A CARDIOLOGIST, my primary focus and passion has long been the prevention of cardiovascular disease in our nation.

I would like to share an exciting and vitally important public-private initiative with significant potential to save lives and prevent disease.

We all are aware that CVD is the leading cause of death in the U.S., with more than two million strokes or heart attacks annually—and more than 800,000 deaths. In fact, one in every three Americans dies of heart disease and stroke—roughly 2,200 deaths per day and 92 individuals per hour!

From an economic perspective, CVD care accounts for one out of every six dollars in


healthcare expenditures, costing our nation \$444 billion annually in medical care and lost productivity. Mediated in part by a massive increase in obesity and associated risk factors, these rates are expected to triple nationally in the next two decades if the trend is not effectively addressed. The great news is that we, as physicians, in addition to our roles as medical and public health leaders in the Chicago area, can lead efforts to prevent these killers of our patients.

Million Hearts™ is a bold national initiative that focuses many existing prevention efforts on an audacious but achievable goal: preventing one million heart attacks and strokes by 2017. It is time for us to take the next big step and bring this goal to fruition. In the Chicago area alone that equates to CVD events among roughly 28,000 friends, colleagues and fellow citizens. The prevention of one million heart attacks and strokes by reducing risk factors for CVD is an enormous task, one which requires coordination and alignment of efforts by both clinical and community-based organizations, as well as individual efforts.

In the clinical realm, Million Hearts focuses on managing the “ABCS”—aspirin for high-risk patients; blood-pressure control; cholesterol management; and smoking cessation. There is also an associated community-based prevention effort to reduce smoking, improve nutrition, and reduce high blood pressure.

Currently, only 47% of people with ischemic heart disease take daily aspirin or another anti-platelet agent; only 46% of patients we diagnose with hypertension have it adequately treated; only one-third of our patients with hyperlipidemia have achieved appropriate control; and less than one quarter of smokers who try to quit get counseling or medications. As a result, more than 100 million people—half of American adults—smoke or have uncontrolled high blood pressure or elevated cholesterol levels; and many have more than one of these cardiovascular risk factors. Increasing utilization of simple clinical interventions alone—and monitoring our efforts—could save more than 100,000 lives a year.

To get involved, visit our website at: www.millionhearts@hhs.gov. Together, we can save a million hearts and many more.

Dr. Galloway is Assistant U.S. Surgeon General and Regional Health Administrator, Region V, U.S. Public Health Service. The opinions expressed in this article are those of the author and do not necessarily reflect the views of the Office of the U.S. Department of Health and Human Services or the federal government. 



Unintended Disclosure of HIV+

Statutory penalties and other damages by Ann Hilton Fisher, JD

HIV REMAINS a uniquely stigmatizing disease despite concerted efforts to make HIV testing and care routine. Associations with illicit drug use and homosexuality, uncertainties about the origins and modes of transmission, and vivid recollections of the days when a diagnosis almost always meant a death sentence, have combined to create high levels of fear throughout society. As recently as 2009, a national study by the Kaiser Family Foundation found that 35% of respondents would feel uncomfortable having their child taught by an HIV+ teacher and 51% would feel uncomfortable eating a meal prepared by someone with HIV. This stigma is often internalized by people with HIV, making people reluctant to seek treatment for this life-threatening illness.

Because stigma is so pervasive, public health officials have always worked to assure people with HIV and those at risk for HIV that their status will be kept strictly confidential. In Illinois, HIV confidentiality is governed primarily by the Illinois AIDS Confidentiality Act (410 ILCS 305/2).

The AIDS Confidentiality Act predates HIPAA. It is more protective of patient confidentiality than HIPAA, so it controls in cases where the two statutes may come in conflict. There are three areas in particular that frequently come up in healthcare settings.

Incidental Disclosures. Every few weeks someone calls the AIDS Legal Council of Chicago to complain that a healthcare provider disclosed their HIV status to someone who was visiting their hospital room or accompanied them to an emergency room. It may be an anesthesiologist coming in the evening before surgery and mentioning that it will be all right if they take their HIV medications in the morning. Or an emergency room doctor accessing the chart of someone who came in after being injured in a baseball game and asking, in front of the teammate who accompanied the patient to the ER, “Are you taking your HIV meds?” Although these incidental disclosures might be permissible under HIPAA, as long as the facility and individuals took “reasonable safeguards” to protect confidentiality, the AIDS Confidentiality Act has no similar exemption. A disclosure of someone’s HIV status to a third party is prohibited absent a “legally effective release.” Regulations specify that a legally effective release must be in writing.

The best practice in this situation is to always ask visitors to leave the room before any discussion of HIV takes place. If the patient indicates that the visitors are aware of his or her status and the patient would like them to participate in the conversation, have the patient sign a release

to that effect, which can then be placed in the patient’s chart.

Duty to Warn. Healthcare providers frequently ask whether they can or must warn the sexual partners of their HIV-positive patients that they are at risk of contracting HIV. HIPAA provides that covered entities can disclose to “a person who may have been exposed to... if the covered entity... is authorized by law to notify such person (45 CFR 164.512(b)(1)(iv)). The Illinois AIDS Confidentiality Act allows, but does not require, physicians (but not other healthcare providers) to tell the spouse or partner in a legal civil union of their HIV+ patient, but only after first trying to persuade the patient to tell the spouse or partner themselves. The law specifically states that it creates no duty to warn and that physicians acting in good faith are protected whether or not they warn the spouse or partner. The law does not permit disclosure to any other partners.

Damages. HIPAA allows no private right of action, instead placing the enforcement responsibility on the HHS Office of Civil Rights and the Department of Justice. Individuals may file complaints, but there is no assurance they will be investigated, and even where serious violations are found that lead to civil monetary penalties, the individual patient is not awarded damages. In contrast, the AIDS Confidentiality Act explicitly provides not only a right to sue for violations of the Act but also statutory penalties for violations. Because these are statutory penalties, the person does not have to prove actual damages. Individuals who do have actual harm can receive more than the statutory damages. The minimum penalty for a negligent violation (such as the overheard bedside conversations discussed above) is \$2,000 per violation. The minimum penalty for a reckless or intentional violation is \$10,000. The law also allows for injunctive relief and attorney’s fees.

Healthcare providers with a question about HIV disclosure should consult their own risk management staff. But the AIDS Legal Council of Chicago is also available to provide training and respond to questions from service providers. Council staff can be contacted at 312-427-8990.

“Every few weeks someone calls the AIDS Legal Council of Chicago to complain that a healthcare provider disclosed their HIV status to someone who was visiting their hospital room.”

The author is Executive Director of the AIDS Legal Council of Chicago. 

A Brief Guide to Disability Insurance

Various factors can work in a claimant's favor **by Mark D. DeBofsky, JD**

“The most desirable coverage is individual disability insurance that pays a fixed monthly benefit and insures against the inability to perform the key duties of one's occupation.”

Introduction

Filling out forms for disability claims can be the bane of a doctor's existence. Besides being time-consuming to complete, doctors are requested to specify functional limitations that are often impossible to measure. Indeed, the entire concept of “disability” is elusive, since a disability determination involves a combination of legal, vocational and medical considerations. The following brief discussion is intended to help physicians better understand how disability insurance works.

Disability Insurance and Social Security Disability Benefits

Obtaining Social Security disability benefits can be the most difficult since the entitlement to benefits requires a complete inability to work. However, various factors can work in a claimant's favor. In addition to objective medical test results and clinical findings, Social Security evaluates the impact of pain and other symptoms, as well as the co-morbidity of multiple impairments. Vocational factors such as the claimant's age, education, and skill level are also taken into consideration.

Since it is difficult to qualify for Social Security disability benefits, and because benefits are capped at approximately \$2,500 per month for the highest wage earners, many professionals such as physicians purchase private disability insurance. The most desirable coverage is individual disability insurance that pays a fixed monthly benefit and insures against the inability to perform the key duties of one's occupation, or even a specialty within that occupation. Benefits may be also payable for partial disabilities or even a loss of income following a recovery from illness or injury. It is also possible to purchase insurance to cover fixed business overhead costs in the event of disability. When premiums for individual coverage are paid with after-tax dollars, the benefits are not subject to federal income taxation.

In contrast to individual disability insurance, many organizations purchase group disability insurance for their members and employees. Those benefits typically represent a percentage of salary and are more likely to be taxable. Group disability benefits are also generally subject to offsets, which include Social Security disability payments (both for the insured and their dependents) as well as other group coverage, which may include disability insurance purchased through a medical association. Thus, instead of a supplement, such coverage may prove worthless if those payments reduce the amount of group disability insurance benefits.

Group coverage is also not necessarily focused on the insured's occupation or specialty—most policies apply a more generalized definition of

disability after an initial benefit period. In addition, group coverage is more likely to include provisions that limit the duration of benefit payments for certain specified conditions such as psychiatric disorders or other illnesses deemed “self-reported” such as migraine headaches, fibromyalgia, and chronic fatigue syndrome. Finally, group coverage is usually subject to the Employee Retirement Income Security Act (ERISA). The applicability of ERISA limits both judicial remedies and court procedures, giving greater advantages to insurers in the event of a dispute over benefits.


Disability Determinations

The determination of disability involves three components—a contractual or statutory definition of disability, medical findings pertaining to diagnosis as well as physical and other restrictions and limitations, and a vocational analysis focused on whether the established limitations preclude employment either in a particular job or generally. Although the Social Security Administration gives limited deference to treating doctor opinions, neither the Social Security Administration nor any insurance company will accept a doctor's opinion that the “patient is disabled” without a description of specific physical, cognitive, or other restrictions and limitations supporting that conclusion. Nor do private insurers afford deference to treating doctor opinions; many also now eschew “independent medical examinations” in favor of record reviews, often without obtaining any input from the treating doctor.

Beware of the myth of the functional capacity evaluation (FCE) as an objective means of assessing disability since none of the test protocols have been validated by rigorous scientific study. While the results of FCE testing may be useful in corroborating treating doctor opinions, it is difficult to extrapolate someone's ability to work on a full-time basis from only a few hours of testing and observation.

Conclusion

More than eight million Americans receive Social Security disability benefits, and many more receive disability insurance. Protecting one's earnings by insuring against unforeseen illness or injury is critical. Those deserving of compensation need the support of their doctors along with experienced legal representation. Even those in good health and in the prime of their careers cannot ignore the risk of disability and should review the adequacy of their own disability protection.

Mr. DeBofsky practices in the Chicago law firm of Daley, DeBofsky & Bryant. 

Enemies No More

CMS launches new partnership with the legal community

IN THE PAST year, the Chicago Medical Society initiated a mutually beneficial new relationship with the Health Law Section of the American Bar Association.

As the article on page 32 shows, our first joint effort was a “Physician-Legal Issues” conference featuring both physicians and attorneys as presenters and audience members. Participants came away with new insight and information about medical practice options available under healthcare reform.

In addition to providing our members with guidance on navigating the healthcare landscape, the partnership helps to bring together two professions with shared professional and personal interests. We say “shared” because the massive shifts in our heavily regulated healthcare system mean that doctor-lawyer alliances are crucial to steering the course and protecting physicians’ rights and interests. In spite of their historic antagonism, the

professions also share core social and ethical values.

As outlined in “Fight Club: Doctors vs. Lawyers—A Peace Plan Grounded in Self-Interest,” which appeared in the June issue of Chicago Medicine, the professions “just don’t know each other.” Attorney-author Andrew J. McClurg, JD, highlighted a survey of medical, law and business students that showed they think remarkably alike except on cost containment issues that affect their own profession. Nevertheless, the different groups strongly agreed that liability reform would be effective at reducing healthcare costs.


McClurg points out that lack of trust in lawyers and doctors can result in legal action when patients and clients are disappointed with unanticipated results. On a broader policy level, he says, the lack of trust can cause the public to be more willing to support government regulation that hurts both professions. “In light of

mounting evidence that public confidence is declining for all professions, doctors and lawyers have a joint stake in working together to build and sustain trust and respect in the professions as a whole.”

The Medical Society supports McClurg’s proposals for new forms of interaction and communication between attorneys and physicians to repair their relationship.

Working with the ABA’s Health Law Section, Chicago Medicine has published a legal section in each issue featuring attorney-written articles. We are also exploring a joint committee for both organizations to work together, as well as a legal referral service for doctors, including blogs and forums.

This partnership paves the way for future educational programming, and is proof the Society continues to reinvent member programs and services on behalf of Chicago’s physicians.

Together we will meet the changes and challenges ahead. 

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ISMS Protects Physicians from Bad Bills

Dodging the reimbursement razor by ISMS President William N. Werner, MD, MPH

Medicaid Cuts

“Everybody is going to get a haircut. No one will get scalped—that’s the basic concept.”

When those words were uttered by our Governor in reference to Medicaid back in February we knew we had our work cut out for us.

With Illinois’ Medicaid reimbursements, doctors have been sporting crew cuts for several years. Fortunately, Illinois physicians have dodged the reimbursement razor this time around.

We didn’t just get lucky when we dodged significant cuts in the \$2.7 billion package of reductions that passed in May. It took tremendous effort from our legislative advocacy team to avoid across-the-board cuts.

In addition to our people on the ground in Springfield, we had two factors working on our side to prevent the cuts: our already-low reimbursement rates, and looming changes to federal law.

Being 40th in the nation isn’t a good track record, but in this case it helped make our case that further lowering of reimbursements isn’t feasible. Current rates don’t fully cover the cost of care and some physicians are forced to limit their Medicaid patient population. An additional cut would only exacerbate the problem.

The Affordable Care Act (ACA) also provided a leg up. During Illinois’ Medicaid reform negotiations (and at the time of this writing), the U.S. Supreme Court had not yet ruled on the constitutionality of the ACA. As part of this law, the federal government plans to fill Medicaid’s gap with Medicare primary care rates in 2013-14; the law requires states to pay for primary care at least at the same level they did in 2009. This also made cutting physician fees here difficult.

Of course, even these difficulties would have been easy to overcome for a General Assembly frantic to fill a \$2.7 billion hole in Illinois’ Medicaid budget—if it weren’t for our strong advocacy. ISMS made tremendous efforts to press our case to lawmakers and explain why physician rates must be protected from further reductions.

Medicaid is still a deeply troubled program, and some of the other policies included in the reform package could further burden physicians or hinder patient

care. But the fact is, ISMS protected our interests when others could not.

I won’t call us “winners” in the Medicaid debate, as the Associated Press did, because many of the problems we’ve identified with the Medicaid program remain. We’re concerned that some of the other policies included in the reform package could further burden physicians or hinder patient care. Nor is it good to be wedged against policy where our patients are deemed “losers,” as many have suggested, because cuts will limit certain treatment options.

Rich Miller, a syndicated columnist who covers Springfield issues, wrote a feature highlighting ISMS’ position of strength in the Medicaid debate when problems arose related to the cigarette tax. We supported the tax, but several lawmakers were being pressured to vote against it by powerful national anti-tax groups. At the end of the day, as the column stated: “in Illinois, some things still trump national party interests. The Medical Society is one of those things.”

Health Care Liens

ISMS advocacy is also strong on issues that don’t make the papers. This year, the Illinois Trial Lawyers Association introduced a bill related to medical liens, a topic too dry for mainstream media that nevertheless can be bread and butter for many physicians.

Essentially, the trial lawyers wanted to further limit physician billing rights. This bill would have taken away the right of the physician to pursue collection of reasonable charges for services provided to an injured person while increasing the amount plaintiffs and their lawyers can recover. It would have limited the amount of any lien to a reimbursement rate established by the injured party’s health insurance company, even though the insurance company may not be responsible for payment of the claim. The bill would have made other reductions to lien amounts and even would have required a lien holder to pay a share of the injured party’s attorney’s fees and litigation expenses.

In the end, however, through the tireless efforts of ISMS’ legislative advocacy team, we were able to remove all the harmful provisions of this bill.


Physician Licensure Fees

An ISMS-backed measure to extend Illinois’ Medical Practice Act was again introduced in the spring session. For the past several years we have been forced to fight each year to extend the Medical Practice Act, without which there would be no rules for what medicine is and who can practice it. Our goal is to pass a ten-year extension; each time there is a vote on the act, it is an opportunity for lawmakers to tinker with what defines medicine in Illinois. Unfortunately, some lawmakers crave such tinkering, and our bill was amended to a one-year extension. It passed out of the Senate, but stalled in the House. The extension will require action in the fall.

Renewing the Medical Practice Act should be simple, but the Quinn Administration and several members of the General Assembly want to double physician licensure fees; separate legislation was even introduced in the Illinois House this year for just that purpose. Proponents argue that the rates haven’t changed in 25 years, physicians in other states pay more and even some professionals here pay higher fees.

The purpose of licensure fees is to pay for the licensure and discipline process. However, over the past several years the state has swept more than \$8 million from the funds we pay and used them for other purposes. As long as the legislature uses the Medical Disciplinary Fund as its piggy bank, smashing it every time they need more money, we will be opposed to any increase in physician licensure fees.

Earlier this spring, Dr. Wayne Polek testified to this effect before a House committee in his capacity as ISMS President. Thanks to his testimony and our advocacy, the bill to double physician licensure fees failed. The fight is not over, however—we expect to deal with this issue once again when lawmakers return in the fall.

(The Chicago Medical Society works through the Illinois State Medical Society to introduce and influence legislation at the state level. The process begins in the CMS Governing Council, a launching pad for resolutions that may be further debated at the ISMS House of Delegates and the American Medical Association.) 

Service of the Month

CMS Career Center and Job Board

IN THIS CHANGING practice landscape, where 49% of residents and 65% of established physicians are joining hospital-owned practices, the Chicago Medical Society can expand your employment reach.

Whether you are looking for a new position, or ready to take the next step in your career, our online Career and Job Center connects medical professionals like you with employers nationwide. Our participation in a national network allows active and passive job seekers to post and view hundreds of positions at leading institutions and groups, with always fresh content.

This resource is for physicians, physician assistants, nurse practitioners and administrative medical staff.

The site's services include career coaching, advice on preparing a CV and interviewing, and a content library. When you open an account, you can store your CV and search-alerts in one place and sign up for special alerts when a new job matches your search criteria.

Easy-to-use tools make searches more organized and efficient.


Recruiters also enjoy access to qualified candidates

across a range of specialties and locations. We help large health systems, private practices, government agencies, and academic medical centers to find physicians and other key staff with the right credentials and experience.

With the click of a button, the site brings job seekers and recruiters together, saving them time and money, and expanding their reach.

We urge you to get the most of your membership by using the Society's Career and Job Center.

If you have suggestions or feedback, be sure to drop us a line.

Please go to www.cmsdocs.org for additional information or call the Society 312-670-2550. 



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A New Twist on Stroke Treatment

Society's mini-internship program teams with primary stroke centers **by Christine Fouts**

Ald. Jason Ervin (28th Ward) left, tells Rush Neurologist Dr. Neelum Aggarwal, and Dr. Howard Axe, CMS President, how he would have recognized his father's recent stroke symptoms if he had known then what he learned during his tour of Mount Sinai's Primary Stroke Center.

Mount Sinai and Swedish Covenant Hospitals were the sites for two recent CMS-sponsored mini-internships that educate legislators on issues in medicine.



THE CHICAGO Medical Society's Mini-internship Program expanded its scope, launching tours of Cook County's regional Primary Stroke Centers on June 4-5. The tours complement the Society's partnership in a citywide campaign to promote the benefits of these specialized stroke treatment centers (see story on page 20).

The first facility visits brought Ald. Jason Ervin (28th Ward) to Mount Sinai Hospital, and Ald. Patrick J. O'Connor (40th Ward) and State Rep. Greg Harris (D-13) to Swedish Covenant Hospital. Legislators heard about risk factors, warning signs, treatment and rehabilitation of stroke patients.

Primary stroke centers provide care efficiently and effectively, with fewer complications, reducing morbidity and mortality, the stroke team said. Patients are more likely to receive acute stroke therapies, like tPA, although the overall goal is to deliver standardized care in a seamless environment that reduces hospitalization.

Because of the infrastructure and organization required to triage and treat patients, stroke experts at Swedish Covenant say it "takes a village" to establish and maintain a primary stroke center that follows the recommendations of the American Stroke Association's Task Force on the Development of Stroke Symptoms.

The stroke center team includes specialists in neurology and neurosurgery, emergency medicine,




radiology, pharmacy, physical and occupational therapy, social work, nursing, and administration. Each member sees the patient within the first hours of admission.

Info on Aldermen's Websites

For many, stroke education is long overdue.

Alderman Ervin said his father suffered a stroke two months earlier and had called his son late in the evening to tell him he was not feeling well. The alderman recalled his advice to his father—who has hypertension, diabetes, and elevated cholesterol—to lie down and see how he felt in the morning—a common reaction to often subtle stroke symptoms. Alderman Ervin said he would have responded differently had he known then what he learned at the Mount Sinai tour. Stroke and primary stroke center information will be made available on the aldermen's websites and in their ward offices.

Note: At press time, additional primary stroke center tours were underway at Mercy Hospital, and Little Company of Mary Hospital. The legislative participants included: Rep. Kimberly DuBuclet (26th Dist.); and legislative staff to House Majority Leader Barbara Flynn Currie (25th Dist.); Sen. Kwame Raoul (13th Dist.); Ald. Will Burns (4th Ward); and Rep. Kelly Burke (36th). The next issue of Chicago Medicine will report on these facility visits.

For information about upcoming tours or the Mini-internship Program, please contact Christine Fouts at cfouts@cmsdocs.org or call: 312-329-7326. 

A Model Response

PARTICIPANTS at the Swedish Covenant Hospital tour met a stroke survivor and his wife. Earlier this year, she called EMS at 12:05 p.m., stating her husband was having a stroke. She reported that her husband's right eye was drooping, his speech was slurred, and he was having trouble breathing. EMS arrived at their home at 12:10 p.m. "Code 60," which indicates stroke, was called at Swedish Covenant at 12:14 p.m. The patient was intubated, underwent a CT scan and lab work at 1:00 p.m., with results available within 30 minutes. The patient was administered tissue plasminogen activator, or tPA, an intravenous clot-buster studies have shown improves outcomes after stroke. The window for tPA is 4.5 hours for the drug to be effective. The patient went home nine days later.

This case should set the standard for stroke care during the citywide educational campaign. Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD, told tour participants. At their urging, the Chicago Medical Society voted in June to work with the City Council on an ordinance to raise stroke awareness and promote specialized centers of care.

Dr. Roberta Glick, Neurological Surgeon at Mount Sinai Hospital, educates mini-internship visitors on stroke, as Dr. Mir Yadhvi, Stroke Program Medical Director at Mount Sinai, looks on.

Council Highlights

Society Adopts New Patient Protections **by Elizabeth Sidney**

“The number of Chicago-area patients using a primary stroke center is well below the national average.”



Dr. Neelum Aggarwal proposes the primary stroke center awareness campaign to the Council.

Primary Stroke Centers

At the urging of two Rush University stroke experts, the Chicago Medical Society voted to partner in a local campaign that will highlight the capabilities of Cook County's 22 regional Primary Stroke Centers.

The initiative, which engages elected officials, including aldermen, and community stakeholders, was one of several resolutions the Society's Governing Council debated on June 12 at its quarterly meeting.

In their testimony, both Drs. Neelum T. Aggarwal and Shyam Prabhakaran said these

dedicated primary stroke centers provide superior care over that in an emergency room or large academic medical center. Equipped to treat acute stroke, the centers are staffed by neurologist experts who can deliver timely clot-busting drugs without delay. Studies have confirmed that patients who access a primary stroke center are more likely to receive IV tissue plasminogen activator (tPA) within the 4.5 hour window.

Time is of the essence because brain cells begin to die only 90 minutes after a stroke.

The educational campaign will highlight the importance of tPA and controlling blood pressure. In addition to targeting city residents, Chicago-area physicians will be encouraged to refer their patients to this resource.

Dr. Aggarwal said she is already instructing aldermen and state legislators through the Society's Mini-internship Program, which pairs a lawmaker with a physician for a day to highlight the complexities in medicine. (See page 18).

Illinois adopted legislation in 2009 allowing for the creation of stroke systems of care and directing EMS to transport acute stroke patients to these hospitals. In 2011, another law identified hospitals capable of providing emergent stroke care. Since then, the number of patients brought to these facilities by paramedics has increased by 30-40%.

However, the number of Chicago-area patients using a primary stroke center is well below the

Where Resolutions Begin

THE CMS Governing Council is the point of origin for resolutions considered by the Illinois State Medical Society and American Medical Association. Resolutions often form the basis of legislation at the state and federal levels. In addition to supporting pro-medicine and pro-patient policies and laws, resolutions can prevent harmful legislation from becoming law. Councilors only may submit resolutions to the Society. If you are not a councilor but wish to author a resolution and find a sponsor, please contact the Medical Society for assistance. All members are welcome to attend Council meetings, which take place four times a year to set policy and conduct business on behalf of the Chicago Medical Society.

national average, the doctors stated.

Delayed Medications


The Society's Governing Council also supported a measure saying that patients discharged from a hospital to a nursing home require seamless care.

The amended resolution, which addresses medication delays, will be relayed to the Illinois State Medical Society for legal study and action.

The resolution's author, Sanford Franzblau, MD, had wanted the discharging hospital to provide a 24-hour medication supply to the receiving facility, as ordered by the patient's attending physician.

But councilors found this approach overly prescriptive and beyond the Society's purview. Some suggested the problem might be resolved on the professional side, by encouraging more collaboration between discharging and admitting physicians.

The Governing Council also heard that the American Medical Association is studying this complex issue. Meanwhile, physicians are constrained at the state level by nursing home law and vigorous DEA enforcement, testified a councilor who once served as president of the State Medical Directors Association. The councilor offered to provide input on this issue to ISMS.

For Council information, contact Ruby Bahena at 312-670-2550 or email: rbahena@cmsdocs.org. 



Dr. Robert Panton, Chairman, left, addresses the Council, flanked by outgoing President Dr. Thomas M. Anderson, Ted Kanellakes, CMS Executive Director, and Dr. Howard Axe, incoming President.

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Outgoing CMS President Dr. Thomas M. Anderson hands the baton of leadership to Dr. Howard Axe at the Society's Annual Dinner.



Society Welcomes New Leader

Building toward our common goals **by Elizabeth Sidney**

President Axe's Career Highlights

HOWARD AXE, MD, is a board-certified internist with the Medical Care Group, a single specialty group in Arlington Heights. He is on the medical staff of Northwest Community Hospital and Alexian Brothers Medical Center, where he serves on the Quality Oversight Committee. Dr. Axe earned his medical degree from Temple University School of Medicine in Philadelphia, and completed both his internship and residency at Michael Reese Hospital in Chicago.

A Society member since 1992, Dr. Axe served as branch president and councilor prior to being elected district trustee, chairman of the Council, and Board trustee. Dr. Axe has chaired Society committees such as: Investment; Committee on Committees; Bylaws/Policy Review; and Physicians Advocacy. Additional committee assignments have included: Building; Budget; Midwest Clinical Conference; Physicians Review; Nominating; Credentials/Elections; Communications/Technology; Healthcare Economics; Continuing Medical Education; and Long-Range Planning.

Dr. Axe is Vice Speaker of the Illinois State Medical Society's House of Delegates, where he has been active since 1993. He currently serves as a Board consultant to the ISMS Governmental Affairs Council and on the CME Accreditation Appeals Panel. His past committee service at ISMS includes the Council on Economics; Resolutions Reference; and Council on Membership and Advocacy.

Dr. Axe represents his hospital medical staff as a delegate to the American Medical Association's Organized Medical Staff Section.

Dr. Axe and his wife Edie have two children; son, Brandon, and daughter, Sydney.

THESE ARE exciting times for the Chicago Medical Society, incoming President Howard Axe, MD, told colleagues and guests during the Society's annual dinner ceremonies on June 12.

The Arlington Heights-based internist assumes office at a defining moment, for both healthcare delivery and the Medical Society, which continues transforming itself to better serve physicians in an evolving delivery system.

In these times of constant flux and uncertainty, with many physicians reporting they feel stressed, the Medical Society is forging ahead with the programs and services members have told the Society they need.

"We invited different constituencies, including the academic community, residency program directors, hospital leaders, and resident and student sections to share in leading the Society," Dr. Axe told his colleagues.

The Society's 164th president relayed how staff and leadership are making the organization more representative of Chicago's diverse physician community and providing greater value to members.

"More than 100 physicians replied when we invited them to participate on our committees, and have a voice in how our organization represents their needs."

The Society also reached out to rebuild and establish relationships with organizations that share common goals and mutual interests with

the Society.

“We are supporting members and patients through “Building a Healthier Chicago” with James Galloway, MD, and “Healthy Chicago” with Bechara Choucair, MD, the city’s health commissioner,” Dr. Axe continued.

Relationships with the Chicago Public Schools and the Health Law Section of the American Bar Association increase the Society’s visibility in the local community. The Society recently co-hosted an educational event with the ABA, providing valuable information to lawyers and physicians, Dr. Axe noted.

Magazine: Tangible Value

On the communications front, a revised *Chicago Medicine* magazine delivers tangible value to members.

“Readers will find informative articles on current issues and trends in healthcare, as well as timely pieces about daily medical practice, on contracting, technology and social media, public health, and medical education,” Dr. Axe said.


Complementing the magazine is the Society’s redesigned Website, which is now easier to navigate and more interactive. The organization is looking at ways to spark member feedback and interaction, he said.

“Spread our message back to your colleagues who might not be members, or those who might consider membership if they were asked to participate,” Dr. Axe encouraged his peers.

“Let them know what we are actively pursuing locally and on a larger stage to help support the art and science of medicine.”

The Society’s new leader has a word or two for those physicians he says complain about the current state of healthcare: Get involved.

Doctors can achieve their shared objectives if they work together, Dr. Axe said.

The reality is that, “All of us have a responsibility and duty to keep the Society viable and relevant to both physician-members and the patients we serve.” 



TOP: Dr. Joseph L. Murphy thanks CMS for presenting him with the very first CMS Lifetime Achievement Award.



MIDDLE: Outgoing CMS President Dr. Thomas M. Anderson presents the Annual CMS Public Service Award to Dr. Godwin Onyema.



BOTTOM: One of Dr. William A. McDade’s twin daughters shares her father’s pride in winning the CMS Physician of the Year Award, along with awardees Hans Arora, Outstanding Student of the Year Award, and Dr. Raj Lal, Appreciation Award.

Officers 2012-2013

Howard Axe, MD, *President*
Robert W. Panton, MD, *President-elect, Chairman of the Board*
Kenneth G. Busch, MD, *Secretary*
Philip B. Dray, MD, *Treasurer*
Kathy M. Tynus, MD, *Chairman of the Council*
Adrienne L. Fregia, MD, *Vice Chairman of the Council*
Thomas M. Anderson, MD, *Immediate Past President*

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Angelica Vargas (*Student*)

Chicago Medical Society Presents Awards

Henrietta Herbolzheimer, MD, Public Service Award—
Godwin Onyema, MD
Physician of the Year

Award—William A. McDade, MD, PhD

Lifetime Achievement Award

Award—Joseph L. Murphy, MD

Outstanding Student of the Year Award—

Hans Arora, PhD

Appreciation Award—

Raj B. Lal, MD

CMS Hosts Annual Awards

A quartet of honorees at June 12 ceremony by Scott Warner



Henrietta Herbolzheimer, MD, Annual Public Service Award

Godwin O. Onyema, MD

As an ob-gyn serving primarily low-income African-American women on public aid, Dr. Onyema exemplifies the spirit of the Herbolzheimer Award. He has been unrelenting in giving service to not only his local community on Chicago's south side, but also to the impoverished in Nigeria. On the home front, he has been an active donor and volunteer for St. Clement's Church Open Pantry program in Harvey that provides nutritious meals to poor and indigent families in the south suburbs. He also led a coordinated effort to discourage gang and drug related activity in the area. And he never forgot the suffering in his native Nigeria, from where he emigrated in 1974. He had initially planned to return to Nigeria. But once he saw the opportunities that his children would have in America, he worked tirelessly so that they could receive the best education possible. He worked his way up to becoming chairman of the department of obstetrics and gynecology at Jackson Park Hospital and saw his children graduate from Princeton, Harvard, Georgetown and Boston College. Their educations would come in handy when they would eventually help their father work towards his dream of building a world-class hospital in Nigeria. With their help, Dr. Onyema established the GEANCO Foundation in 2005 to raise funds to build the hospital. GEANCO represents the first letter of each family member's name, and the hospital will be named Augustine Memorial, in honor of Dr. Godwin's father. Statistics shows that Nigeria has the second largest HIV-positive population in the world; malaria kills 300,000 Nigerian children and 7,000 mothers every year; and one million children die each year before their fifth birthday. Dr. Onyema said his organization is working diligently to get the hospital underway. "I am grateful to the Chicago Medical Society for honoring me and letting me tell my story about our lifesaving work," he said. For more information on the foundation, visit the website at www.geanco.org.



Physician of the Year Award

William A. McDade, MD, PhD

When choosing the winner for this category, the committee sought to recognize a physician for his or her achievements as a clinician, researcher, educator and leader. Dr. McDade was their unanimous choice. As deputy provost for research and minority issues at the University of Chicago, where he is also associate professor in the department of anesthesia and critical care, Dr. McDade has received numerous awards and honors during his career, including Outstanding Community Service Award from Family Rescue Inc, Inc. He was the first recipient of the AMA's Recognition of Excellence in Eliminating Health Disparities Award. He also completed major research projects, including a minority medical education program sponsored by the Robert Wood Johnson Foundation. He's currently involved in an ongoing program to give underrepresented minority college and medical students the opportunity to engage in advanced biomedical research through experiences in laboratories at the University of Chicago. Dr. McDade's research is focused on the molecular and clinical treatment of sickle cell disease. He is actively involved in several professional organizations, including the National Medical Association, American Society of Anesthesiologists, Chicago Society of Anesthesiologists, where he served as president, and the Cook County Physician's Association. Dr. McDade is also deeply involved at the national, state and local levels of organized medicine. In addition to serving on numerous committees and sections of the AMA, he is a past president of the Chicago Medical Society, and is currently vice president of ISMS. Community service has also been an important part of his life; he has served on the board of directors of Family Rescue, a domestic violence shelter and support organization, and has lectured frequently to both medical and community groups on sickle cell disease. Dr. McDade and his wife Jennifer are parents of three-year-old twin girls.



Outstanding Student of the Year Award


Hans C. Arora, PhD

Seeking a medical student who is most likely to become a well-rounded outstanding physician or clinician, the awards committee affirmed Hans Arora as their choice. Dr. Arora is currently a student at Northwestern University's Feinberg School of Medicine, in the medical scientist training program. He earned his PhD in molecular and cell biology at Northwestern earlier this year. While he will earn his MD degree in 2013, Dr. Arora has already received numerous honors and awards, and has published in a number of high impact journals. In addition, he has delivered more than 20 scientific abstracts and poster presentations, and has taught classes at Northwestern University. A member of the school's student organizations, Dr. Arora served as president of the Dance Interest Group, and was co-founder of the Feinberg Cooking Club. He is currently a leadership coach at Northwestern University, and serves on the Physician Advisory Council of Building a Healthier Chicago. Dr. Arora's involvement in organized medicine is substantial. As a member of the AMA's Medical Student Section, he currently serves on the Council on Medical Education, and previously served as the national Chair of the Medical Student Section. He serves ISMS as a trustee, and as a member of the Council on Governmental Affairs. He has also served CMS as a trustee, and as co-chair of the CMS Student District, among other roles. When asked to express what winning the first Chicago Medical Society Outstanding Student of the Year Award means to him, Dr. Arora said, "I am so honored. By becoming involved in organized medicine, I learned about a world of issues that affect the way I will one day care for patients that cannot be taught with a textbook or stethoscope. I've met countless physicians across all specialties and practice types who have been role models and mentors through the Chicago Medical Society, and I am humbled by such recognition."



Lifetime Achievement Award

Joseph L. Murphy, MD

He's been there, done that, and then some. To say that Dr. Joseph Murphy has achieved a lifetime of accomplishments is an understatement. A past president of the Chicago Medical Society (1998-99), Dr. Murphy has vigorously devoted his energies to just about every important aspect of medicine that exists—while still finding time to raise seven children with his wife Marilyn. Board-certified in internal medicine and geriatric medicine, he tended diligently to his patients in solo private practice; taught medicine at both Northwestern and Loyola, chaired the department of medicine at Columbia Grant Hospital, and served as acting chairman at St. Joseph Hospital—and that's only a small sampling of his involvement in medicine. He has been a member of many professional societies, and served as president of the Illinois Society of Internal Medicine. He also served organized medicine through his multi-pronged involvement with the AMA, where he is immediate past chair of the Senior Physicians Group Governing Council; his work at ISMS has been voluminous, and he is the current chair of the ISMS/OMSS Governing Council. And his involvement with the Chicago Medical Society has been legendary; in his more than 40 years as a member, Dr. Murphy has served in more than a dozen different roles, culminating in the presidency—and he is still actively involved in the CMS Council. In presenting the award, outgoing CMS President Dr. Thomas M. Anderson thanked Dr. Murphy for his commitment to his profession and his community. Dr. Murphy responded: "Decades raced by virtually unnoticed and then behold, you're a senior physician. It's been a wonderful and challenging lifetime journey. I didn't go it alone. Many generous and gracious individuals guided me in endless ways: my family, friends, patients, teachers, and, of course, colleagues like you—brilliant and benevolent mentors." 



Local Docs Advance National Policies

Physicians listen to testimony during a Reference Committee session at the AMA Annual Meeting in Chicago.

ILLINOIS physicians brought nine resolutions to the American Medical Association annual meeting this past June. Five of those measures were authored by Chicago Medical Society members and adopted by the Illinois State Medical Society prior to the June 16-20 conference.

Educating Medical Providers as First-Line Responders to Stop Human Trafficking

Originating at the Chicago Medical Society, this resolution was considered along with a similar one directing the AMA to work with the Department of Health and Human Services to develop guidelines on identifying human trafficking victims, and to encourage editors and publishers to include human trafficking screening information in medical training literature.

The AMA voted to study ways of addressing the importance of understanding and recognizing the signs of human trafficking, including physician education.

Obesity Should Be Considered a Chronic Disease State

Thanks to another Chicago Medical Society

resolution, the AMA will study whether to classify obesity as a disease. Testimony highlighted evidence of metabolic abnormalities that persist even after weight loss in formerly obese patients, while others emphasized that obesity is a risk factor for other diseases. The Chicago resolution also urged reimbursement of doctors for counseling and managing patients who are overweight or obese.

Stimulate Antibiotic Research and Development

As proposed by the Chicago Medical Society, the AMA will support legislation that requires the reevaluation of FDA guidelines for antibiotic clinical trials, including an increase in the patent protection period and priority review of antibiotics.

During testimony, delegates heard that the U.S. House and Senate passed different versions of the FDA Reform Act of 2012, and are currently working to reconcile their respective bills. This legislation would give next generation antibiotics expedited approval; direct the GAO to evaluate whether new FDA authorities should implement the modified approval process, e.g., clinical trials for limited target populations; and extend market exclusivity.

Medicare Records Retention and Overpayment Recoupment

Calling it another unfunded mandate, the AMA voted to continue opposing a plan to collect within 60 days any overpayments for Medicare services, as outlined in a resolution by a Chicago Medical Society member. The organization will also fight a proposed rule to require practices to report overpayments that were discovered within ten years of the date those funds were received, rather than the current six-year requirement.

The Chicago resolution directed the AMA to express its objections to the U.S. Department of Health and Human Services.

Synthetic Gasification

The AMA will support further research on the health effects of clean coal technologies, including synthetic gasification plants, as urged by a Chicago Medical Society member.

Revise the Patient Protection and Affordable Care Act

This Illinois resolution was combined with several others to form the basis of an action plan in the event the U.S. Supreme Court struck down the individual mandate. The AMA would evaluate its existing policies, with the goal of decoupling the guaranteed issue mandate from the individual mandate, and alternatively coupling guaranteed issue to pre-existing coverage. The AMA would also have begun preparing for alternate federal healthcare reform options if any or all of the PPACA was struck down.

Out-of-Network Benefits and Standardization of Plan Terminology

The actions requested in this Illinois resolution are being addressed through current AMA policy and advocacy efforts. The House reaffirmed existing policies in lieu of this resolution.

Dispensing Inappropriate Quantities of Formulary Medications

This Illinois resolution directs the AMA to work with third party payers to ensure that limits on prescription drugs and supplies include an exceptions process so that patients can access higher or lower quantities if medically necessary. The AMA also will support state legislative efforts and develop model state legislation to ensure that third party payers that institute quantity limits include such exceptions, without undue burden on patients and physicians. Moreover, physicians can appeal adverse determinations, and payers must provide easily accessible lists of medications, supplies and requirements for the exception process on their Web sites. Payers must indicate the clinical criteria or FDA label that support the plan's quantity limitations; payers cannot require additional patient co-pays if an exception request has




been approved based on medical necessity. Finally, payer decisions and appeals must be made within two working days in non-urgent situations and one working day in urgent cases. Denied appeals can be submitted to an independent review body for a final binding decision.

As one physician takes the mike to discuss a resolution, others wait their turn at a Reference Committee.

Accurate Evaluation of Pain Control during Hospital Visits

The AMA will study the host of complex issues raised by this Illinois resolution, which directs the organization to work with the Centers for Medicare and Medicaid Services to support the development of an accurate and meaningful evaluation tool to assess pain control and management during hospital and ER visits. The AMA will also address the removal of reimbursement decisions that are based on subjective surveys.

The AMA will hold its interim meeting Nov. 10-13. Please go to www.ama-assn.org for details. 

AMA Leaders with Illinois Roots

THE AMA INAUGURATED Jeremy A. Lazarus, MD, as its 167th president. Born in Chicago, Dr. Lazarus graduated from Senn High School, which was named in honor of the AMA's 49th president, Nicholas Senn, MD. Dr. Lazarus earned his medical degree with honors in psychiatry from the University of Illinois College of Medicine. In addition to his private practice, Dr. Lazarus is a clinical professor of psychiatry at the University of Colorado Denver School of Medicine.

Our state's own William E. Kobler, MD, a board-certified family physician in Rockford, was elected as trustee, giving Prairie State physicians a voice on the AMA Board. A graduate of Northwestern University Medical School, Dr. Kobler is currently part of the Sisters of the Third Order of St. Francis medical group within the OSF healthcare system. He is also a retired clinical assistant professor in the Department of Community and Family Medicine at the University of Illinois College of Medicine at Rockford. He served as ISMS president from 2003-2004 and as its Board chairman from 2006-2008.



Chicago a Leader in Innovative Care

National acclaim for delivery models led by local physicians **by Elizabeth Sidney**

Outgoing CMS President Dr. Thomas M. Anderson, center, speaks before health-care leaders on June 4. He was joined by panelists, from left, Drs. William B. Bund, III, Paul B Handel, Ramanathan Raju, and Bechara Choucair.

PRIVATE AND public systems are working in tandem to overcome barriers to good health and reduce the staggering costs of healthcare, outgoing Chicago Medical Society President Thomas M. Anderson, MD, told 250 healthcare leaders recently.

In his speech to policymakers and stakeholders, the CMS leader also reported that Chicago's physicians have gained national attention for care models that will improve quality and lower costs, while opening access to medical care and public health services for those without coverage.

This evolution and adaptation will continue with or without the health reform law of 2010.

Dr. Anderson made these remarks during a forum to exchange ideas and information, which will be used to develop critical solutions to a broad range of challenges affecting the health of community residents.

State of the Health of Chicago was also a first step toward identifying and engaging organizations and individuals to collaborate and coordinate resources and services.

Hosted by the Institute of Medicine of Chicago, the program took place on the Northwestern University campus last June 4.

New Care Models in Chicago

Local physicians are already leading improvements



in health delivery and quality, Dr. Anderson said.

Chicago is home to one of the nation's first ACOs—a partnership between Advocate Health Care and Blue Cross Blue Shield of Illinois. Led by CMS member Lee Sacks, MD, the Advocate ACO has earned acclaim for linking patients to services and wellness programs, including healthy food for those who live in food deserts. The model has shown it can reduce costs and improve patient outcomes.

Another success involves physicians at Northwestern University, led by Daniel Derman, MD, who implemented an intensive medical home for patients. Under this model, originally formed by the Boeing Company for its employees, physician care and other outpatient resources are concentrated on the 20% of patients with chronic

conditions who account for 80% of costs.

Dr. Anderson reported that patients seen under this model may receive personalized medical care plans and special attention, such as reminders by a nurse and doctor to do simple things like getting up and taking a walk during a TV commercial break, or to eat right and take medications as prescribed.

The intensive medical home provides a reimbursement code for doctors to hire a nurse care manager as well as other incentives to improve the health of patients. As the team quarterback, the intensive home physician is responsible for leading improvements in care and patient outcomes, Dr. Anderson said.

Preventive care plays a large role in good health, and to that end, the Medical Society is pushing insurers to recognize overweight and obesity as chronic medical conditions. Doctors should be paid for rigorous, close monitoring of patients who need to lose weight, the Society's

Governing Council said recently. In fact, the Council adopted a resolution to correct this gap, as did the Illinois State Medical Society, Dr. Anderson told the audience. At its June House of Delegates meeting, the AMA voted to study whether obesity should be classified as a disease.

Patient Commitment a Must

Forum discussion also revolved around initiatives to encourage individuals to take control of their health, mirroring the Chicago Medical Society's belief that accountability must occur at all levels of the healthcare system, for reform to work effectively.

"All the efforts of the medical team will fail if doctors and patients don't share a commitment to good health, Dr. Anderson reaffirmed for the audience.

"We support patient incentives, like lower premiums, gym memberships, gift cards, and educational materials, to adopt healthy lifestyles. We also believe there should be penalties in the form of higher premiums for patients who will not comply with treatment recommendations, like quitting smoking," he explained.

The Medical Society endorses efforts to reduce patients' reliance on overcrowded emergency rooms. The University of Chicago's Urban Health Initiative, now eight-years-old, educates patients how to access primary care for non-emergency needs. Staff provides links to eligible doctors in a patient's medical home, and schedules appointments for patients before they even leave the hospital, with doctors, clinics, and primary care health centers throughout Chicago's South Side. Today, two in five patients keep the appointments. While not perfect, this number is a major step up from eight years ago, Dr. Anderson stated.

More Accessible Care

Chicago-area doctors are making it easier for residents to access outpatient medical care. Some are keeping their offices open longer and on weekends, providing a benefit to working families and the economy when employees don't have to take time off work.

Specialists, too, are becoming more accessible. At Loyola University Health System, the medical care provider has satellite clinics throughout the

"We support patient incentives like lower premiums, gym memberships, gift cards and educational materials, to adopt healthy lifestyles. We also believe there should be penalties in the form of higher premiums for patients who will not comply with treatment recommendations, like quitting smoking."

south and southwest suburbs that are staffed beyond normal business hours into the evenings and on Saturdays.

Aside from the urgent care center or emergency room, an academic medical center and its specialists were not known for evening hours

and weekends just a few years ago, Dr. Anderson noted.

Doctors have for years provided charity and discounted care, often without the expectation of payment. "In the current economy, doctors write off even more unpaid bills, even in the face of declining reimbursements and

rising practice expenses like new technology," Dr. Anderson explained.

Unlike their hospital counterparts, physicians do not get a property tax exemption to offset the amount of charity care they provide.

Teamwork, not Competition

The Society supports public and private health systems working together.

When the CEO of the Cook County Health and Hospitals System, Ramanathan Raju, MD, asked the health community to collaborate rather than compete, we helped relay his message, Dr. Anderson said.

"We can make Medicaid more efficient by coordinating and sharing resources. Competition has become an arm's race, duplicating services and creating excess capacity in hospitals when the need is for better outpatient care, he said.

Through its partnership in Building a Healthier Chicago, the Society educates city residents how to control high blood pressure, lose weight, eat healthfully, and exercise. This coalition, which is led by the Department of Health and Human Services, Region V, includes the Chicago Department of Public Health and Institute of Medicine of Chicago.

Shift toward Large Group Practice

Gone are the days when doctors can go into solo practice. In response to economic forces, physicians are joining larger practices, a trend that will only continue with deteriorating government reimbursement, Dr. Anderson predicted.


This shift will likely encourage more people to pursue careers in medicine, especially primary care, he said. Increasing numbers of women are entering medicine, benefitting from the inviting hours and working conditions. And doctors will no longer have to take calls four nights a week, making them happier and more productive.

The Future

"Sparkling new academic hospitals such as Ann & Robert Lurie Children's Hospital of Chicago, and new hospital pavilions at Rush University Medical Center and the University of Chicago Medicine, as well as the coming new Rehabilitation Institute of Chicago, are vital to the city," Dr. Anderson said.

"These institutions are good for patients and also a tool to attract new research talent and patient-care physicians to our city, further making Chicago a world-class center for medical innovation. They are also led by physicians, Dr. Anderson concluded.

The Institute of Medicine of Chicago will issue a white paper reporting on the proceedings of the program, which will lay the groundwork for interdisciplinary workgroups that will develop and implement interventions to reduce the barriers to good health.

Faculty participants were as follows: Cook County Board President Toni Preckwinkle delivered the keynote address for State of the Health of Chicago. Joining her and the Chicago Medical Society's President Thomas M. Anderson, MD, were Ramanathan Raju, MD, CEO of the Cook County Bureau of Health and Hospitals System; Bechara Choucair, MD, Commissioner of the Chicago Department of Public Health; Paul B. Handel, MD, and William B. Bund III, MD, JD, MBA, Vice President-Health, Safety, Security, and Productivity, Navistar International Corporation. 

"In the current economy, doctors write off even more unpaid bills, even in the face of declining reimbursements and rising practice expenses like new technology," Dr. Anderson explained.

Welcome New Members!

THE CHICAGO Medical Society welcomes its newest members elected in June 2012. We are now seven voices stronger!

District 2

Michael L. Tam, MD

Student District

Sanaz Mahmoudi

Angelica Vargas

Adam S. Vohra

Resident District

Andrew R. Hsu, MD

Ryan S. Kukor, MD

Daniel J. Musick, MD

Calendar of Events

JULY

18 2012 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens

Workshop is intended for physicians, physician assistants, nurses, practice managers, and dental professionals, who will learn to:

- Implement a training program for healthcare employees who may be exposed to bloodborne pathogens.
- Identify appropriate personal protective equipment (PPE).
- Develop an emergency response plan.
- Create a written exposure control plan for healthcare workers assigned as first-aid providers.
- Develop a strategy to prevent the spread of pandemic flu within the practice.

10:00 a.m.–12:00 noon;
Speaker: Sukhvair Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 2.0 Credits. CMS member or staff \$89 per person, non-member or staff \$129 per person. *To register or learn more, please contact Elvia 312-670-2550, ext. 338; or email emedrano@cmsdocs.org.*

AUGUST

8 2012 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens

(See course description above.)

- 10:00 a.m.–12:00 noon;
Speaker: Sukhvair Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; Webinar (login access information

will be provided with confirmation). Participants may earn up to 2.0 Credits. CMS member or staff \$89 per person, non-member or staff \$129 per person. *To register or learn more, please contact Elvia 312-670-2550, ext. 338; or email emedrano@cmsdocs.org.*

16 Illinois Society of Plastic Surgeons—General Membership Meeting

Sculptural Rejuvenation of the Face. Speaker: William Little, MD, Clinical Professor of Plastic Surgery at Georgetown University; 6:30 p.m.–8:30 p.m.; The Metropolitan Club, Michigan Room, 233 S. Wacker Dr., Chicago. *To RSVP, please contact Amanda 312-670-2550, ext. 325; or aworley@cmsdocs.org.*

22 Annual Golf Outing & Parliamentary Procedures Workshop

An interactive and engaging session covering basic principles and rules of parliamentary law, with the latest update on the newly revised Robert's Rules of Order, 11th Edition, which supersedes all previous editions, and automatically becomes the parliamentary authority in organizations whose bylaws prescribe any other version of Robert's Rules of Order. Parliamentary Workshop 8:00 a.m.–12:15 p.m.; lunch 12:15–1:00 p.m.; tee time 1:00 p.m. Speaker: Joan M. Bundley, MPH, RN, Professional Registered Parliamentarian & Mediator; Chicago Marriott Oak Brook Hills Resort & Willow Crest Golf Club, 3500 Midwest Rd., Oak Brook, IL. This is a non-CME activity; CMS member or staff \$125 per person. (See Golf Outing ad on page 34.) *To RSVP, please contact Elvia 312-670-2550, ext. 338; or emedrano@cmsdocs.org.*

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By registering with *Illinois Helps*, the Illinois Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), you can be a part of an alert system and be the first to respond to a significant disaster or public health emergency.

Once you have registered to become a volunteer, your professional credentials will be verified and your information will become part of the secure statewide database of volunteer healthcare professionals.

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information email:
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Register Now!
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New Practice Environment?

Doctors and lawyers collaborate **by Elizabeth Sidney**

Dr. Howard Axe, CMS President, welcomes attendees to the Physician-Legal Issues Conference, co-hosted by the American Bar Association Health Law Section. He is joined by Dr. Stephen L. Ondra, Chief Medical Officer, Northwestern Memorial Hospital.

THE CHICAGO Medical Society co-hosted a conference on emerging issues for physicians and practice options available to them this past June 14-15.

The event, held in conjunction with the American Bar Association and its Health Law Section, underscored the Society's collaboration with the legal sector to provide members with the tools and information to succeed under a new system.

The partnership also represents a new reality in medicine; physicians must increasingly rely on legal experts to navigate the practice environment.

Impact of Reform Law

The program kicked off with a panel discussion featuring Medical Society member Stephen Ondra, MD, on the state of the physician. Panelists said that regulatory burdens, limited access to capital, and the contradictory goals of "bigger and better" with "lower costs and innovative solutions" create significant challenges for practitioners today.

Their remarks set the stage for a comprehensive review of practice options for physicians in today's healthcare market.

With the enactment of the Patient Protection and Affordable Care Act in 2010, hospitals scrambled to buy up practices, employ doctors, and create clinically and financially integrated organizations with their medical staffs or community physicians, said ABA Physician-Issues Interest Group Co-Chair Kathleen L. DeBruhl in her historical overview.

This trend, combined with uncertain economic and political times, led to the erosion of independent physician practice, with whole markets of primary care doctors and some specialists becoming hospital employees.

The reshaping of health delivery means that most physicians eventually will have to decide on their practice's future, predicted the ABA's Health Law Section Past Chair David W. Hilgers, JD.

Practice Options and Settings

Doctors are exploring modes of practice outside of hospital employment. Their options include practice expansion, mergers, partnerships with hospitals and health insurers, and high-tech micro practice, Catherine Hanson, vice president of the Private Sector Advocacy and Advocacy Resource

Center at the American Medical Association, told participants.

Doctors can expand their practices by collaborating online or virtually, without actually creating a central facility. “You can have a larger physician-integrated practice where the physicians are practicing in their offices,” Hanson said.

She cautioned that physician networks are strictly regulated under the anti-trust laws, which could prevent them from forming collaborations. Unlike hospitals, the networks are not granted broad exceptions.

“In many cases, there is not enough of an upside to creating a network. If you are going to spend between two and twenty million to create one of these organizations, you need to know that in order to be successful, you are going to have to recoup quite an investment.”

Remaining Independent

Physicians have shown their resiliency as health-care evolved from the family doctor who treated generations of patients to the enactment of the Affordable Care Act, DeBruhl said.

Doctors can indeed remain independent, but strategic planning is critical to success.

“Physician leaders in both the hospital and community must be proactive, not just react, as so many other providers are doing, she told participants.

Taking the time to create a mission statement can keep strategy and decision-making on track; practices of all sizes will see the benefit. This should be followed by an assessment of the age and generational differences within the practice; referral sources; existing and future markets; hospital relationships; recruitment needs; payer relationships; staff needs; and technology and equipment.

Practices can align through mergers that collaborate with local hospitals as independent medical staff. Merger alignments consolidate management, insurance lines, billing and software, health insurance premiums, malpractice costs, professional and administrative expenses, DeBruhl explained.

Integrating primary care with specialty practices can work if team members are able to overcome different management styles and treat primary care specialists as equal partners in the practice.

Adding a physician extender, or non-physician primary care practitioner, can build up revenue, as does funding new services or participating in joint ventures.

Independent practice also requires remaining vigilant of the political process.

“A local legislator who is watching for changes to workers comp or malpractice legislation on a physician’s behalf can be very meaningful,” DeBruhl noted.

The Real Threat of Fraud

A number of provisions in the reform law focus on fraud in healthcare. The conference updated




participants on recent enforcement activities affecting physicians. Doctors and legal panelists, including David Douglass, a former federal prosecutor and current defense counsel, and Dennis Mihale, MD, offered strategies for preventing billing and coding errors that could turn into civil and/or criminal cases.

Constructive Government Dialogue

With expanded regulation and enforcement, the dialogue between the government and the medical community is critically important, stressed Shantanu Agrawal, MD, of the Medicare Office of Program Integrity, and American Medical Association attorney, Cybil Roehrenbeck, JD, during a roundtable on improving communication.

The Physicians-Legal Issues conference took place at the new Radisson Blu Aqua Hotel in Chicago.

Look for the Chicago Medical Society to announce future collaborative efforts with the ABA Health Law Section to educate and inform members. 

TOP: Panelists discuss “The State of the Physician.” From left: attorneys Catherine Hanson, David Hilgers and Dr. Ondra.

BOTTOM: Dr. William McDade discusses “Racial Disparities in Healthcare,” during the evening reception.



CMS 2012 Golf Outing

Wednesday, August 22, 2012

Chicago Marriott Oak Brook Hills Resort
& Willow Crest Golf Club
3500 Midwest Rd., Oak Brook, IL

Agenda

12:15 PM Luncheon

1:00 PM Golf, Shotgun Start, Scramble Format

AFTER GOLF Cocktails & Awards

2012 Annual Golf Outing

Chicago Marriott Oak Brook Hills Resort & Willow Crest Club, Wed., August 22, 2012

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\$125 Per Person

(No. of Attendees)

Total \$ _____

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ADDRESS _____

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GOLF PARTNERS (UP TO 3)

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Questions?

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"No matter what area of medicine we are in, we must not take our eyes off the prize—the patient," says surgeon and academician Dr. Herand Abcarian.



It's All About Doctor-Patient

Academic leader tells what's most important **by Scott Warner**

DON'T EVER intend to become irrelevant," says Herand Abcarian, MD. Nor would that be a likely scenario for the 71-year-old chairman of the Division of Colon and Rectal Surgery at John H. Stroger, Jr., Hospital of Cook County. This Iranian native has been amassing a treasure trove of accomplishments and service since he came to Chicago nearly 50 years ago, and he isn't about to let the fire dim now.

Speaking between surgeries at Stroger, where he had been since 7:00 a.m., and planned to remain until 5:30 p.m. (a typical day), this acclaimed expert mused about what's important to him in medicine.

"I've been in academic medicine my entire career—training residents, publishing papers, doing research," he said. And what I do isn't better than my colleagues who aren't in an academic environment. My personal surgeon is not in academic medicine—the majority of doctors are not in academic medicine. They are in the

trenches—doing God's work on earth!"

And, he adds, "No matter what area of medicine we physicians are in, we must not take our eye off the "prize"—the patient. No matter what lies ahead, single-payer system, Obamacare, or private practice—at the end of the day, it's still about having a one-on-one with our patients."

Dr. Abcarian laments that medicine has become so politicized, and that so many physicians are discouraged. "Medicare got you down?" he asks. "Don't get out because you're mad at the government—think of your patients!" When I meet college students who want to go into medicine, I tell them, "don't think about money—if you want money then become an investment banker; it's all about the doctor and the patient."

While Dr. Abcarian still looks forward to staying active in medicine, he knows there will come a time when he'll have to slow down. "We all need a close friend to tell us when it's time to hang up—and that's even more important for surgeons, because our mistakes are more visible."

And then what will he do?

"I don't play golf, and I won't stay home and watch TV with my wife," Dr. Abcarian says. "I can still do outpatient surgery, and teach, keep publishing papers, and continue mentoring younger physicians."

Dr. Abcarian is currently under contract for a 300-page book on anal fistulas, his specialty, and this fall he will be teaching in Germany, Mexico, Italy, and lecturing in Switzerland in December. And he plans to learn the newest advances in his travels, too.

"Use it or lose it," he says. "I plan to be active as long as my head is clear." 

Dr. Abcarian's Career Highlights

IN ADDITION to serving as chairman of the Division of Colon and Rectal Surgery at John H. Stroger, Jr., Hospital of Cook County, Dr. Abcarian is professor of surgery at the University of Illinois at Chicago, where he served as head of the Department of Surgery. He is also affiliated with Gottlieb Memorial Hospital in Melrose Park. A well-published author, Dr. Abcarian is a member of more than 20 professional associations. He earned his medical degree from the Tehran University School of Medicine, and completed his internship and residencies in general surgery and colon and rectal surgery at Cook County Hospital.

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