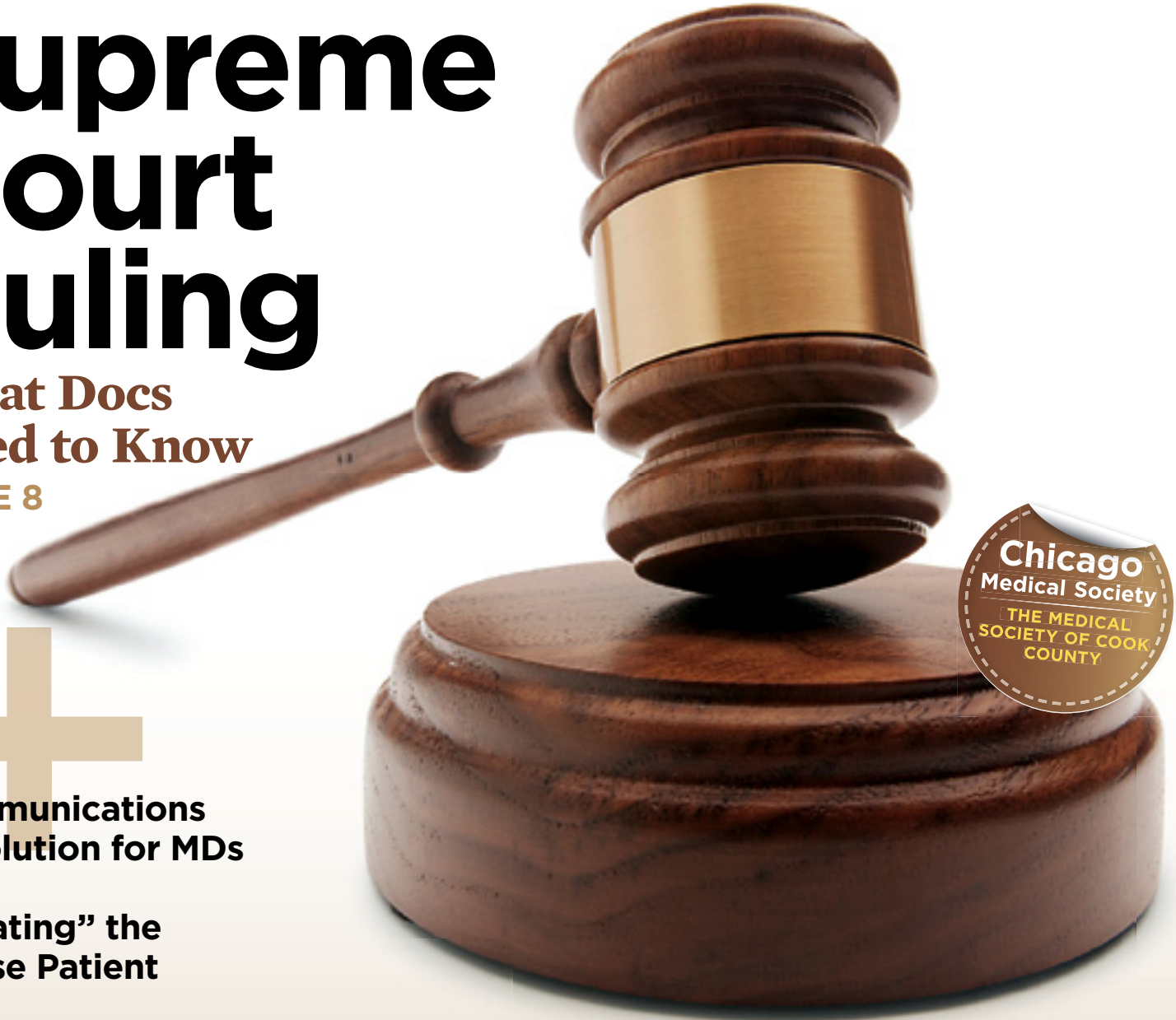
Chicago MEDICINE

Supreme Court Ruling

What Docs Need to Know

PAGE 8



Chicago Medical Society
THE MEDICAL SOCIETY OF COOK COUNTY

Communications Revolution for MDs

"Treating" the Obese Patient

Growing Specter of Untreatable Gonorrhea

August 2012 | www.cmsdocs.org

I am ISMIE.

Dedicated.

Innovative.

Committed.

Evan S. Oblonsky, MD, Radiologist
Policyholder since 2000

As a policyholder, I am proud to know that ISMIE Mutual Insurance Company has protected physicians and our practices for over three decades. They are committed to the physicians of Illinois as our advocates and partners. Founded, owned and managed by physician policyholders, ISMIE works to keep our reputations and livelihoods intact.

ISMIE Mutual has continuously insured all specialties throughout Illinois since 1976. Policyholders know they can depend on us to remain committed to them not only as their professional liability insurance company, but also as an advocate and partner.

Depend on ISMIE for your medical liability protection – so you can focus on the reason you became a physician: to provide the best patient care possible.

Not an ISMIE Mutual policyholder and interested in obtaining a comparison quote for your medical liability coverage? Contact our Underwriting Division at 800 782-4767, ext. 3350, or e-mail us at underwriting@ismie.com. Visit our website at www.ismie.com.

ISMIE
Mutual Insurance Company
The Physician-First Service Insurer®

Protecting the practice of medicine in Illinois

Volume 115 Issue 8 August 2012

FEATURES

PRESIDENT'S MESSAGE

FRONT OFFICE

PUBLIC HEALTH

LEGAL

LEGISLATIVE ADVOCACY

MEMBER BENEFITS

NEWS & EVENTS

WHO'S WHO

The Supreme Court and Healthcare

BY NOW EVERYONE knows the U.S. Supreme Court's decision on the Affordable Care Act. However, what most of us don't know is how the ACA will truly re-shape the healthcare delivery system, and the impact it will have on the cost of care. Shortly after the decision was announced, almost every special interest group had a comment or spin on how they thought the decision would help or hurt their constituency. The Chicago Medical Society was also asked to relay its position. While our Governing Council has deliberated the issue, along with the ISMS House of Delegates in response to resolutions brought by members, our organizations have long focused on following the health reform principles we adopted years ago. We quickly released to the media our position stating the ACA does not address several key concerns.

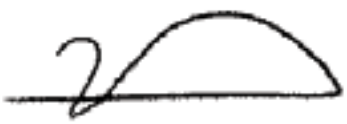
- The doctor-patient relationship. Our organizations are focused on enhancing this relationship and limiting interference by third-party insurance carriers and government in the interactions and decisions of physicians and their patients.
- Flexible evidence-based protocols. While we support such protocols whenever possible, we believe they should recognize patients' diverse health statuses and co-morbidities, as well as their different goals and expectations.
- Medicare SGR fix. Our organizations have long pushed for a permanent fix to the broken Medicare payment system, known as the SGR.
- Medical liability reform. We continue our efforts to reform the professional liability system through caps on non-economic damages at both the state and national levels.
- The Supreme Court's decision contains a provision on the Medicaid program. As Illinois physicians are keenly aware, our state's Medicaid fee schedule ranks 41 in reimbursement. This payment is well below the cost of providing care, and is often delayed up to nine months. Your medical societies argue that any expansion of this program will require extensive modifications to truly guarantee increased access to healthcare.

In relaying our physicians' perspective on these overlooked issues, CMS and ISMS are working in greater unity to focus our resources for the greatest impact. When we addressed the Supreme Court's decision, our messages were consistent. Now we need to hear from members like you on how the Act and Supreme Court decision are affecting your practice and your patients.

To make your voice heard on healthcare delivery and other issues, all members, not just councilors, soon will have the ability to submit resolutions to our organizations. Resolutions will be promptly assigned to the appropriate committee for deliberation, Council debate and prompt action. In the coming months, you'll hear more about our efforts to streamline policymaking and boost participation.

You'll also hear about the county medical societies communicating with each other and working closely with ISMS, along with plans for strengthening the federation of organized medicine in Illinois. ISMS Board Chairman Steven M. Malkin, MD, is leading strategy and planning meetings around these important topics.

Please engage your medical societies and leaders on behalf of your practice and profession.



Howard Axe, MD
President, Chicago Medical Society

Chicago MEDICINE

EDITORIAL & ART

EXECUTIVE DIRECTOR
Theodore D. Kanellakes

ART DIRECTOR
Thomas Miller | @thruform

CO-EDITOR/EDITORIAL
Elizabeth C. Sidney

CO-EDITOR/PRODUCTION
Scott Warner

CONTRIBUTORS
Abel Kho MD; Neelum T. Aggarwal, MD; Jalayne J. Arias, JD; Bechara Choucair, MD; William Ciganek, MD; Jenny Conviser, PsyD; Ann Hilton Fisher; Jere E. Freidheim, MD; Shyam Prabhakaran, MD; Elizabeth A. Snelson, JD; Sidney S. Welch, JD; Howard Wolinksy; William Wong, MD; Ashley Worrell

CHICAGO MEDICAL SOCIETY

OFFICERS OF THE SOCIETY

PRESIDENT
Howard Axe, MD

PRESIDENT-ELECT
Robert W. Panton, MD

SECRETARY
Kenneth G. Busch, MD

TREASURER
Philip B. Dray, MD

CHAIRMAN OF THE COUNCIL
Kathy M. Tynus, MD

VICE-CHAIRMAN OF THE COUNCIL
Adrienne L. Fregia, MD

IMMEDIATE PAST PRESIDENT
Thomas M. Anderson, MD

CHICAGO MEDICINE

515 N. Dearborn St.
Chicago IL 60654
312-670-2550
www.cms.org

Chicago Medicine (ISSN 0009-3637) is published monthly for $20 per year for members; $30 per year for nonmembers, by the Chicago Medical Society, 515 N. Dearborn St. Chicago, Ill. 60654. Periodicals postage paid at Chicago, Ill. and additional mailing offices. Postmaster: Send address changes to Chicago Medicine, 515 N. Dearborn St., Chicago, IL 60654. Telephone: 312-670-2550.

"When it comes to Meaningful Use, athenahealth did all the legwork... and then they made it easy for me to do."

–Dr. Reavis Eubanks

This is how Dr. Eubanks got paid for Meaningful Use.

After practicing medicine 35 years, Dr. Reavis Eubanks knew it was time for an EHR. As a solo physician, he needed an easy transition and an effective way to begin earning up to $44,000 in Medicare incentive payments.

athenahealth helped Dr. Eubanks go from paper to payment in just six months. With guidance every step of the way and proven, cloud-based services.

- Best in KLAS EHR*
- Free coaching and attestation
- Seamless clinical workflow
- Guaranteed Medicare payments**

85% of eligible athenhealth providers attested to Stage 1 Meaningful Use. And we're ready for Stage 2.

Visit **www.athenahealth.com/ChicagoMed** or call **800.981.5085**

*ambulatory segment for practices with 11-75 physicians
** If you don't receive the Federal Stimulus reimbursement dollars for the first year you qualify, we will credit you 100% of your EHR service fees for up to six months until you do. This offer applies to HITECH Act Medicare reimbursement payments only. Additional terms, conditions, and limitations apply.

athenahealth
Cloud-based practice management, EHR and care coordination services

CHICAGO MEDICAL SOCIETY

presents these exciting travel programs for 2013

OCEANIA CRUISES

SPLENDORS DOWN UNDER

February 24 – March 14, 2013 • *Marina*
From $5,311 • INCLUDES AIRFARE

Visit the land of koalas and kangaroos as you explore fascinating cities down under. Marvel at the stunning landscapes and exotic wildlife of New Zealand, Tasmania, and Australia while cruising aboard the deluxe Oceania Cruises *Marina*.

MAYAN MYSTIQUE

March 18 – 28, 2013 • *Riviera*
From $2,155 • INCLUDES AIRFARE

Discover Eastern Central America from the comfort of the elegant *Riviera*, Oceania Cruises' newest ship. Cruise the Caribbean to lush islands and ancient lands brimming with culture and natural splendor, where rainforests and colonial towns abound.

BALTIC TREASURES

July 21 – August 1, 2013 • *Nautica*
From $3,999 • INCLUDES AIRFARE

The treasures of Northern European are revealed as you cruise the Baltic Sea aboard Oceania Cruises' elegant *Nautica*. Discover poignant landmarks, medieval towns, onion-domed cathedrals and distant monarchies, sailing to Berlin, Gdansk, Klaipeda, Riga, Tallinn, St. Petersburg and Helsinki.

PEARLS OF THE MEDITERRANEAN

October 10 - 18, 2013 • *Riviera*
From $2,199 • INCLUDES AIRFARE

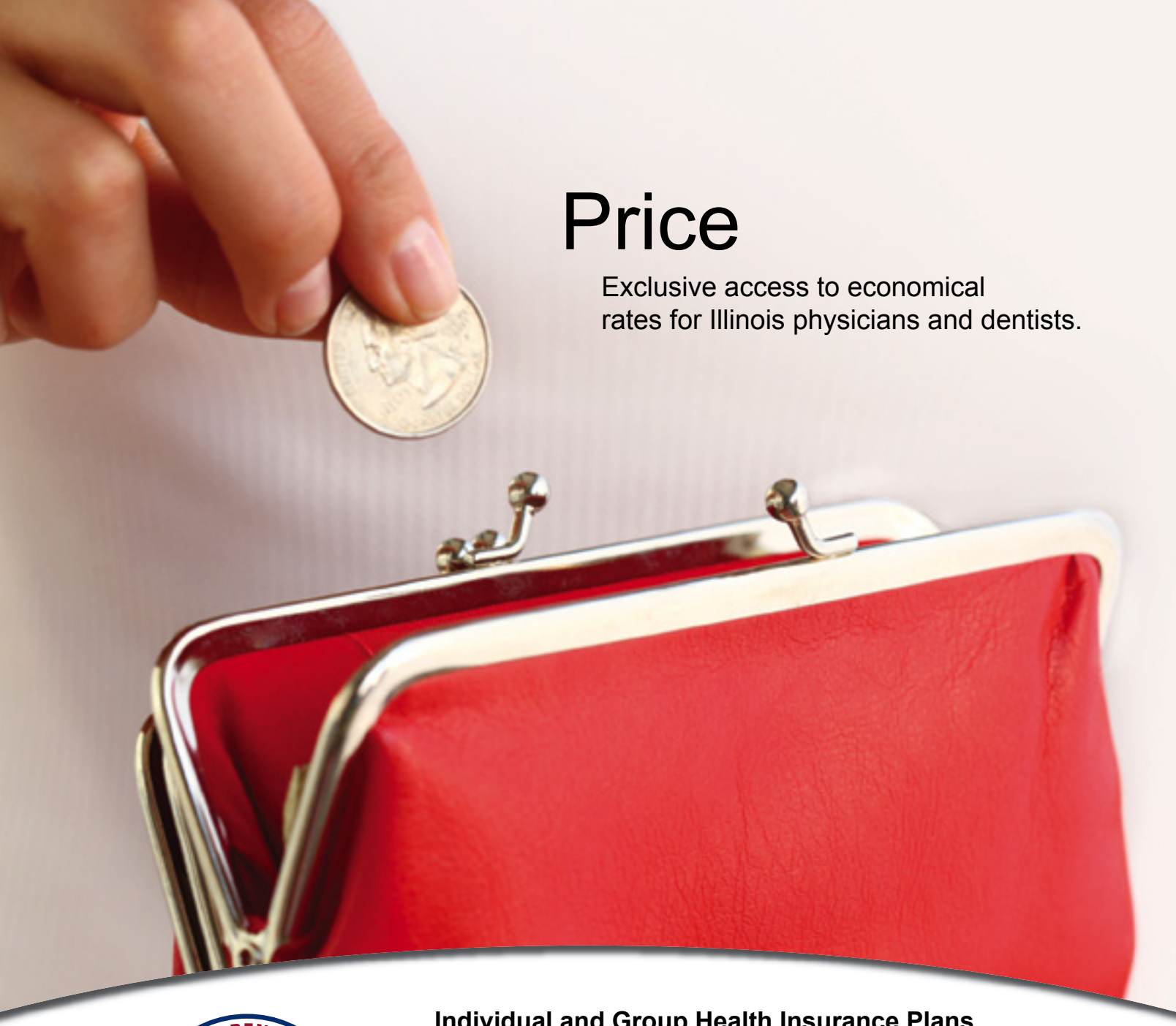
Discover the upscale pearls of the Mediterranean aboard Oceania Cruises' newest vessel, the elegant *Riviera*. Explore Provence from Marseille, experience the French Riviera in St. Tropez, and enrich yourself among renowned Italian art and natural beauty in Portofino, Florence, Capri and Amalfi.

Prices are per person, double occupancy

For additional information and a color brochure, contact:

GOnext

800-842-9023 or 952-918-8950



Price

Exclusive access to economical rates for Illinois physicians and dentists.

Individual and Group Health Insurance Plans

When it comes to your health insurance, you deserve the best combination of freedom, choice and price. Freedom to use any doctor, specialist and hospital without referrals. Your choice of plans, coverage options and deductibles. *Designed by physicians for physicians*: call now for your personal consultation and competitive rate quote.

ISMS/CMS Members
1-800-621-0748 • www.pbtinsurance.com

ISDS Members
1-866-898-0926 • www.isdsinsurance.com

Sponsored by:

Illinois State Dental Society

PBTLIC is a wholly owned subsidiary of:

ISMIE

Administered by Affinity Insurance Services, Inc.

E-8883-0111 CMS

The Solo Physician and Health IT

What it takes to become a "paperless" practice **by Abel Kho MD, MS**

ONE OF THE most interesting aspects of my work in the Chicago Health IT Regional Extension Center program is meeting and working with innovative physicians in Chicago. As providers across the city integrate technology into their practices, they are finding novel ways to support their patients and improve the quality of the care they provide.

The following article includes highlights of my interview with Chicago internist Irene Silva, MD, the first physician to demonstrate "Meaningful Use" through the CHITREC program.

Dr. Silva has been using the eClinicalWorks EHR system in her Streeterville solo practice since 2007. In the last five years, she also implemented a patient portal and set the goal of becoming completely paperless.

I met Dr. Silva at a White House Healthcare Summit that celebrated physicians who are advancing health IT technology.

The Solo Practice that Could

Dr. Kho: Now that you're a Meaningful User, how has it changed your practice day to day?

Dr. Silva: Ever since we went live, each day gets easier. This was not an easy transition. We were up all night trying to input records. But once it's done—it is so enjoyable. I am on top of every patient and don't miss anybody. You can leave yourself alerts, and do recalls from the registry [to send reminders]. When you go to sleep you don't have to think about the things you should have done. You also know who didn't go for lab testing and you can pursue the patient and ask why they didn't appear in the interface. I cannot tell you how much Meaningful Use has done for my practice, and the practice of medicine.

Internist Irena Silva, MD, right, is integrating technology into her Streeterville practice with the goal of becoming completely paperless.

Are you a totally "paperless" practice now?
We are almost there. I have forms that patients can actually fill out. They print them out and bring them in, and all we have to do is scan them. I actually get the medical history form, but I have my own electronic form. The information comes in and it's amazing.

How do the patients feel about the portal?
They love it. There is nothing better for patient communication. I know I'm in contact with my patients 24/7, and with some on the weekends. If they need a medication or have, say, a bladder infection, I simply call them. But if it's not an emergency, I just contact them through the portal.

And how about the staff?
My staff is really young, so I'm very lucky. I hired them after the transition, and so this is all they know. My staff members are like fish in the water; they are amazing.

Do some of them have prior experience?
No. They just picked it up, and I think that's one of the selling points of eClinicalWorks: it's so user-friendly. My staff are not old like me—I'm still transitioning to electronic records.

Do you find that in some ways EHRs are more work than paper or are there things you would change?
It's all second nature after five years. I don't think EHRs are extra work; your brain gets used to a new system.

How was your experience with CHITREC?
I don't think I would have been able to make the transition without you. I'm not computer savvy and thought the goal was unreachable. But when the implementation manager came, she was boom, boom, done. I was amazed. Physicians are terrified, and need to know about the services your organization provides.

Dr. Kho is an internist, and the co-executive director of the Chicago Health IT Regional Extension Center. For more information on CHITREC services, visit www.chitrec.org.

The Dos and Don'ts for Proper Attending Physician Documentation

Ensuring medical necessity compliance **by Ralph Wuebker, MD, MBA**

AS MEDICAL necessity continues to be a hot-button issue in the healthcare industry, getting the level of service correct every time is not only necessary, but critical to remaining compliant with the Conditions of Participation (CoP) set forth by the Centers for Medicare and Medicaid Services (CMS). Overuse of inpatient or observation statuses can have detrimental effects on the patient, physician and hospital.

In lieu of a compliant process, the knowing overuse of inpatient status could lead to a false claims issue and/or incorrect reimbursement due to improper classification. Overuse of observation can cause hospital data to appear incorrect. The length of stay, mortality data and cost of inpatient care could be elevated and market share data lowered artificially.

The bottom line is that it's all about giving every patient the correct status. And getting it right starts with the first patient encounter, generally by a hospitalist, ER doctor, or attending physician. Accurate and thorough physician documentation has always been an important part of the utilization review (UR) process, but it has been spotlighted recently because of new regulations.

Florida's Medicare Administrative Contractor, First Coast Service Options Inc., started reviewing physician claims. Effective Jan. 1, 2012, FCSO was also to begin performing post-payment review of the admitting physician's and/or surgeon's (Medicare) Part B services for inpatient admissions that are denied either because they do not meet the level of care criteria (they could have been performed in a less intensive setting, or outpatient basis), or because the documentation did not support the medical necessity of the procedure.

But MACs aren't the only government contractors with the ability to target attending physicians. Recovery Auditors (RAs), formerly known as Recovery Audit Contractors (RACs), also review evaluation and management (E&M) services on physician claims under Part B. The review of duplicate claims or E&M services that should be included in global surgery were available for review during the RAC demonstration and will continue to be available for review.

Increased scrutiny by government auditors of attending physician documentation has added even greater emphasis on the importance of recognizing poor practices, correcting them, and then encouraging proper documentation for every case.

To ensure proper documentation, physicians should include a clear plan of care and impression in the history and physical (H&P). Notes for procedures should always address any risk linked to medical history. Also, continued-stay reviews with a recommendation for inpatient status should always include current progress notes or orders to justify the basis for continued acute care following stabilization.

The CMS Medicare Benefit Policy Manual highlights five key pieces of documentation for determining medical necessity of inpatient status. These points include:

- Medical history
- Current medical needs
- Severity of signs and symptoms
- Facilities available for adequate care
- Predictability of an adverse outcome

To expand on "predictability of an adverse outcome," a physician may want to start with the basic questions below:

- Risk assessment—Is this a high- or low-risk patient, and why?
- Prior Response—Did the patient fail to respond to a prior treatment?
- Concern for a serious outcome if the patient is not closely monitored on admission—Given the patient's history and current presentation, what kind of adverse outcomes are likely?
- Notation that the standard of care is being met—Are you following the treatment guidelines set forth by the American College of Cardiology?

Following the tips above can help improve physician documentation, but only when paired with open communication. It is imperative to educate and collaborate with attending physicians so they understand the importance of thorough and accurate documentation. In the end, it will make everyone's lives a little easier and keep the hospital and physician within the law.

Ralph Wuebker, MD, is vice president of Executive Health Resources' (EHR) ACE (Audit, Compliance and Education) Team. This group of physicians conducts audits and regular visits to client hospitals to provide ongoing education on Medicare and Medicaid compliance and regulation issues, as well as medical necessity and utilization review. Dr. Wuebker can be reached at: ralph.wuebker@ehrdocs.com.

This article is adapted and reprinted courtesy of RACmonitor e-news. Appeared January 31, 2012.

University of Chicago physicians check their iPads. (From left) Charles Rhee, resident; Bhakti Patel, fellow; Mark Gajjar, resident; James Woodruff, program director, Internal Medicine Residency Training; and Jennifer McDonnell, resident. (Photo by Dan Dry for University of Chicago Medicine.)

PHOTO: MEGAN DOHERTY, UNIVERSITY OF CHICAGO MEDICINE.

Smartphones Sparking Communications Revolution for MDs

by Howard Wolinsky

SMARTPHONES, especially iPhones, have been catching on big time, as a means for physicians to stay in touch.

In 2001, only 30% of physicians said they had a smartphone, a computer-like phone with Internet capability and helpful apps. As smartphones got even smarter, the numbers grew. As of May this year, 85% of more than 3,000 practicing physicians said they had one, according to Manhattan Research's Taking the Pulse survey. Physician adoption outpaced the public adoption of smartphones by about two to one.

Aptilon Corp. found in a survey of 340 physicians in 2011 that a whopping 61% of doctors expected to buy the iPhone vs. 9% opting for an Android from Google or BlackBerry from Research in Motion, and the remainder a basic cellphone. While most of the public owns Android-based phones with the operating system from Google, most physicians own iPhones.

Michael Ross, MD, chief medical officer of NaviNet, the largest real-time health-care communications network in the U.S., says: "The iPhone clearly is the smartphone to beat with docs."

Add tablet computing to the mix, especially iPads from Apple, and you're witnessing a communications revolution led by the white coats. (See accompanying article.) Manhattan Research's survey showed that 62% of physicians have iPads, nearly doubling the penetration since last year.

Still, smartphones and regular cellphones haven't displaced pagers, the long-time standby for physician communications. Ted McNaught, president of Critical Alert Systems, the third largest pager carrier in the U.S., wrote in mobihealthnews: "New smartphone paging apps are promising emergency medical personnel the same fast, reliable service as pagers. But before you retire your pager, remember that smartphone apps are only as reliable as the cellular or WiFi network they operate on."

He notes that the phone still encounters "dead zones," dropped calls and poor in-building reception. And when major disasters hit, cellphone communications have failed. In last year's tornado disaster in Joplin, Mo., paging service at the local medical center was uninterrupted. In such disasters, power needed to recharge cellphones can fail.

These drawbacks aside, smartphones are opening new communications channels for physicians, going beyond those

of traditional pagers.

New York City digital consultant Robb Hecht says, "Physicians are increasingly using smartphones and iPads/tablets to look up medical information in real-time. The best phones for physicians are iPhones because of their apps (and related iPad synching capabilities with the mother computer)."

Bhakti Patel, MD, a pulmonary critical care fellow at the University of Chicago, says she is "non-technical" but made an easy adjustment to her iPhone in 2007 when Apple put them on the market.

"It's so intuitive and user friendly it adapts to any type of learner even if you're a novice and never had a touchscreen device and smartphone. It's approachable and accessible," Dr. Patel says.

iPhones are available from the major carriers, AT&T, Sprint and Verizon, and Apple starting at $199 for the latest iPhone 4S depending on the service plan and features.

Chris Chapman, chief resident in the internal medicine program at the U. of C., says the three-inch screens on the phones do not lend themselves well to reading journal articles or accessing electronic medical records. For those applications, he prefers the iPad.

There are some who stand by the BlackBerry, which has been fading in market share but changed the market in 2002 with its addictive QWERTY keypad that enabled physicians and other professionals to thumb-type email rapidly. Ironically, in the spirit of, "if you can't beat em, join em," the latest BlackBerry Torch phones have touchscreens rather than keypads.

Michael Hobaugh, chief of the medical staff at LaRabida Children's Hospital, is a fan of his BlackBerry Style flip phone, the smallest in the line. He uses the Style in conjunction with a computer in the exam room.

"I've got Epocrates on the Blackberry and I use that to check medicine dosages and to look up factoids and that sort of thing."

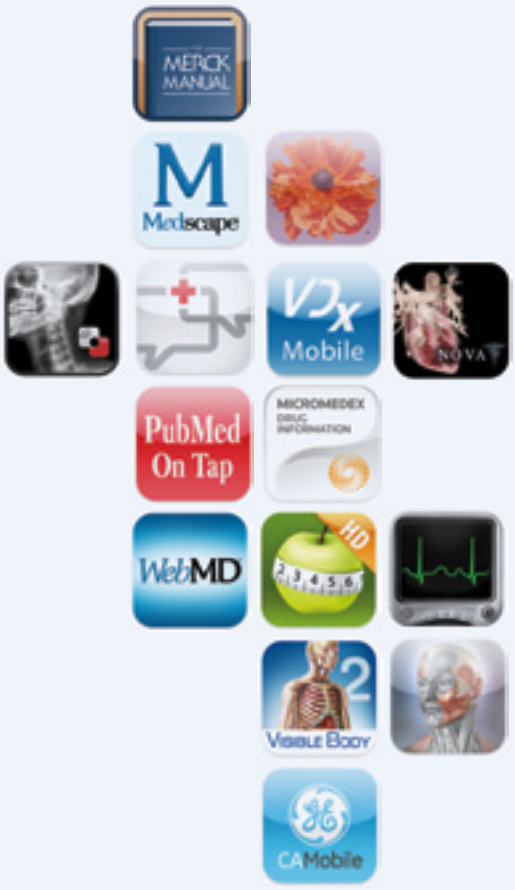
He says Epocrates brings him medical news alerts, quizzes, formulas and other useful information. He says the servers at his hospital were restricted to BlackBerry, but the network has opened up. He says he ultimately may switch to an iPhone.

Physicians find the large selection of apps available at the Apple App Store for both the iPhone and iPad a major reason to buy these tools.

"The advantage of the iPhone is the large volume of software available. They just have more apps at this point by a fair number. When a new app is introduced, it's for sure going to show up on iOS [the Apple operating system] first," Dr. Hobaugh notes. (See accompanying story.)

Howard Wolinsky is the former medical and technology reporter for the Chicago Sun-Times. He previously worked as a staff writer for American Medical News and as an instructor in the graduate program at Northwestern University's Medill School of Journalism.

An App a Day



NO LONGER do physicians have to use their lab coat pockets as their "peripheral brains," stuffing them with The Merck Manual or other books.

Instead, they can tote a smartphone or a tablet computer to carry the data and resources they need, a virtual library, to back up their medical decisions.

Apple's iPad and iPhone are the physician market leaders in tablets and smartphones. Part of the secret is in the apps.

The App Store offers more than 500 free or inexpensive medical apps, which are the fastest growing category after games and travel. Topics include reference, education, EHRs, patient monitoring, imaging, point of care, and personal care (for consumers.)

Apps for health professionals also are available for BlackBerry from Research in Motion and phones with Google's Android operating system, but these smartphones are considered "secondary markets."

Christopher Chapman, MD, chief resident in the internal medicine residency at the University of Chicago, says app choice will depend on the physician's specialty and stage of practice.

He says some applications work just as well for the iPhone and iPad. However, he adds, perhaps the most important one, Citrix Receiver, in his opinion, is too small for clinical use on the iPhone.

"At the University of Chicago internal medicine residency program, we are working with freshly minted doctors who are still in training, and a result, we are using applications that focus not only on clinical use but also on education," he says.

"A more seasoned physician may find the clinical tools most useful, although with the increasing literature base and push for evidence-based medicine, they might even find the ease of access to reference tools useful."

Dr. Chapman recommends:

Clinical

Citrix Receiver
Qx Medical Calculator
STAT ATP III
GRACE ACS Risk Model
Ahrq ePSS

Education

Responseware
Harrison's Principles of Internal Medicine—E-book via Inkling
Goodreader
Epocrates
Micromedex Drugs/Interactions
Dropbox
On-live desktop
Feeddler RSS

"Treating" the Obese Patient

Do you know what to say to them? **by William Ciganek, MD, and Jenny Conviser, PsyD**

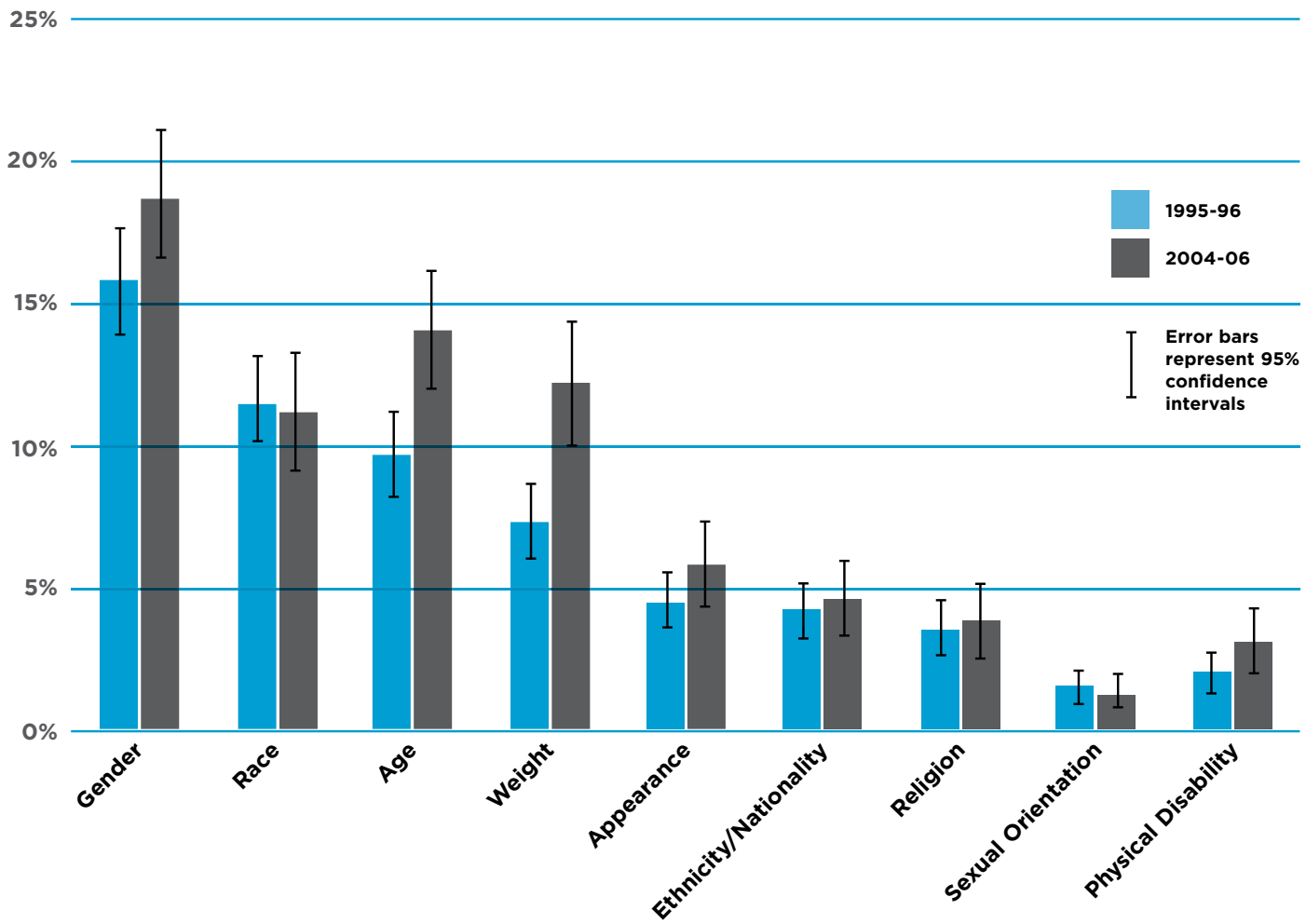
A 6′0″, 342-LB., 48-year-old male arrives for a scheduled office visit with his internist. This patient was treated previously for asthma, hypertension, hypercholesterolemia, diabetes, upper respiratory infections, and received other routine medical care. On this day, the patient reports pain in his left knee when walking. Rather than examine the knee or order tests, the physician immediately recommends bariatric surgery.

The physician said, "If you're like me, I'm sure you like starchy foods and eat a lot of bread and sugar. The best way you can help your knee is to get bariatric surgery so you can lose weight and move with less effort."

The patient was stunned. "I couldn't wait to get out of there," he says. "I felt totally dismissed." The patient requested his records and left the practice. He saw another physician who examined the knee, ordered an MRI, diagnosed a torn meniscus, referred the patient for arthroscopic surgery and prescribed six weeks of physical therapy.

Physicians will always differ in their approach to their work and patients. There should be permission for differences. However, do some physicians know what to say to their patients who are overweight or obese? Are some physicians overly focused on the obese condition while others are insufficiently focused? In one study, researchers found only 18% of patients aged 2-18 with Body Mass Index (BMI) equal to or greater than the 95th percentile had their obesity diagnosis

Trends in Rates of Perceived Discrimination Among Americans Ages 35-74



ANDREYEVA, PUHL, BROWNWELL (2008)

documented. The authors stated that obesity documentation, counseling and laboratory testing in pediatric patients were "suboptimal."

Obesity rates in the U.S. have been rising dramatically since 1976 and have now reached epidemic proportions. In the state of Illinois, obesity rates have increased more than 80% in the past 15 years. The Centers for Disease Control and Prevention (CDC), reports that 35.7% of the U.S. adult population is overweight (BMI > 30) and another 25% to 30% is obese. In Chicago alone, 64.2% of adults in the metropolitan area are overweight or obese. Children in Chicago have higher obesity rates (35%) than children nationwide (31%) generally. In Cook County, 23% of adults are inactive or not exercising at all, according to a 2011 CDC report.

In the years to come, many of your patients will be overweight or obese. Creating an office culture and communication style that accommodates the needs of obese patients has never been more important.

Patients who feel comfortable in your office and with your care are more likely to remain patients. Early intervention and consistent medical care can help reduce the risk of complications and co-morbid conditions. Accommodation is important across medical specialties and particularly so in obstetrics, gynecology, internal medicine, and pediatrics.

With the obese comprising a significant percentage of your patient population, accommodating them is not only good medicine, but also ultimately good for business.

Overweight and obese conditions can have multiple causes including genetics, metabolism, behavior, environment, culture, socioeconomic factors, and more. Unfortunately, obesity is easier to identify than it is to treat. While interventions are available, overweight and obese conditions remain highly refractory.

Many people have difficulty sustaining healthy behaviors long-term. Weight escalation has even been observed 18 months after bariatric surgery. In fact, diet and weight control behavior often leads to increased obesity and eating disorders five years later.

Weight-related disorders can begin in childhood and persist throughout adulthood, particularly as cardiovascular disease. In Chicago, Hispanic males (ages 2-19) are twice as likely to have a BMI over the 95th percentile when compared with non-Hispanic white males. The earlier the onset of the obese condition, the greater the risk of co-morbid illnesses like heart disease, stroke, type 2 diabetes, and certain types of cancer. As recently as 2008, annual medical costs associated with diabetes reached $147 billion in the U.S.

We encourage physicians and their staff to:

- Prepare for increasing numbers of overweight and obese patients.
- Remember that patients are affected by powerful weight biases in our communities.
- Focus on creating a thoughtful recovery culture for overweight patients.
- Understand the importance of treating the whole patient, not the weight condition alone.

Weight Bias Affects Your Patients

In the U.S, overweight conditions often are falsely associated with lack of will power, poor self- control, lack of nutritional knowledge, and more. Conversely, a thin body is more often associated with power, control, success, and intelligence. These erroneous assumptions constitute "weight bias." Weight bias exists in families, schools, communities, and the workplace. Weight and size discrimination is the third most commonly reported form of discrimination among adults ages 25-74 in the U.S.

Social media has increased exposure to size-related teasing and bullying, especially among teens and young adults. Because of weight bias, overweight or obese people are at greater risk for depression, anxiety, low self-esteem, and poor body image. Being overweight may influence opportunities for jobs, promotion, and salary increases. Overweight children are two to three times more likely to attempt suicide than are normal weight children. Obese adults are at increased risk for comorbid conditions and premature death.

Some patients avoid appointments to escape the scale or weight-related discussions. Internalized weight stigma increases the risk of obesity and eating disorders. Patients are less likely to stay on diets, exercise, or feel motivated to lose weight.

Office communication and practices can perpetuate the stigma of overweight and obesity. Weight bias may affect physicians' care of the overweight patient. Investigators have reported that some physicians feel less interested in treating obese patients, more negatively about obese patients (e.g., the patient would not follow their advice) and spend less time with them. Other studies show that higher BMI was associated with lower physician respect. Researchers found that medical students engaged in derogatory humor toward obese patients but understood their behavior would be unacceptable if the patients had cancer. Researchers found physicians devote less time to educating the person about health matters and schedule fewer cancer screenings for their overweight patients. Such patients are less likely to return for recommended follow-up visits and evaluation compared to non-obese patients.

Overweight or obese patients may feel that healthcare providers are quick to assume they are personally responsible for the presenting problem or advise weight loss to treat the problem. Patients may feel that they are a "weight problem" and their other health concerns are overlooked. Early exposure to weight bias in childhood can influence our attitudes and decision-making in adulthood. Therefore, we should be aware of our personal biases and how they may affect our work, and even seek additional support if needed.

Accommodating the Patient

- Furniture and facilities, including gowns and instruments, should accommodate patients of all sizes. Larger patients may have difficulty standing after sitting on low or soft-cushioned furniture.
- Printed materials should be free of size and weight bias.
- Use terms like "weight" and "unhealthy weight" rather than "fat" "chubby."
- The scale should accurately accommodate patients of various weights.
- Consider the use of bio-electrical impedance equipment to measure percentages of fat, water, and lean body mass. Compare patients' results with their personal history and avoid comparing results only with "ideal" body-weight data.
- Avoid stereotypical attitudes about obese patients that are without scientific merit.
- Weigh patients only when medically necessary. Ask or invite patients to step on the scale rather than order them to do so.
- Appreciate that different patients need different kinds of support or intervention.

Communicating with Patients

The first step is inquiring whether patients have concerns about their weight or shape and how they might wish to

proceed. The weight alone will not tell the whole story. A 300-pound person may recently have lost or gained 50 pounds, or remained the same weight for years. The number is the same in each situation but the circumstances differ vastly. This individual may or may not be knowledgeable about fitness and nutrition. How patients' experience their weight will highlight both the problem and degree of interest in advice or support.

At this point, the physician should ask what help or support is desired before offering medical feedback. Hearing the patient's concerns may be more beneficial than providing weight-loss advice alone.

The doctor can then offer information on unbiased support services, including mental health, fitness, nutrition and diet, and eating disorders. Patients can benefit from weight-related blogs, pedometers, body bugs that estimate calorie expenditure, smartphones that beep when it is time for a snack, and "Siri" who can remind us of our goal in the first place. It's helpful to talk with the patient about any patterns of weight fluctuation or stability. Percentile ranking and/or height/weight chart information might not be helpful to the patient. Classifying someone as overweight can even result in unhealthy eating behavior and weight gain.

Patient & Physician Resources

ACADEMY OF NUTRITION AND DIETETICS
800-877-1600
www.eatright.org

ILLINOIS CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Coverage, Reimbursement, Quality Improvement/Maintenance of Certification Projects and Community Resources
illinoisaap.org/projects/obesityprevention/prevention-care

OBESITY PREVENTION INITIATIVE
Mary Elsner, JD, Director
312-733-1026, ext. 220
www.melsner@illinoisaap.com

OBESITY PREVENTION INITIATIVE
Julie Shaffner, MPH, Manager
312-733-1026, ext. 214
www.jshaffner@illinoisaap.com

CONSORTIUM TO LOWER OBESITY IN CHICAGO CHILDREN
312-573-7764
www.clocc.net

UNIVERSITY OF ILLINOIS
Marian L. Fitzgibbon, PhD
Department of Medicine M/C 275
Section of Health Promotion Research
1747 W. Roosevelt Rd, Room 558
Chicago, IL 60608
www.mlf@uic.edu

AMERICAN ASSOCIATION OF DIABETES EDUCATORS
Laura M. Downes, CAE
200 W. Madison, Suite 800
Chicago, IL 60606
312-601-4877 (Direct)
ldownes@aadenet.org
Illinois Public Health Institute
www.iphionline.org
312-850-4744

ILLINOIS ALLIANCE TO PREVENT OBESITY
www.preventobesityil.org

OVER EATERS ANONYMOUS
505-891-2664
www.oa.org

PEDIATRIC PRACTICE RESEARCH GROUP
Lurie Children's Hospital
Chicago, Illinois 60611

NATIONAL ASSOCIATION OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS
Patricia Santucci, MD
Nervosa and Associated Disorders
www.ANAD.org

WEIGHT WATCHERS
www.weightwatchers.com

OBESITY ACTION COALITION
800-717-3117
www.obesityaction.org/advocacy/state-resources/illinois-state-resources

William Ciganek, MD, is a board-certified psychiatrist on staff at Northwestern Memorial Hospital and clinical instructor in the Feinberg School of Medicine. Jenny Conviser, PsyD, is assistant professor of psychiatry and behavioral sciences in the Feinberg School and on the hospital staff. The two doctors founded and co-direct Inspire Behavioral Health Centers. Dr. Conviser co-founded and co-directs Insight Behavioral Health Centers. Dr. Ciganek is a consultant for Insight.

Tips for Healthy Conversation

Healthcare professionals should keep the following in mind:

- Promote "overall health," not "weight loss."
- Recognize the multiple causes of overweight and obesity.
- Use respectful and non-biased language.
- Adopt a holistic perspective in choosing interventions.
- Promote enjoyable physical activities and healthy eating.
- Encourage healthy behaviors (fewer high-sugar drinks, more fruits and vegetables, physical activity).
- Create a recovery culture in the office, clinic, or hospital.
- Respect small changes.
- Define success uniquely for each patient.
- Listen to the patient's weight-related interests and goals.

SUPREME COURT RULING

What Docs Need to Know

by Sidney S. Welch, JD, MPH, and Ashley Worrell

The Chicago Medical Society supports new forms of interaction and communication between attorneys and physicians. As such, the Society initiated a new relationship with the Health Law Section of the American Bar Association this past year. Our partnership with the ABA aims to bring together two professions with shared professional and personal interests. In addition to educational programming, the Society is currently exploring a joint committee for both organizations to work together, as well as a legal referral service for doctors.

THE U.S. SUPREME COURT decision on June 28 (National Federation of Independent Business et. al. v. Sebelius, Secretary of Health and Human Services), upheld the provisions of the Patient Protection and Affordable Care Act (PPACA), with the exception of the Medicaid expansion provisions.

The majority opinion, authored by Chief Justice John Roberts, noted the Court's role in the decision: "Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our nation's elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices."

Jurisdiction Not Barred

The Court began by determining that it had jurisdiction over the case by determining that the Act does not necessarily imply a tax, meaning that it would not fall under the scope of the Anti-Injunction Act, which would bar the Court from rendering a decision. The Anti-Injunction Act precludes lawsuits on taxation purposes until after the tax is paid and can only be used to obtain a refund.

Individual Mandate

In a 5-4 decision, the Supreme Court upheld PPACA's individual mandate, which required individuals to purchase health insurance providing a minimum level of coverage or face a "penalty." The decision, which rested on the last of the government's three arguments, defined the penalty provision for not obtaining health insurance as a "tax," which could be controlled under Congress' taxing authority. In doing so, the majority opinion dismissed the government's arguments that the mandate was enforceable under the Constitution's Commerce Clause and its Necessary and Proper Clause.

The Commerce Clause

The Constitution authorizes Congress to "regulate commerce with foreign nations, and among the several states, and with the Indian tribes." Under this provision, the government theorized that Congress may order individuals to buy health insurance because the failure to do so affects interstate commerce. However, in the majority opinion, Chief Justice Roberts concluded that the mandate was not supported by the Commerce Clause. He opined that Congress, in establishing the individual mandate, "regulated in advance" (future actions of buying insurance), and no precedent exists to support such future actions under the Commerce Clause. Instead, it can only regulate commerce that is already established (i.e., activities that have already occurred). Whereas the government argued that the mandate's cost shifting nature is integral to the regulation of interstate commerce because it drives down costs, the Chief Justice compared the provision to requiring people to buy vegetables and eat their broccoli because eating healthy food would also drive down the costs of healthcare.

In disagreeing with the majority's opinion that the Commerce Clause did not support the mandate because Congress may not regulate "inactivity," Justice Ginsburg argued that the courts have viewed the Commerce Clause as a "technical legal conception" that case law does not support. Justice Ginsburg and the justices joining her opinion argued that the majority was incorrect in ruling that the individual mandate created something to be regulated that was not already present. Rather the healthcare markets and interstate health insurance systems are an existing entity that the individual mandate is used to regulate, rather than a future activity.

Necessary and Proper Clause

The government's second argument, that the individual mandate is valid under the Necessary and Proper Clause, fell to a similar fate. This clause of the Constitution vests the power to "make all laws which shall be necessary and proper for carrying into execution" the powers enumerated in the Constitution. Chief Justice Roberts held that even if "necessary," the individual mandate is not "proper" because it is amounts to an inappropriate expansion of federal power and is not as narrow in scope as other laws upheld under the Clause in the past. Additionally, the Chief Justice mentioned that, in every circumstance where the Court has upheld the extension of power under the Necessary and Proper Clause, it has involved exercising authority that is derivative to another power already granted. The individual mandate, he concluded, while possibly "necessary" to PPACA's insurance reforms, would not be a "proper" means for effectuating those refers because of its expansion of federal power.

"For the immediate future, the wave of consolidation and integration, largely of physicians and hospitals, will continue."

Individual Mandate as a Tax

The majority ultimately ruled that the individual mandate could be upheld as a taxable measure under Congress' authority to lay and collect taxes. Chief Justice Roberts relied on precedent stating that "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." The majority opinion reasons that, though not a tax by name, the individual mandate is a tax in form based on the language of the statute. Because the mandate does not apply to those who do not pay federal income taxes, is paid to the IRS, and is determined by the number of dependents and amount of household income, the individual mandate could be viewed under the taxing authority of Congress. Additionally, the penalty required would not be so high that one is forced to buy health insurance and is not only limited to willful violations. The Chief Justice analogized the mandate to the increased tax for cigarettes, which is clearly used to deter their purchase and is a lawful use of Congress' taxation authority. By upholding the mandate, the Court has simply said that Congress has acted within its existing authority; it did not create any new federal powers.

The dissenting opinion, comprised of Justices Scalia, Kennedy, Thomas, and Alito, counters that the individual mandate is a means to compel behavior, and thus cannot be considered merely a tax. According to the dissent, the majority's argument that the mandate is not a penalty because it does not punish unlawful behavior was ill-conceived. The dissent also points to the mandate's location in PPACA. Rather than sitting among the other "revenue provisions," the individual mandate remained at

the forefront within the "operative core" of the first title. The dissent further argues that to consider the individual mandate anything other than a requirement to purchase healthcare insurance would require the statute to be re-written entirely.

Medicaid Expansion

Medicaid, which originally applied to four groups (the disabled, blind, elderly, and needy families with dependent children), is to be expanded under PPACA to all individuals under 65 with incomes below 133% of the federal poverty line. In a seven-justice majority, the Supreme Court struck down the provision in PPACA that would deny Medicaid funding to states that do not comply with the Medicaid expansion.

The majority struck down the provision on the basis of the Spending Clause, which allows Congress "to pay the debts and provide for the . . . general welfare of the United States." Relying on precedent, the Court concluded that Congress may use financial incentives to encourage states to act in a particular manner but, when "pressure turns into compulsion" the legislation has gone too far. Chief Justice Roberts compared the Medicaid penalty to a "gun to the head" because states stood to lose their entire Medicaid funding. According to the majority, because states do not have the option to opt out without severe penalty, that is, losing all existing Medicaid funding on top of any new funding from the program, it creates more than a minor penalty and would be impermissible under the Constitution.

The majority viewed the Medicaid expansion as a new project rather than an addition to old law. The Court reasoned that Congress could impose conditions for the new program or reasonable expansions thereof, but it could not deny existing funding for failure to comply with provisions of a new program that the states did not see coming. Justice Ginsburg and Justice Sotomayor disagreed, reasoning instead that the Medicaid expansion did not constitute a new program, but simply an outgrowth of the existing one. Additionally, where the majority noted that states could not foresee new conditions coming and could not be bound by them, the dissenting opinion pointed out that the Medicaid Act put all states on notice that the program might expand when it reserved a right "to alter, amend, or repeal any provision."

Rest of PPACA Affirmed

In deciding to strike down the Medicaid expansion penalties to states not in compliance, the Court was tasked with determining whether to uphold the balance of PPACA. The Chief Justice, despite a strong dissent, concluded that Congress would not have intended for all of PPACA to be eliminated should this provision be struck down. As such, the Court ruled that any constitutional violation of the Medicaid expansion was entirely remedied by striking down that specific provision and leaving the balance of PPACA otherwise intact. Justices Kennedy, Scalia, Alito, and Thomas disagreed, believing that it is not the role of the Court to sever one part of a statute and allow the rest to stand as it could "impose unknowable risks that Congress could neither measure nor predict."

Ultimately, the decision left the Affordable Care Act largely intact, basing its decision on Congress's authority to tax rather than the Commerce Clause or the Necessary and Proper Clause. The only section that will be removed is the penalty eliminating all Medicaid funding from states that do not comply with the program's expansion.

Implications for Physicians

Lawyers, politicians, pundits, and the public are still trying to digest the immediate and potential implications of the Supreme Court's decision. Our thoughts as to potential implications for physicians are as follows:

- At a practical level, we know that provisions of PPACA, such as the ban on specialty hospitals, the disclosure of physician interests in ancillary services, the Sunshine Act, the fraud provisions described below, and some of the benefits for physicians outlined below will remain in effect for now.
- As a practical matter, we know some issues critical to physicians remain unaddressed, including reimbursement, access to care for patients due to physician shortages, and cost-containment.
- The decision affirms some of the benefits of PPACA for physicians, such as patients' improved access to care, assuming physician supply, elimination of patients' concerns regarding pre-existing conditions, elimination of the Medicare Part D donut hole, primary care physician payment rates and bonuses, geographic payment differentials benefits for rural areas, and tax credits for small businesses.
- Payment mechanisms remain in flux and enter an era of "collaboration" and "quality" measures with value-based purchasing, shared savings, quality measures, bundling, and others.
- Fraud enforcement will increase with the need to fund healthcare expansion. These efforts will be assisted by provisions of PPACA that remain in effect for now, including the 60-day overpayment rule, the self-disclosure protocol, a liberalized intent standard, enhanced Civil Monetary Penalties, and relaxed standards for qui tam actions.
- We also know or can predict with some assurance that, for the immediate future, the wave of consolidation and integration, largely of physicians and hospitals, will continue due to reform internal and external to PPACA. Physician engagement will be critical.
- Physicians can take comfort in some expanded coverage for their patients. The scope, degree, quality and long-term reality of the coverage expansion remain to be seen.
- Election platforms in the fall certainly will include healthcare reform as a component. Physician engagement will be critical.
- Challenges to the scope of the Supreme Court's decision, particularly with respect to the Commerce Clause and the taxing authority, will be tested in the future.
- Physicians, as employers and employees, will face decisions about insurance offerings to their own employees and for themselves, with options depending, in part, on practice or employer size.
- States will struggle to make decisions about whether to opt-in or opt-out of the Medicaid expansion, which will have significant impact on physicians and their patients. Some of this decision-making may be deferred to election time, much will involve politics, and much will involve cost-benefit decisions over the short-and long-term.

The decision will continue to have intended and unintended consequences as we wrangle with a new era of healthcare. We will update you as new issues arise.

Ms. Welch is a partner with the healthcare practice of Arnall Golden Gregory LLP (www.agg.com) *representing physician practices on a national basis. Ms. Worrell is a rising second-year law student at the Georgia State University College of Law. A copy of the decision can be accessed at* www.supremecourt.gov.

CHICAGO MEDICAL SOCIETY

Let's be everywhere we need to be.

Fast / Easy / Secure • Save Time, Improve Patient Care

- Complete directory of your medical society colleagues in the palm of your hand
- On-demand HIPAA-compliant messaging with multi-media collaboration
  - — Send and receive high-res images such as X-rays or EKGs instantly and much more.

Available on the App Store

ANDROID APP ON Google play

iPhone / iPad / Android

DocbookMD is supplied at no charge to Medical Society Members. Go directly to the iTunes App Store or Google play on your device and download DocbookMD, then complete the registration process. You will need your Medical Society member ID number ready.

docbookMD®

Snuffing Out Smoking

You can make a difference in Chicago **by Bechara Choucair, MD**

THE PREVENTION and reduction of cigarette use is one of the top priorities of the City's public health agenda, Healthy Chicago. Our goal is to reduce the number of Chicagoans who smoke and prevent our youth from picking up their first cigarette, while also limiting people's exposure to secondhand smoke. Our focus is mostly on interventions with the greatest impact. We work on developing and implementing policies throughout the City and on increasing the work we do with community organizations to deliver interventions and prevent tobacco exposure. This approach allows us to reach more people and target vulnerable populations.

In cities across the U.S., policies that limit access to tobacco products and create smoke-free environments have been effective ways to reduce the toll of tobacco. In Chicago, new policies have been implemented to limit tobacco use and exposure to smoke. In May, the Chicago City Council passed an ordinance that impose higher fines for the sale of tobacco to minors and for the sale of unstamped (untaxed) cigarettes; a new fine for retailers who conceal unstamped cigarettes; the prohibition of the sale of cigarettes during a retail investigation; and a ban on tobacco vending machines.

In addition to legislative policies, the adoption of smoke-free environments by other public and private sector entities has also made great progress toward our Healthy Chicago goals. Over the past two years, in collaboration with the Respiratory Health Association on the Chicago Tobacco Prevention Project (funded by the Centers for Disease Control and Prevention), we have helped numerous organizations adopt smoke-free and tobacco-free campus policies. These include public and private apartments and condominiums, hospital and college campuses, schools, and mental health and substance abuse treatment centers. One highlight of these efforts was our partnership with the Chicago Housing Authority (CHA), which piloted smoke-free housing at four of its neighborhoods resulting in more than 1,600 units of smoke free housing.

Even Chicago's beaches are now smoke-free, thanks in part to the Healthy Chicago public health agenda.

We are also working with community organizations so they can provide more smoking cessation outreach to the public. Our partners have provided nearly 5,000 smokers in Chicago with nicotine replacement therapy, and our delegates have provided smoking cessation services and support to over 100,000 residents. In addition, we have assisted more than 25 community health clinics to integrate the Ask, Advise, Refer (AAR) model into their electronic health record systems. This program ensures that patients who smoke are consistently screened for tobacco use, educated about the dangers of tobacco, and referred to the Illinois Tobacco Quitline and other local resources for cessation support. As a result of this intervention, over 100,000 residents were screened for tobacco use and referred appropriately for smoking cessation support.

Raising awareness about tobacco control policies and preventing tobacco use among youth is an important element to our local strategy. In partnership with the Respiratory Health Association and the Illinois Department of Public Health, we began a new public awareness campaign to stop the sale of cigarettes to youth, which includes ads on CTA trains and buses that encourage residents to call 311 if they see tobacco being sold to a minor. This is particularly important as studies show the majority of adults who smoke began smoking before they are 18 years old. Other public awareness campaigns this summer remind residents that Chicago's play lots and beaches are smoke-free to protect kids and families from the dangers of secondhand smoke.

Although we have made substantial progress, there is more work ahead of us. There are also ways that you can make a difference. For example, adopt a 100% smoke-free or tobacco-free campus at your clinic or hospital. Consider incorporating the Ask, Advise, Refer model of tobacco screening, and integrate this quick and easy routine into your medical practice to ensure that all of your clients are screened for tobacco use and referred to local resources for cessation support. Promote the Illinois Tobacco Quitline (1-866-QUIT-YES), through posters, emails and other outreach to help people who want to quit smoking.

Dr. Choucair is commissioner of the Chicago Department of Public Health. Please contact him at Choucair@cityofchicago.org *or* @choucair *on Twitter. He also encourages you to follow the Chicago Department of Public Health on Twitter @* ChiPublicHealth.

Stroke in Women

Higher morbidity and mortality? **by Neelum Aggarwal, MD, and Shyam Prabhakaran, MD**

ON AVERAGE, every 40 seconds someone in the United States 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 die from stroke.

One study showed that women may experience longer delay from arrival to the emergency rooms to the time they are evaluated for stroke symptoms. This may be due to possible gender differences in the reporting of acute stroke symptoms. In a commonly referenced study of 1,189 admissions that ended with a validated 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 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 and level of consciousness.

Differing Treatment for Women?

Once women have been diagnosed with stroke, their medical treatment may differ from that of men. Management of stroke may differ based on gender issues, similar to the well-documented gender differences in the treatment of cardiac disease, where women are less likely to receive major diagnostic and therapeutic procedures. Differences may also exist in stroke prevention. Men with stroke are more likely to have significant co-morbidities, such as higher rates of ischemic heart disease and diabetes compared with women who have higher rates of hypertension and atrial fibrillation. This cardiovascular medical history profile noted in men may favor more aggressive preventative treatment in men than in women.

Aspirin and warfarin are effective medications for stroke prevention in men and women. Carotid endarterectomy (CEA) is another important treatment for primary and secondary prevention of stroke in patients with significant carotid stenosis. Although carotid disease is more common in men, some studies have shown a higher rate of post-operative complications in women, with post-operative stroke seen more frequently in women than men. 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 carotid arteries.

For stroke and heart disease, commonly recognized risk factors of smoking, elevated cholesterol, previous stroke, and large artery atherosclerotic disease hold true for both men and women. Workup following a new stroke should be similar in both sexes. Hypertension and elevated cholesterol become more common in women as they age. Cholesterol levels typically will increase at age 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 that may predispose women 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. 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 foliate. Last, oral hormone replacement used by menopausal women may increase the stroke rate.

"Management of stroke may differ based on gender issues, similar to the well-documented differences in the treatment of cardiac disease, where women are less likely to receive major diagnostic and therapeutic procedures."

The last four years have seen the development of Primary Stroke Centers (PSCs) in the Chicago area. These stroke centers 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. For a list of these centers, please contact the Chicago Medical Society 312-670-2550 or email *cfouts@cmsdocs.org*.

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 an associate professor at Northwestern University, Feinberg School of Medicine. His research focuses on acute ischemic stroke, transient ischemic attack, and intracranial stenosis.

Advocating for You in Cook County

The Chicago Medical Society is a key member of the county board's nominating committee

CMS President Dr. Howard Axe, seated in the foreground, attends a recent meeting where he recommended candidates for the Cook County health systems's independent governing board.

ONE OF THE WAYS the Chicago Medical Society fulfiof the waysIls its public health mission is by recommending candidates for the Cook County health system's independent governing board.

And because of our active role in the selection process, two Medical Society-backed physicians were recently chosen as finalists to fill a new board opening.

The Society has served on the nominating committee since 2008, when our organization was invited to be part of the process that reviews candidates for the governing body.

In recent weeks, County Board President Toni Preckwinkle filled four board vacancies left by members who had reached the end of their terms on June 30 or had stepped down.

The latest opening came up when a member resigned in mid-June.

Peter Orris, MD, MPH, president of the Society's District 6, and David Ansell, MD, MPH, join one non-physician as the three finalists.

Preckwinkle relies on our organization as a referral source for highly qualified individuals to oversee the vast county health system. Represented by President Howard Axe, MD, the Medical Society collaborates with key non-profit leaders to present her with nominees.

The independent governing board makes policy, hiring, and contracting decisions on behalf of the nation's third largest public health system. Its 11 members work in concert with Preckwinkle and Ramanathan Raju, MD, the county health system's CEO.

As a nominating committee member, the Chicago Medical Society advocates on behalf of patients in the County health system as well as our doctor-members who practice on the public health frontlines.

The Society-supported finalists — Drs. Orris and Ansell — have extensive public health and leadership experience, and would bring their perspective and insight to the board, Dr. Axe said after the committee met on July 3.

Public Health Veterans

Dr. Orris is professor and director of the

Occupational Health Service Institute of the University of Illinois at Chicago School of Public Health, and associate director of the School of Public Health's Great Lakes Center for Occupational and Environmental Safety and Health. He maintains an active clinical and teaching practice in occupational medicine and is the chief of the clinical department at the UIC Medical Center. Dr. Orris was an attending physician at Cook County Hospital for 35 years.

Dr. Ansell is professor and chief medical officer of Rush University Medical Center. He volunteers at the Community Health Clinic, a free clinic in Chicago, and is board president of the Metropolitan Chicago Breast Cancer Task Force, which he helped create. The group works to improve the quality of breast cancer screening and care for minority women in the Chicago area. Dr. Ansell visits the Dominican Republic each year to provide medical relief, and is part of a Chicago-based effort that provided medical relief after the Haiti earthquake. He made two trips to Haiti in 2010. In addition to writing extensively about health disparities, Dr. Ansell recently published the book "COUNTY: Life, Death and Politics at Chicago's Public Hospital."

Strong Medical Perspective

Doctor-led organizations bring strong representation to the nominating process. Along with the Chicago Medical Society, participants include Rush University Medical Center (Larry Goodman, MD); Chicago Department of Public Health, (Bechara Choucair, MD); and Cook County Physicians Association (Niva Lubin-Johnson, MD).

Future Outlook

The financial health of the County health system appears brighter these days. The projected shortfall of $267.5 million for 2013 is a clear sign its finances are stabilizing, Preckwinkle told the media last June 27. In releasing the preliminary budget for 2013, she highlighted the projected budget shortfalls of $487 million for 2011 and $315 million for 2012. Declining revenue streams are the key driver for the 2013 shortfall, largely due to patient billing fees and the planned .25% sales tax rollback, Preckwinkle said. Decreases in the County's tobacco tax ($20 million), decline in court filings ($12 million), and gasoline and diesel tax ($3.8 million) are additional contributing factors. Preckwinkle restated her commitment to completely rolling back the unpopular Stroger sales tax as necessary for economic growth in Cook County. The budgetary impact of the rollback is projected to be $9 million less than anticipated.

History of the Independent Board

BOTH THE BOARD and nominating committee were formed at a pivotal time for county government and the health system's future. The "Goodman Report" of October 2007 called for the creation of such a board following a review committee's study. A month earlier, former County Board President Todd Stroger had warned of a $307 million budget deficit for 2008. He proposed a $750 million fix by increasing the Cook County sales tax. The $3.3 billion budget for 2008 increased spending by nearly 7% and generated strong public outcry. During a five-month stalemate, Stroger was unable to persuade a majority of commissioners to approve his budget, and concern grew that a government shutdown of services was inevitable. In March 2008, Commissioner Larry Suffredin provided the additional vote needed to pass the tax increase. Suffredin explained he agreed to the unpopular tax increase in exchange for Stroger's relinquishing control of the county health system for three years, and to avert a service shutdown. A 1% increase to the sales tax took effect July 1.

As these events unfolded, the county board approved an ordinance in February 2008 that created an interim board of directors and attached nominating committee. The Chicago Medical Society accepted an invitation to serve on the committee. In April, the committee submitted the names of 20 candidates to President Stroger who approved six candidates, as did the board. In May 2008, an amendment to the ordinance increased the number of board members to 11, up from 9. Four more candidates were subsequently approved. The first regular business meeting of the board took place in July 2008, and an interim CEO (David R. Small) was appointed in August of that year. In March 2009 the board appointed William T. Foley as CEO, and he took charge in May. In June 2010, the County board approved an ordinance that removed the automatic sunset clause from the original ordinance. The board approved the strategic plan and five-year forecast in July.

With Foley's resignation, Terry Mason, MD, took charge in May 2011 as interim CEO. The board subsequently approved an amendment to the ordinance to create terms for initial board members. It also approved the creation of the Cook County Health Foundation, a not-for-profit corporation to raise funds.

Finally, during a July 2011 meeting of the board, Ramanathan Raju, MD, was appointed as CEO, with a start date of October 3, 2011.

SOURCES: *www.cookcountygov.com* and "Cook County Board of Commissioners Report Feb. 23, 2007-Dec. 1, 2009," by Dick Simpson and Tom Kelly; University of Illinois at Chicago Department of Political Science.

Bad Bugs: The Growing Specter of Untreatable Gonorrhea

Call for vigilance **by William Wong, MD**

Neisseria gonorrhoeae has a long history of developing drug resistance to antibiotics that have been used to treat it.

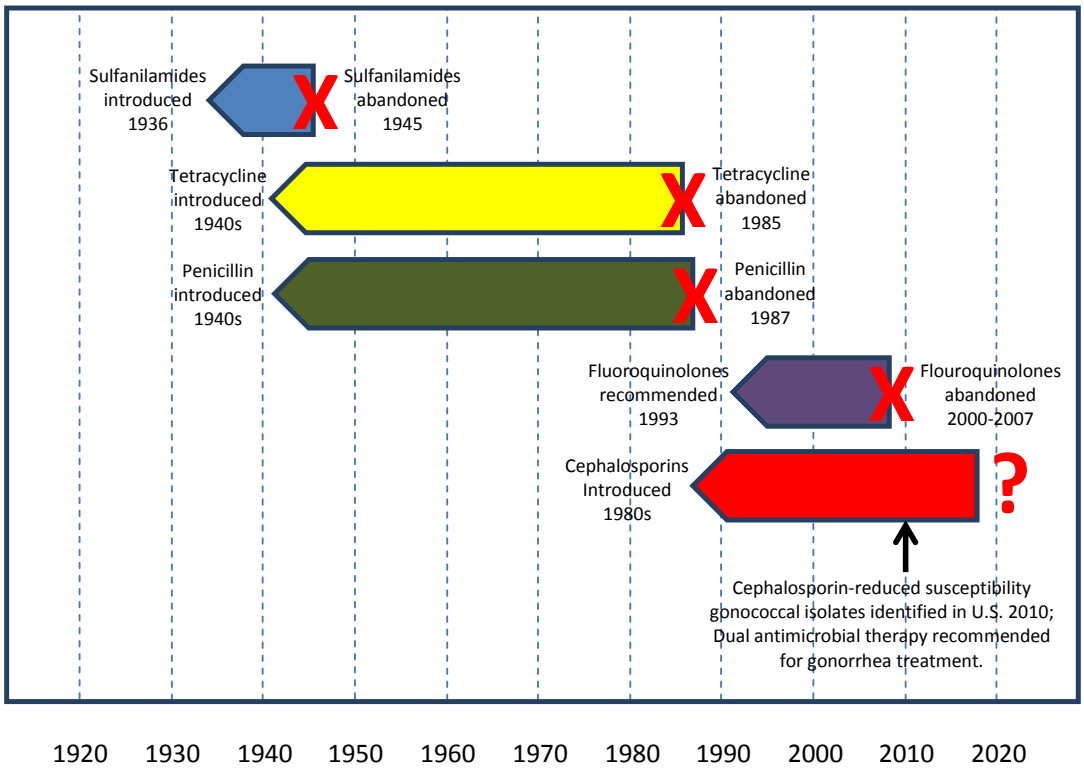
THE HISTORY of drug resistance in gonorrhea follows the history of the antibiotic era. However, during the past three years, the wily gonococcus again has shown its remarkable resilience, developing reduced susceptibilities to our last line of antibiotics used to treat infection. Since decreases in antibiotic susceptibility precede the emergence of resistance, we are looking at an imminent future of extensively drug-resistant, if not untreatable, gonorrhea that includes the inability to prevent the severe sequelae of this common, community-acquired, sexually-transmitted infection (STI).

Gonorrhea is the second most commonly reported communicable disease in the U.S., with more than 600,000 new infections occurring annually. Neisseria gonorrhoeae often presents asymptomatically, especially in women, resulting in an unrecognized infection and unwitting transmission to sexual partners. The significant health consequences of gonococcal infection include: infertility, pelvic inflammatory disease, ectopic pregnancy, and chronic pelvic pain in women; epididymitis and orchitis in men; and disseminated gonococcal infection in susceptible individuals. Similar to other inflammatory STIs, gonococcal infection facilitates the transmission of HIV by two to five times, accelerating the HIV epidemic in vulnerable populations. Furthermore, gonorrhea disproportionately affects women, youth, men who have sex with men, and communities of color, thereby creating a large cost burden for society. Yet gonorrhea can be readily identified through screening with available laboratory tests, prevented with a variety of low-cost clinical strategies, and, for the moment, even cured, using relatively inexpensive antibiotics.

Unfortunately, Neisseria gonorrhoeae has a long history of developing drug resistance to antibiotics we have used to treat it. Gonococcal drug-resistance emerged to sulfanilamides in the 1940s, to tetracyclines and penicillins in the 1980s, and more recently, to fluoroquinolones in the last decade [Figure 1]. Gonorrhea developed resistance to each successive antibiotic introduced and used to treat this common infection, resulting in the loss of entire drug classes that comprise the armamentarium of our antimicrobial defense. Once antimicrobial resistance in gonorrhea emerges, the genes conferring drug resistance persist among circulating strains of gonorrhea in the community and appear to be sustained over time.

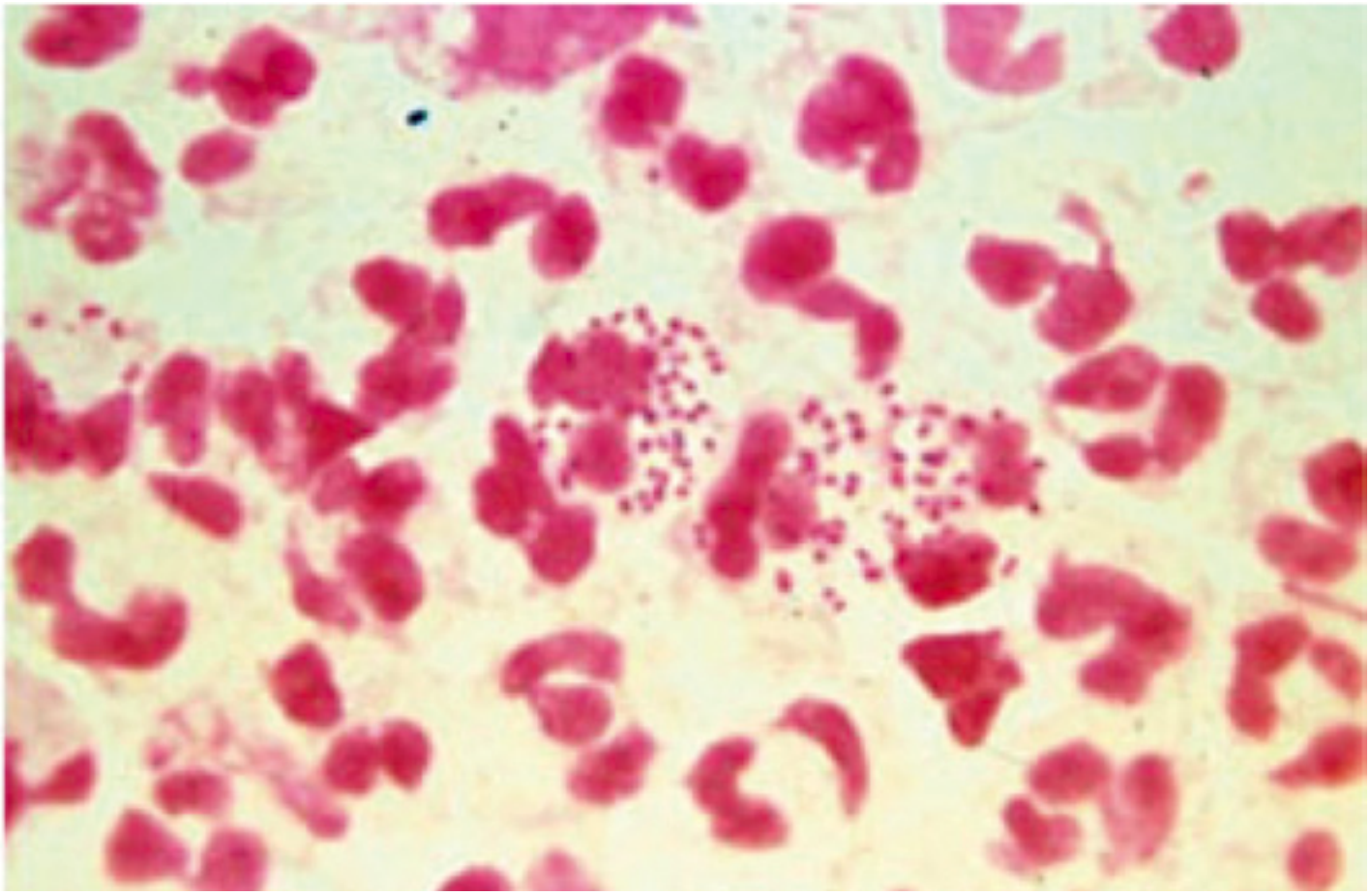
Figure 1.

Advent of Antimicrobial Resistance in *Neiserria gonorrhoeae* in the United States 1920-2012



The Fluoroquinolones

The emergence of fluoroquinolone-resistant gonorrhea in the U.S. illustrates the rapid emergence of resistance to an antimicrobial class of drugs. Fluoroquinolones were recommended by the Centers for Disease Control and Prevention (CDC) for the treatment of uncomplicated gonococcal infection in adolescents and adults



Gram stain showing gonorrhea as gram-negative intraceullular diplococcic contained within polymorphonuclear cells. Image courtesy of Dr. Joseph Engelman, San Francisco City Clinic; San Francisco Department of Public Health, California.

in 1993. First identified in Asia, fluoroquinolone resistance was identified in Hawaii and the Pacific Islands in 2000, resulting in the discontinuation of fluoroquinolone treatment for gonorrhea acquired in Hawaii, the Pacific Islands, and in Asia. However, the prevalence of fluoroquinolone-resistant gonorrhea among men who have sex with men (MSM) throughout the U.S. increased by 2002, prompting the CDC to discontinue national recommendations for fluoroquinolone treatment of gonorrhea in MSM. Finally, with the increased prevalence of fluoroquinolone-resistant gonorrhea among heterosexuals in the U.S., the CDC discontinued recommending any fluoroquinolone regimens for treatment of gonorrhea in 2007. Thus, the entire drug class of fluoroquinolones was lost within 16 years of its introduction for use in treating gonorrhea. A single class of antibiotics, the cephalosporins, was the recommended therapy for treatment of gonorrhea in the U.S. by 2007.

The Cephalosporins

Cephalosporin susceptibility among Neisseria gonorrhoeae has been rapidly declining in the U.S., as documented in recent sentinel surveillance data. Established in 1986, the Gonococcal Isolate Surveillance Project (GISP) is a CDC-sponsored national sentinel surveillance system developed to monitor gonococcal antimicrobial susceptibilities among symptomatic men seen in sexually transmitted disease clinics in the U.S. From 2006 to 2010, the proportion of GISP isolates for which the minimum inhibitory concentration (MIC) of cefixime is elevated (≥0.25 μg per millimeter) (i.e., indicating decrease susceptibility to antibiotic levels) increased from 0.1% in 2006 to 1.4% in 2010 nationally, representing a 14-fold increase. Additionally, the proportion of GISP isolates for which the MIC of ceftriaxone is elevated (≥0.125 μg per millimeter) increased from 0.0% in 2006 to 0.3% in 2010, representing a three-fold increase nationally. Increases in the proportion of gonococcal isolates with reduced susceptibility to cefixime were greatest in the western U.S. (from 0.2% to 3.6%) and among men who have sex with men (from 0.2% to 4.7%). Additionally, treatment failures and trends of decreased gonococcal susceptibility to cephalosporins have been reported in Europe and in Asia.

Reduced susceptibility to cephalosporins results from several chromosomal gene mutations (penA, penB, and mtrR genes, and the novel mosaic penA DNA cassette) that affect penicillin binding, entry and exit in the gonococcus.

Dual Therapy for Now

Rising trends in antimicrobial resistance in gonorrhea to cephalosporins are of particular concern.

In previous emergences of antimicrobial-resistant gonorrhea, control strategies and treatment recommendations changed to an alternate recommended antibiotic. With the emergence of cephalosporin-resistant gonorrhea appearing inevitable, the final class of effective antibiotic treatment for gonorrhea may be lost. At this time, no other well-studied and effective antibiotic treatment option beyond cephalosporins or other antibiotic combination is available. GISP data suggest that gonococcal resistance to cefixime might emerge before the development of resistance to ceftriaxone. Therefore, the CDC currently recommends two antibiotics (i.e., dual therapy) when treating gonorrhea to ensure effective treatment, using ceftriaxone 250 mg by intramuscular injection in combination with azithromycin or doxycycline. Azithromycin 1 gram orally is preferred over doxycycline due to the prevalent tetracycline resistance in the U.S. [Figure 2]. All patients treated for gonorrhea should be offered condoms, tested for HIV, referred for risk reduction counseling, and retested for gonorrhea and HIV three months later. All sex partners with contact within the last 60 days should be treated with ceftriaxone and azithromycin dual therapy. Actions taken now to ensure adequate treatment of gonococcal cases may delay the advent of cephalosporin-resistance gonorrhea.

Fig. 2. Summary of CDC Gonococcal Infection Treatment Recommendations for 2012.

Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum
Ceftriaxone 250 mg IM in a single dose OR, IF NOT AN OPTION **Cefixime** 400 mg orally in a single dose OR Single-dose injectable **cephalosporin** regimens PLUS **Azithromycin** 1g orally in a single dose OR **Doxycycline** 100 mg orally twice a day for 7 days
Uncomplicated Gonococcal Infections of the Pharynx
Ceftriaxone 250 mg IM in a single dose PLUS **Azithromycin** 1g orally in a single dose OR **Doxycycline** 100 mg orally twice a day for 7 days

Vigilance and Prompt Action

In addition to ensuring prompt and effective antimicrobial therapy, vigilance is needed to identify and effectively treat gonococcal infections. Taking a culturally-competent sexual history can identify individual risk factors for gonococcal infection. The U.S. Preventative Services Task Force recommends routine screening for gonorrhea infection in all sexually active women, including those who are pregnant, if they are at increased risk for infection. Increased individual and population risk factors include: young age <25 years, previous gonorrhea or other STIs, new or multiple sex partners, inconsistent condom use, recent involvement in commercial sex work or drug use. Cephalosporin-resistant gonorrhea would present as clinical treatment failures, and evidenced by persistent symptoms or positive follow-up tests in patients who had received the recommended treatment regimen. Clinicians should ensure adequate treatment with an effective regimen when a suspected treatment failure is identified. Performing a test-of-cure using culture with susceptibility testing (if available) or a nucleic acid amplified test is recommended. Sex partners should be treated effectively to prevent re-infection of the patient. As with other complicated medical cases, clinicians should consider consulting with an infectious disease specialist on all treatment failures. Additionally, cephalosporin treatment failures should be reported immediately to the local public health department. Prompt recognition of treatment failures is critical to lessening the risk of gonococcal sequelae in the patient and in their sexual partners, and to reducing the spread of drug-resistant gonorrhea in the community.

New Tools Critical

Additional research to identify effective novel antimicrobial therapies and drug combinations are urgently needed in light of the real and growing threat of untreatable gonorrhea. Additional diagnostic options are needed to ensure that multi-drug resistant gonorrhea can be identified quickly and managed in the outpatient setting. The goal of long-term disease control rests with the development of a gonococcal vaccine; however, this remains distant. Without additional clinical tools, we meet a near-future in which highly drug-resistant gonorrhea is prevalent with limited treatment options available. In the meantime, current clinical management strategies involve higher doses of antibiotics, combination antibiotic therapies, and increased laboratory testing, including tests-of-cure, to identify and treat this common and preventable community-acquired and sexually transmitted infection known as gonorrhea.

Dr. Wong is medical director (acting) of the STI/HIV division, and medical director of public health preparedness and emergency response, at the Chicago Department of Public Health. He can be reached at will.wong@cityofchicago.org.

The Physician's Obligation to Family Caregivers

Limits on the physician-patient relationship **by Jalayne J. Arias, JD, MA**

FAMILY CAREGIVERS provide an incredible amount of support to patients and serve as an integral part of healthcare delivery. In 2009, more than 42 million Americans served as caregivers. The American Medical Association estimates that family caregivers provide 80% of community care at an economic value of $200 billion annually. This support, however, is matched by adverse physical, psychological, and spiritual effects characterized as "caregiver burden." Reports of negative psychological effects experienced by caregivers include depression (39%), anxiety (40%), anger, resentment, fatigue, and sleep deprivation.

A recent trend towards "family-centered" care for elderly, pediatric, and chronically ill patients alters clinicians' relationships with family member caregivers. As a result, caregiver burden may be considered a factor in treatment approaches. Clinicians' duties must be evaluated when caregiver burden (1) causes physical and psychological harm in the caregiver, or (2) reduces quality of care for patients.

Physical and Psychological Harm

Caregivers have higher rates of physical morbidities than their non-caregiver counterparts. For example, caregiver burden in spouses increases the risk for coronary heart disease and increases the rate of emergency department visits or hospitalization. Most important, negative psychological and physical consequences are compounded by the caregivers' neglect of their own needs and health in response to their duties. Recent literature and policy statements have emphasized the importance of assessing caregivers and family members for signs of stress and burden. However, these statements fail to characterize a physician's duty to address caregivers' needs.

Civil liability, as determined in medical malpractice claims, requires that, (1) the defendant (physician) owes the plaintiff (caregiver) a duty; (2) the duty has been breached; and (3) the breach causes injury. Numerous jurisdictions have extended the reasoning supporting a clinician's duty to a third party established in Tarasoff v. The Regents of the Board of California. Under this seminal case, the Court found the mental healthcare provider had a duty to warn the third-party about the immediate risk of danger from the patient. In those jurisdictions, a clinician's duty to address caregiver burden may be an extension of Tarasoff. However, the Illinois Supreme Court has explicitly declined extension of this reasoning. Instead the Court has held that a plaintiff cannot maintain a medical malpractice action against a physician "absent a direct physician-patient relationship" or a "special relationship." Under this reasoning it is unlikely that a clinician would be found to owe a duty to family caregivers absent a "special relationship," unless a patient-physician relationship has been otherwise established.

Reduced Quality of Care

Caregiver burden can lead to diminished care for the patient and dangerous or abusive behaviors. Depressive symptoms and resentment in caregivers have been associated with self-reported "potentially harmful behavior." Such behavior may include psychological harm (e.g., yelling at the patient) or physical harm (e.g., slapping the patient). Potentially harmful behaviors were heightened when the caregiver experienced psychological stress along with anger.

Under the traditional healthcare model, a physician owes a patient numerous primary duties (e.g., maintaining confidentiality). These duties are established through the physician's fiduciary duty. They may include the duty to provide the caregiver with sufficient information and training to care for the patient. While a physician's duty to address caregiver burden that results in compromised care may be unclear, a clinician has the duty to report incidents of abuse. This duty is triggered when treating a patient for an injury stemming from physical abuse or if there is suspected abuse of a child or adult protected by adult protective services. Abuse may include physical, verbal, or financial abuse. Under Illinois law, clinicians are protected from civil and criminal liability when they make reports in good faith. Conversely a failure to report abuse may result in referral to the Illinois State Medical Disciplinary Board.

Conclusion

Researchers and clinicians have identified numerous interventions, including referral to a specialist or support and advocacy groups offering necessary services (e.g., respite care), training for caregivers to reduce anxiety associated with medical care, and counseling or psychological services. However, clinicians will continue to be challenged by caregivers' needs. Incorporation of caregivers' need will require continued evaluation of the legal duties owed or triggered by a "family-centered" approach.

The author is a fellow in advanced bioethics at the Cleveland Clinic.

"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 Regulation of Hospital Medical Staff

What new federal regulations mean for your hospital practice

by Elizabeth A. Snelson, Esq.

"Every physician who does anything in a hospital is affected."

MEDICARE CONDITIONS of Participation have a lot to do with what you get to do in the hospital.

Even if your practice does not include Medicare beneficiaries. Even if you are not a Medicare participant.

If you take care of patients in a hospital, the Medicare Conditions of Participation are determinative. For the hospital to qualify for Medicare payments, it has to satisfy the federal regulations known as the Conditions of Participation. The overwhelming majority of hospitals in the U.S. participate in Medicare, so every physician who does anything in a hospital is affected. And, like most regulations, politics come into play, as they did in a recent process to change those Conditions.

Where is the Medical Staff?

As part of a general initiative to streamline regulatory oversight of healthcare, the Centers for Medicare and Medicaid Services ("CMS") undertook a broad review of the Conditions of Participation, yielding proposed changes published Oct. 24, 2011. As stated in the introduction to the proposed Conditions, the identification and prioritization of issues was a "result of outreach to hospital stakeholders, such as the American Hospital Association (AHA) and TJC (The Joint Commission)." The hospital perspective of the proposal was unmistakable. In addition to cutting restrictions on allied health professionals practicing in hospitals, the proposed Conditions would have undermined medical staff organizations, as follows:

- Any system of multiple hospitals could eliminate the medical staff organizations in the individual hospitals, replacing them with a single "unified" medical staff, thereby diluting the medical staff leadership and representation.
- Physicians would be allowed to have privileges and carry them out without being members of the medical staff, thereby diminishing if not effectively eliminating an organized medical staff.
- Authorized hospital systems to consolidate their governance into one board, thereby sacrificing local oversight and collaboration with the physicians caring for the sick at that location.
- There was no corresponding proposal to change the Condition of Participation at §482.12(b), which states that, "The governing body must appoint a chief executive officer who is responsible for managing the hospital." Consequently, every hospital would still have its own CEO—but not its own board chairman or chief of staff. Administrators would run the hospitals without having to deal with a board or a medical staff organization.

Medical Staff Organizations Mandated

Medicine was generally in a reactive rather than proactive position on the proposal for changes in the Conditions of Participation, but still, react it did. Triggering the AMA response was a November 2011 resolution by the AMA Organized Medical Staff Section that called on the AMA to "actively oppose any Centers for Medicare and Medicaid Services (CMS) policy that would bypass or remove the clinical quality and safety oversight, credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff." Other medical societies acted also. CMS reported that of the 1,729 public comments filed during the comment period, "(a)pproximately 1,100 of the comments were part of a write-in campaign from anesthesiologists that supported what they described as CMS' upholding of physician supervision requirements, but objected to what the letters described as an effort to replace physicians with nurses."

The final regulations suggest organized medicine was successful in educating CMS on the importance of the medical staff organization. Gone is any indication that a system of multiple hospitals can get by with a single medical staff. Further, the "privileges only" scheme was dropped. Consequently, under the final regulations, hospitals will not be able to steer employed physicians to a "privileges only" category without the rights attached to medical staff membership.

Stayed Tuned

To increase physician participation in hospital governance, the final regulations also mandated that every hospital board have at least one physician member. However, the American Hospital Association vehemently objected to having even a single physician on every hospital board, and on procedural grounds CMS postponed implementation of this new requirement. The remaining changes in Conditions of Participation are effective July 16, 2012; additional rule-making on the physician board member requirement is anticipated.

Elizabeth A. Snelson, Esq. is legal counsel for the Medical Staff, PLLC. She can be reached at easesq@snelsonlaw.com.

Reaction to the Supreme Court's Ruling on the Affordable Care Act

CMS and ISMS: journey to reform far from over

IT IS GOOD NEWS that Illinoisans will have the responsibility and tools for obtaining health insurance coverage. And it is also positive to note the important coverage provisions, such as the protection against denial for pre-existing conditions, which remain in place," Illinois State Medical Society President William N. Werner, MD, stated in response to the U.S. Supreme Court's decision upholding the Affordable Care Act on June 28.

"However, much work remains to be done before we can truly call our health system "reformed," he added.

The Chicago Medical Society, which collaborates with the Illinois State Medical Society to enact improvements in the nation's health system, issued its own statement.

"Our organization has long supported incremental approaches to health reform that expand access to medical benefits to all Americans through a public and private coverage system," CMS President Howard Axe, MD, commented.

"We support reform that enhances the doctor-patient relationship; permanently fixes the broken Medicare payment system, known as the SGR; ensures professional liability safeguards such as caps on non-economic damages," he continued.

"The Chicago Medical Society will continue working with ISMS to address our shared concerns."

As outlined by Dr. Werner, significant challenges remain. The following is a summary:

Medicare Payment Reform

Our Medicare program's financial health edges closer to a cliff each day Congress fails to enact reform. Currently, physicians face an across-the-board reimbursement cut of about 30% on Jan. 1, 2013. Without Medicare payment reform, our Medicare patients' access to care is in peril.

Medicaid Reform

The Act builds coverage through significant Medicaid expansion. This is not a sensible policy in states such as Illinois with struggling Medicaid programs. Patients already receiving care through Medicaid face hurdles that those with other forms of insurance do not. Illinois' current Medicaid reimbursement levels rank behind 40 states when compared to the Medicare fee schedule. The ACA provides for a temporary and limited Medicaid reimbursement increase, but more must be done to fix this program.

"Much work remains to be done before we can truly call our health system reformed."

Medical Liability Reform

Despite a dire need for reform, Illinois courts have struck down strong medical liability protections here on more than one occasion. Federal reform is needed to help Illinois with our medical workforce recruiting. Currently, half of the physicians who train here leave after residency. Two-thirds of those who depart cite our liability climate among their chief reasons for leaving. National physician supply projections suggest we will soon have an inadequate number of doctors to meet the needs of our patients. Illinois needs medical liability reform as a component of a comprehensive policy to address our medical workforce needs.

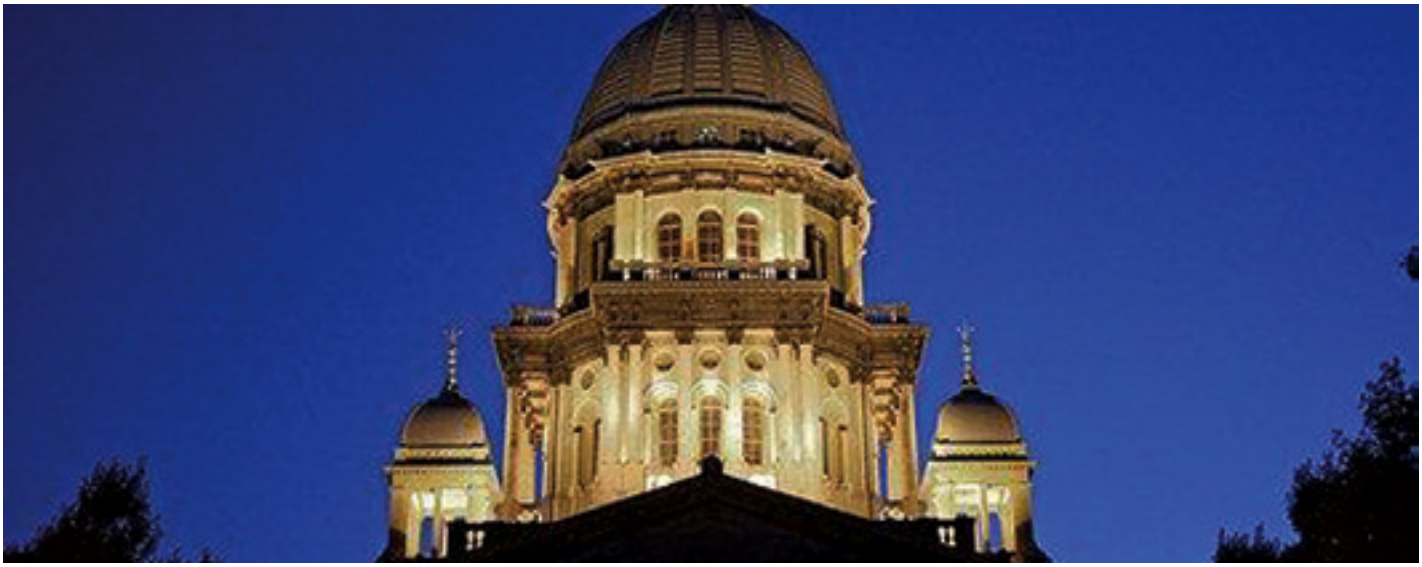
Until we address these issues, our journey toward a sensible and cost-effective healthcare system is far from over. The ISMS Health Care Reform Principles are designed to assist Congress in crossing the finish line with health reform. We urge them to roll up their sleeves and finish the job.

ISMS Health Principles

ISMS supports the following healthcare system reform principles summarized as follows:

- Healthcare delivery and finance system reform should use the current public-private system as a basis and focus on incremental evolutionary change.
- All patients should have access to a health benefit plan that would include catastrophic coverage as well as preventive services, appropriate screening, primary care, immunizations, and prescription drug coverage.
- Health insurance reform is needed to allow public and private plans to develop innovative coverage plans, including health savings accounts and high deductible plans, to encourage patients, physicians, and other healthcare providers to pursue high value care.
- All healthcare expenditures should receive equal treatment for purposes of tax deduction and tax credits.
- Professional liability reform—including caps on noneconomic damages—should continue to be pursued and defended as a way to reduce direct and indirect costs (defensive medicine) and to address the adverse effect the current medical liability system has on the physician-patient relationship and access to health care.
- Use of information technology in healthcare delivery should be encouraged to improve quality and safety of care, enhance efficiency, and control costs.
- Healthcare education and literacy must be an important part of any medical care financing and delivery system reform.
- Healthcare reform proposals should include provisions for physicians to set and negotiate their own fees in order to adequately compensate physicians and other providers for the promotion of personal and public health.
- Evidence-based protocols should support, not replace the patient-physician relationship.
- ISMS objects to third-party insurance carriers interfering with the practice of medicine and the patient-physician relationship.

The ISMS Health Reform Principles can be read in full online at www.isms.org.



Redistricting and its Ramifications

Apathy not an option in this election year **by Jere E. Freidheim, MD, Chairman, IMPAC Council**

View of the State Capitol: Every legislator needs to know that Illinois physicians will stand together, and will strongly support those who stand with them.

"Your IMPAC membership helps to counteract the powerful influence of trial lawyers and other groups who seek to undercut physicians' ability to serve their patients."

THERE IS ONE word that strikes fear into the hearts of legislators everywhere: redistricting. This convoluted process of drawing new legislative boundaries can have a dramatic effect on state politics, and for better or worse, Illinois will be feeling this effect in November.

Legislative redistricting takes place every ten years, after the release of the data from each U.S. Census, and it means several things.

First, it means that every seat in the General Assembly and Illinois' congressional delegation is up for grabs. That's 118 Illinois House seats, 59 Illinois Senate seats, and 18 seats in the U.S. House of Representatives, for a total of nearly 200 legislators who will be seeking votes, campaign funding, and other support. Second, it means that many Illinois residents may be voting in districts that are very different from what they are used to, and choosing between candidates they may not know; voters must do their homework in advance of the election to determine which candidates are aligned with their priorities.

Finally, it means that many legislators will face unique challenges in their respective races this year. Some districts were drawn to include two incumbents, who will now have to face each other for a single seat, or simply move to another district. Others were drawn to include demographics and constituencies that their legislators are unaccustomed to. All this may mean that some legislators' ears will be more open than usual to their constituents' priorities...or to influence from powerful outside groups.

That's where ISMS and IMPAC come in. Your ISMS membership helps support our powerful legislative advocacy efforts year-round, but in order to have maximum impact on important legislation in Illinois, nothing speaks louder than your gift to IMPAC. Your gift to IMPAC provides financial support to candidates who are friends of medicine, and our support for these candidates helps build the kind of issue-awareness that Illinois physicians need. By joining IMPAC, you ensure that your political influence goes far beyond the vote you cast in November.

IMPAC resources are allocated through extensive research and deliberation, using candidate questionnaires, established criteria, and other objective measures to determine which candidates deserve support. As a member of IMPAC, you have a voice in this process as well. The IMPAC Council is committed to soliciting and considering input from individual IMPAC members, who know better than anyone whether their elected representatives can be trusted to promote good healthcare policy.

Your IMPAC membership helps to counteract the powerful influence of trial lawyers and other groups who seek to undercut physicians' ability to serve their patients, and even dilute the very meaning of the phrase "practicing medicine." With the Medical Practice Act coming up for renewal again this year, shriveling budgets at all levels of government, and the growing influence of payers and others at cross purposes to physicians, apathy is not an option. Every legislator needs to know that Illinois physicians will stand together, and will strongly support those who stand with them. Joining IMPAC is the only way to make this clear.

Visit *www.impaconline.org* now to support the future of your profession.

Members in the Driver's Seat

Chicago Medical Society policies begin with your resolutions

OUR organizations' strong stance on health system reform began with resolutions from grassroots members like you.

Participating in the Chicago Medical Society and Illinois State Medical Society, your colleagues crafted the principles and policy statements our organizations released on June 28 following the U.S. Supreme Court's announcement.

The CMS Governing Council is your launching pad for policy and action. This democratic forum debates measures and submits them to the ISMS House of Delegates and American Medical Association for adoption and implementation. Resolutions are fine-tuned at each stage, gaining support and momentum.

In addition to health system reform, your colleagues' resolutions form the basis of public health legislation locally and statewide. There is no better place to make your voice heard.

How to Write a Resolution

If you want your societies to adopt policy or take action, now is the time to get started. Simply put, resolutions are a great way to make your concerns heard.

Like ISMS and AMA, the Chicago Medical Society has guidelines that members are encouraged to follow.

Attention to these matters will streamline the process and make your message more effective.

Preparation

- Check existing CMS/ISMS/AMA policy by calling 312-670-2550, ext. 335; or emailing *esidney@cmsdocs.org.*
- Check information for accuracy and attach supporting documentation or links to appropriate sites.
- Plan to give testimony to the Resolutions Reference Committee. Evidence and documentation may be required. A meeting notice will alert you to the time and date.

Resolution Format

- Choose a title that reflects the action you want.
- Write "Resolved" portions to stand alone, since only the "Resolved" portions are adopted.
- Spell out the nature and purpose of the resolved clauses. They should:
  (a) state new CMS/ISMS/AMA policy
  (b) modify current policy
  (e) reaffirm CMS/ISMS/AMA policy
  (d) rescind policy
  (c) modify CMS bylaws
  (f) direct CMS/ISMS/AMA to take action

Submission

Submit resolutions via e-mail to *esidney@cmsdocs.org;* or fax to 312-670-3646, or mail to the CMS Offices, 515 N. Dearborn St., Chicago, IL 60654. Receipt of resolutions will be confirmed by a return message.

HEALTH CARE FRAUD:
Protect Yourself and Your Practice

The *Centers for Medicare & Medicaid Services*, in collaboration with the *Chicago Medical Society,* will host the **HEALTHCARE FRAUD AWARENESS SYMPOSIUM** on September 20, 2012. The purpose of this event is to raise awareness and to educate physicians on how to safeguard and protect their professional and medical identity and their most valuable assets–their medical practice and their patients–from fraud. Look for additional details soon.

Please save the date as attendance will be limited.

Date: September 20, 2012 **Time:** 9 am–1:30 pm

Location: Jesse Brown VA Medical Center
820 South Damen Avenue
Chicago, IL 60612

Service of the Month

Your platform for reimbursement growth

CLOUD-BASED technology frees physicians from the costs and hassles of an office-based electronic billing system.

Marca, the Chicago Medical Society's preferred reimbursement vendor, utilizes the technology to make medical billing more effective and efficient, so the healthcare team can focus on seeing patients.

The MarcaFuture platform not only compounds the massive amount of information, resources, and systems needed to uncover dollars, it also complies with the huge changes in medical practice payment.

Incorporating intelligence and intuition, the technology seeks to identify and maximize payment for all healthcare professionals from a wide mix of third-party payers.

"The Chicago Medical Society is hosting events in September on healthcare fraud, and how to prepare for ICD-10 CM implementation."

Marca's cloud-based claims management system saves you money too. Registered users enjoy free, unlimited use of the platform's medical record archival system 24/7.

Offices need simply send patient information by land or cell phone, voice or scan, or web browser. The platform functions with both keyboard and voice recognition and is accessible from any Internet-connected device or phone.

The MarcaFuture platform fully integrates HIPAA-security, permitting staff to schedule appointments and services online with an unlimited number of health providers and locations.

Marca also handles the practice's entire back office operation. The company can provide practice consultation, office management, medical consulting, and other online operations.

The Chicago Medical Society endorsed Marca in 1980. For more information, please visit *www.marcafuture.com*.

Coming in September

The Chicago Medical Society is hosting events next month to keep you and your practice informed of the latest requirements. We encourage you to sign up for a program below.

19 Healthcare Fraud Prevention

A panel discussion reviews what providers and practice managers need to know to avoid errors and other issues that could lead to an investigation.

Upon completing this session, participants should be able to:

- Explain the role of the U.S. Attorney's Office.
- Identify enforcement activities and the consequences of fraud and abuse.
- Make necessary changes and improvements in the way they run their medical practices.

6:30-7:30 p.m.; Speakers: Mark E. Schneider, Chief of Appeals, Criminal Division; and Linda A. Wawzenski, Assistant U.S. Attorney, Deputy Chief, Civil Division, Civil Healthcare Fraud Coordinator; U.S. Attorney's Office, Northern District of Illinois; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 1.0 credit. CMS member or staff may attend at no cost; non-member or staff $25 per person.

20 Healthcare Fraud: Protect Yourself and Your Practice

Co-hosted by the Centers for Medicare and Medicaid Services and Chicago Medical Society, this event will raise awareness and educate physicians on safeguarding their professional and medical identity, their medical practice, and their patients from fraud. Please save the date as attendance will be limited.
9:00 a.m.-1:30 p.m.; Jesse Brown VA Medical Center; 820 S. Damen Ave., Chicago.

21 ICD-10 CM: Preparing for a Successful Implementation

This half-day CME program reviews the key elements, four phases, and essential timeline needed to be ready in 2013.
8:30 a.m.-12:00 noon; Speaker: Nelly Leon-Chisen, RHIA, Director, Coding and Classification, American Hospital Association, Chicago; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 3.5 credits; CMS member or staff $49; non-members or staff $149 per person.

To RSVP for these programs, please contact Elvia at 312-670-2550, ext 338; or *emedrano@cmsdocs.org*.

Advancing Stroke Care

The Chicago Medical Society gets the word out **by Christine Fouts**

COOK COUNTY'S 22 Primary Stroke Centers provide prompt specialized care, but many patients and their doctors remain unaware of this life-saving community resource.

The Chicago Medical Society is getting the word out through its Mini-internship Program. While the mentoring program has traditionally educated legislators on the complexities of medical practice, its scope expanded earlier this year to include public health advocacy.

By arranging guided tours of certified primary stroke centers, the Society is showing physicians and legislators the services these facilities offer to reduce mortality, improve recovery from stroke, and prevent stroke from occurring in the future.

Recent tours brought Rep. Kimberly DuBuclet (D-26) and staff from the offices of Rep. Barbara Flynn-Currie (D-25), Sen. Kwame Raoul (D-13), and Ald. Will Burns (4th Ward) into Mercy Hospital's primary stroke center, and Rep. Kelly Burke (D-36) to Little Company of Mary Hospital. The mini-internships followed visits to both Mount Sinai Hospital and Swedish Covenant Hospital in early June.

Learning about challenges and methods unique to each center, legislators also gain insight into the needs of their constituents. Of the four primary stroke mini-internships, Mount Sinai Hospital claims the highest incidence of hemorrhagic stroke due to drug use in the community. Medication adherence and mistrust of physicians are additional issues for the hospital. Swedish Covenant Hospital reported the highest number of walk-in patients from myriad countries and cultures. On a typical day, 20 different languages come through the doors, presenting challenges around consent, cultural interpretations of stroke, and language barriers. The Swedish Covenant facility costs $250,000 yearly to operate, and the hospital employs a telemedicine robot named Sheldon to assist staff and patients.

Mercy Hospital has seen its patient population diversify over the years; Chinese is now the third official language of its patients. The hospital's extensive outreach includes routine health checks at no cost and patient education. As a result, more people with stroke symptoms are calling EMS, which automatically takes them to a primary stroke center. Little Company maintains extensive data on services, and tour participants were able to observe the weekly stroke rounds, including patient scans and treatment recommendations for unique and difficult cases.

Leading the Mercy tour were Jeffrey Kramer, MD, chief of neurology and medical director of the stroke program, and Helene Connolly, MD, medical director of the ED.

Dr. Helene Connelly, director of the Emergency Department, Mercy Hospital and Medical Center, talks to the Mini-internship tour group about ED staff communication. She stands in front of two large screens showing patients currently admitted. This technology enables Mercy staff to carefully track stroke patients and so-called "door-to-needle" time, or administration of tPA.

The Little Company team included Michael Schwartz, MD, neuroscience medical director and president- elect of the medical staff; Kent Armbruster, MD, vice president of medical affairs; Michael O'Mara, DO, emergency medicine medical director; physiatrist Mark Tracy, MD; Irving Fuld, MD, medical director of diagnostic imaging; hospitalist Sujith Sundararaj, MD; and Michael Thomas, DO; president of the medical staff.

The tours capped off with roundtable suggestions for the Chicago Medical Society's stroke awareness campaign. Little Company doctors said efforts should be local, so that people are treated for stroke close to home. Keeping families together also enhances continuity of care during rehabilitation, they said. Others suggested the Society focus on helping people understand what medicine can and cannot do to improve patient outcomes. The roundtables addressed medication access issues and medication compliance. Some hoped the Society can work with pharmacies and medical facilities to improve access to stroke-related medications for people in their communities.

More tours are planned in September at Advocate Illinois Masonic, Stroger Hospital, Trinity Hospital, St. Mary and Elizabeth Hospitals, and Holy Cross. The CMS Mini-internship will travel to as many of the Cook County stroke centers as possible, with tours continuing into 2013.

Have a Say in Policy, Legislation

COMMITTEES ARE the backbone of the Chicago Medical Society. They allow members to request the formal study of specific issues in medicine, and ensure that a reviewing body will give direction to the organization. As the origin of new policies and legislative initiatives, committees are open to all members.

The Medical Society understands the time constraints on physicians, and so has created an online forum for each committee. These online forums permit virtual meetings, where members can hold online discussions about the committee's objectives or charge. To view a sample forum, please visit the Medical Society's "CMS Connect" section of our website at *www.cmsdocs.org*.

The 12 Chicago Medical Society committees range from public health to technology to advocacy. If you would like to join a committee, please follow the instructions at the end of this page.

Bylaws/Policy Review

Reviews suggested changes in the Bylaws and recommends amendments to the Council when appropriate; reviews Council actions and statements in the CMS Policy Manual for appropriateness and timeliness.

Communications/Technology

Monitors the world of technology, and informs and educate members on the use of computer and technology applications in the clinical setting and for personal use.

Continuing Medical Education

Ensures that CMS is in compliance with the Essential Areas and Standards for Commercial Support (SCS) of the Accreditation Council for Continuing Medical Education (ACCME); initiates, implements and evaluates CME programs; and assists related groups in structuring CME programs under joint sponsorships.

Credentials/Elections

Determines the number of voting members present during Council Meetings, announces quorums, acts as tellers, if necessary, and takes charge of all general elections.

Health Care Economics

Monitors local managed care trends, health delivery service and quality; advises CMS of significant trends, reviews the actions of the professional liability insurance industry, informs CMS about health planning in Chicago and Suburban Cook County; evaluates the effects of physician reimbursement and medical policies proposed by the federal government and third-party payers.

Long-Range Planning

Ensure that CMS has a well-conceived five-year strategic plan that includes an analysis of the Society's trends, strengths and weaknesses and the environment of medicine; prescribes actions to position CMS for the future. The plan is updated annually.

Membership/IMG

Develops strategic plans for the ongoing recruitment and retention of members, including residents and students; reviews all applications for new membership, status change requests, dues waivers and transfers, and report its recommendations to the Council; reviews physicians who have resigned or forfeited their membership and wish to be reinstated; supports measures to encourage complete integration of IMGs into American medical practice; represents the issues of concern to IMGs in CMS and the IMG community.

Senior Physicians Group

Provides a vehicle for CMS senior physicians to support CMS through outreach, education, and mentoring.

Subcommittee on Joint Sponsorship

Helps plan CME activities and provides detailed review of all applications received from related organizations for joint sponsorship; advises the full CME Committee on trends, concerns, and requirements; assures that CMS activities and joint sponsorship programs are in full compliance with the Essential Areas and Standards for Commercial Support of the Accreditation Council for Continuing Medical Education (ACCME).

Physician Advocacy

Represents and protects the rights, responsibilities, and interests of physicians in all modes of medical practice, including solo, group, employed, and academic; and in all hospital medical staff issues, including physician self-governance, credentialing, medical policy development, peer review, patient advocacy, and quality of care; resolves complaints, disputes, or conflicts involving any physician member of a medical staff and any structured medical entity.

Public Health

Reviews and responds to any request for advice, opinion, or for program approval directed to CMS by any health department, municipal health committee, or public health body in Cook County. Also initiates contact with such groups when directed by the CMS President, Executive Committee or Council, on matters of concern to organized medicine.

Resolutions Reference

Receives all resolutions referred by the Council; holds hearings on those resolutions, and reports recommendations to the Council.

How to Join a CMS Committee

Each year the Chicago Medical Society appoints members to its various committees. All physicians are encouraged to become active participants in the Society by volunteering for any committee they wish.

To sign up, please send us an email, fax, or letter listing the following information: Name, address, city, state, zip code, email address, phone and fax numbers. Be sure to indicate which committee(s) you wish to serve on. Fax to 312-670-3646; or email *rbahena@cmsdocs.org*. Or, download a form on our website: *www.cmsdocs.org*.

Calendar of Events

AUGUST

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

22 CMS Executive Committee Meeting Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m., Maggiano's Banquets, 111 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or *rbahena@cmsdocs.org.*

22 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 a.m.; Maggiano's Banquets, 111 W. Grand Ave., Chicago For more information, please contact Ruby 312-670-2550, ext. 344; or *rbahena@cmsdocs.org.*

22 Annual Golf Outing & Parliamentary Procedures Workshop Workshop provides an interactive 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 is intended to automatically become the parliamentary authority in organizations whose bylaws prescribe any other version of Robert's Rules of Order. 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; Marriott Oak Brook Hills Resort & Willow Crest Golf Club, 3500 Midwest Rd., Oak Brook; this is a non-CME activity; CMS member registration fee: $125 per person. To RSVP, please contact Elvia Medrano 312-670-2550, ext. 338; or *emedrano@cmsdocs.org.*

SEPTEMBER

7 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. 9:30-11:30 a.m.; Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; DoubleTree Hilton Hotel, Oak Brook; participants may earn up to 2.0 Credits; CMS member or staff $89 per person; non-member or staff $129 per person. To RSVP, please contact Elvia 312-670-2550, ext. 338; or *email emedrano@cmsdocs.org.*

15 Philippine Medical Association of Chicago 52nd Inaugural Induction Ball. Proceeds will benefit next year's surgical-medical

Welcome New Members!

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

District 2
John J. O'Keefe MD

District 5
Kathryn J. Mencel MD

Student District
William W. Phillips

Resident District
Henry C. Lin, MD
Anna A. Piotrowski MD

chicago white sox

HEALTHCARE NIGHT

The Chicago Medical Society invites you to healthcare night!

WHAT: A social and networking event for CMS medical students, residents, and young physicians at a Chicago White Sox game
WHEN: Friday, September 7, 2012, at 7:10 p.m.
WHERE: U.S. Cellular Field
333 W. 35th St.

Limited Seats Available on a First-Come, First-Serve Basis! CMS has reserved a block of seats in the lower reserved area.

Tickets are **$15** for CMS medical students, residents, and young physicians. **$20** for regular CMS members, and **$30** for non-members. All ticket purchases include dinner.
Please RSVP as soon as possible to ensure your attendance at this exciting event!

We accept credit cards (Visa & Mastercard Only), checks, or cash.
Payment in ADVANCE is REQUIRED!
To Reserve Your Tickets, Please Contact Christine Fouts 312-329-7326; or email: *cfouts@cmsdocs.org.*

CHICAGO MEDICAL SOCIETY

Calendar cont'd

mission in the province of Surigao del Norte, Philippines; Hyatt O'Hare Hotel, Rosemont. For more information, please call 773-858-2185.

18 CMS Governing Council Meeting The Society's governing body meets four times a year to conduct business on behalf of the Society. The policy-making Council considers all matters brought by officers, trustees, committees, councilors, or other CMS members. 6:00-9:00 p.m., Maggiano's Banquets, 111 W. Grand Ave., Chicago; members are welcome to attend at no cost. To RSVP or learn more, please contact Ruby 312-670-2550, ext. 344; or *rbahena@cmsdocs.org.*

19 CMS Executive Committee Meeting Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; CMS Building, 33 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or *rbahena@cmsdocs.org.*

19 Healthcare Fraud Prevention This panel discussion reviews what providers and practice managers need to know to avoid errors and other issues that could lead to an investigation. Upon completing this session, participants should be able to:

- Explain the role of the U.S. Attorney's Office.
- Identify enforcement activities and the consequences of fraud and abuse.
- Make necessary changes and improvements in the way they run their medical practices.

6:30-7:30 p.m.; Speakers: Mark E. Schneider, Chief of Appeals, Criminal Division; and Linda A. Wawzenski, Assistant U.S. Attorney, Deputy Chief, Civil Division, Civil Healthcare Fraud Coordinator; U.S. Attorney's Office, Northern District of Illinois; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 1.0 credit. CMS member or staff may attend at no cost; non-member or staff $25 per person. To RSVP, please contact Elvia 312-670-2550, ext. 338; or *emedrano@cmsdocs.org.*

20 Illinois Society of Plastic Surgeons-General Membership Meeting. Preoperative Analysis and Surgical Principles in Aesthetic Breast Surgery. 6:30-8:30 p.m.; Speaker: Elizabeth Hall-Findlay, MD; Metropolitan Club, Michigan Room, 233 S. Wacker Dr., Chicago. To RSVP, please contact Amanda 312-670-2550, ext. 325; or *aworley@cmsdocs.org.*

21 ICD-10 CM: Preparing for a Successful Implementation. This half-day course reviews the key elements, four phases, and essential timeline needed to be ready in 2013. 8:30 a.m.-12:00 noon; Speaker: Nelly Leon-Chisen, RHIA, Director, Coding and Classification, American Hospital Association, Chicago; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 3.5 credits; CMS member or staff $49; non-member or staff $149. To RSVP, contact Elvia 312-670-2550, ext 338; or *emedrano@cmsdocs.org.*

classifieds

Personnel Wanted

Part-time physician needed. Octapharma Plasma is seeking a contract physician for its Aurora Donor Center. This position requires just four hours per week and is a perfect opportunity to earn additional income. The physician must bring independent medical judgment and discretion to issues in donor safety, health and suitability of plasmapheresis and/or immunization. On-the-job training provided. Learn more at *www.OctapharmaPlasma.com*. Send resume/CV to *careers@octapharmaplasma.com*.

Family practice clinic on northwest side of Chicago looking for primary care physician. Excellent opportunity with eventual partnership and takeover of the building and practice. Fax resume to 773-379-9001; or call 773-287-2200.

Full-time or part-time position for internist or family practitioner in busy Chicago area. Good pay and benefits. Will sponsor H1Visa. Fax CV to 708-474-4574 or email: *sarojverma@comcast.net*.

Mobile Doctors seeks a full-time physician for its Chicago office to make house calls to the elderly and disabled. No night/weekend work. We perform the scheduling, allowing you to focus on seeing patients. Malpractice insurance is provided and all our physicians travel with a certified medical assistant. To be considered, please forward your CV to Nick at *nick@mobiledoctors.com;* or call 312-848-5319.

Primary Care—MD at Home is looking to hire BE/BC primary care physicians to make house calls on the elderly homebound. Contact Matt Turman at 312-243-2223 or email: *mturman@md-athome.com*.

Infertility specialist gynecologist needed in the suburban Chicago area. Please send CV to a*dministrator@networkgci.net* or fax 847-398-4585.

Urologist or urogynecologist specializing in urinary incontinence needed in the suburban Chicago area. Please send CV to *administrator@networkgci.net* or fax 847-398-4585.

Part-time physicians needed. Surgical family planning center in the Chicago area needs various specialties including anesthesiologist, gynecologist, urologist, internist, and other specialties. Please send CV to *administrator@networkgci.net* or fax 847-398-4585.

Office/Building for Sale/Rent/Lease

Downtown Elmhurst medical suites for rent, from 781-2,400 sq. ft. in the established busy Elmhurst Professional Center, with excellent parking, x-ray and lab facilities on site. Call Mickey at Prudential Realty 630-279-9500.

Space for rent. Winnetka Professional Center. Great downtown location. Two available suites can be rented separately or together for up to six operatories. Call 847-446-0970 for details.

Business Services

Physicians' Attorney—experienced and affordable physicians' legal services including practice purchases; sales and formations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0060; or 847-212-5620 (mobile); 5250 Old Orchard Road, Suite 300, Skokie, IL 60077-4462; *shj@sjesser.com; www.sjesser.com*.

Advertiser Index

Call for Mental Healthcare Parity

Psychiatrist has plans for precarious times **by Scott Warner**

As president-elect of the Illinois Psychiatric Society, Dr. Linda Gruenberg is working with her organization to increase access to mental health care, including promoting telepsychiatry to hospitals in underserved areas.

THE WAY DR. LINDA Gruenberg analyzes it, more needs to be done for patient mental health than the medical profession can shake a stick at.

Although she speaks softly, this psychiatrist who trained as a police officer before medical school, and is now president-elect of the Illinois Psychiatric Society (IPS), is not to be taken lightly. She's unrelenting when discussing the issues.

"It's a precarious time—patients are underserved and access to care is especially limited within the mental health community. This has a far-reaching effect throughout the healthcare system," she says.

For example, Dr. Gruenberg laments that the continuing financial crisis is causing mental health centers in Cook County to shutter, resulting in emergency rooms potentially being clogged with patients who have mental health issues. Another concern is the number of people suffering a mental health crisis who get sent to jail, rather than to a hospital. "And the correctional system ends up providing mental healthcare—but when the detainee is released, they're without access to their medical records, linkage, and continuity of care," Dr. Gruenberg says.

What to Do?

Dr. Gruenberg has plans, and she's working not only with IPS, but also with the Chicago Medical Society as a councilor. She targeted several areas:

- Insurance companies often expect primary care doctors to identify and treat mental health disorders prior to referral to a psychiatrist; Dr. Gruenberg would like primary care physicians to have support in obtaining answers for the psychiatric care of their patients.
- She wants patients to be able to access psychiatric care with the same ease they can obtain other medical treatment.
- Sparsely populated areas in Illinois offer little or no psychiatric services, and Dr. Gruenberg is working with IPS to promote telepsychiatry to hospitals in underserved areas, especially in emergency rooms, where patients can be seen through a confidential link.
- Police are often not equipped to handle a mental health crisis situation. "We want to be able to provide them with support and training through the police academy," Dr. Gruenberg says.

"This is just the beginning of what we need to do."

Dr. Gruenberg assumes the presidency of the Illinois Psychiatric Society in May next year.

Dr. Gruenberg's Career Highlights

HER DIVERSE background has given Dr. Gruenberg a rich overview of psychiatry. An assistant professor in the Department of Psychiatry at Rush University Medical Center, Chicago, Dr. Gruenberg also serves on the affiliate staff of NorthShore University HealthSystems, and is a clinical and forensic psychiatrist in private practice as well. She is a diplomate of the American Board of Psychiatry and Neurology with added qualifications in forensic psychiatry, and a distinguished fellow of the American Psychiatric Association. Dr. Gruenberg has lectured on clinical matters in psychiatry and on forensic psychiatry and law, in addition to having taught in the Department of Criminal Justice at Loyola University of Chicago. She currently serves on the Chicago Medical Society's Governing Council and is a delegate to the Illinois State Medical Society.

Experts & Advocates in **Liability Protection**

For Illinois practitioners, we're experts and advocates in medical liability insurance. Our licensed staff provides answers and support, while our agency sponsors the legislative advocacy and educational programs of the Chicago Medical Society.

We're run *by* physicians *for* physicians, and you'll appreciate the difference true professionalism can make.

CMS Insurance

A SUBSIDIARY OF **CHICAGO MEDICAL SOCIETY**

FOR MORE INFORMATION, PLEASE CALL US AT
312.670.2550 OR VISIT US ONLINE AT **www.cms-ins.com**