Chicago
MEDICINE

Vaccines

Exemption rates are on the rise. Here's what you need to know.

PAGE 16

Flu: It's Not Too Late to Innoculate!

Member Benefits: What You Get From Your Society

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FEATURES

PRESIDENT'S MESSAGE

PRACTICE MANAGEMENT

PUBLIC HEALTH

LEGAL

MEMBER BENEFITS

WHO'S WHO

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A Season for Gratefulness

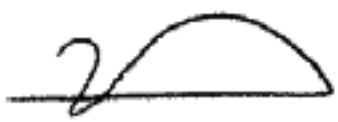
SINCE THE HOLIDAY season is upon us, and we begin to reflect on those things that are most important to us, let us remember to give thanks to those whose support and encouragement have helped us in our daily lives. At Thanksgiving, most gather with family and friends to commemorate a harvest festival dating back to the Pilgrims. But more than a day of turkey and football, this can be thought of as the beginning of a season of gratitude—a time when we reflect not on our future dreams and aspirations, but rather a time to be grateful for where we are and what we have, for the relationships we strive to maintain, and the freedoms which we all enjoy. I hope that this gratefulness can extend beyond a one day celebration to become a theme for the season.

First, as physicians, we need to remember all of the preparation required for entering the medical profession—the dedicated teachers and instructors during our schooling, the help we received from classmates as we studied for exams, our preceptors during clerkships, and certainly to the patients who were willing to spend the time to help us learn and hone our communication and physical diagnosis skills. Let us remember and thank our parents, siblings, spouses and children, who all have sacrificed something for our profession, whether it was financial support for our education or the time we might have spent with family and loved ones had we not pursued our mission to help those who needed our services. Let's not forget to be grateful for the dedicated staff in our offices who help us run our practices and help us stay focused on our task of caring for those in our community. And, this holiday season, let us acknowledge our colleagues on the healthcare team, including the nurses, nurse practitioners, and physician assistants, technicians, medical assistants, social workers, physical, occupational and speech therapists, phlebotomists and the many others involved in patient care.

Next, let us, as physicians, acknowledge and be grateful for our relationships with each other. We all have been guided, shaped and molded partly by the interactions we have had with colleagues and peers throughout our careers. We learn from each other, collaborate, and share ideas on how to best care for our patients. I am reminded of the adage I learned in residency, which said, "see one, do one, teach one," and think of my colleagues and the wisdom they have imparted upon me throughout the years.

Now, think of the collective strength we could have if we, as physicians, could speak with one voice on topics pertaining to the delivery of healthcare and the well-being of our patients. In order to achieve this, we all must recognize and convey the value of membership in the Chicago Medical Society and all of organized medicine. When our colleagues sit on the sidelines and don't join our organization, they are not simply abstaining from participation. Inaction negatively impacts our efforts and our advocacy. This is why your leadership is working on creative ways to attract and retain physicians who have not understood our mission or who don't see the value in speaking collectively for our profession. I welcome any ideas from you or your colleagues on making your membership in the Chicago Medical Society more valuable. I encourage you to speak often of our organization's value and relay the benefits of membership in organized medicine.

With the stress that is often associated with this time of year, I hope you can all find your true meaning of the holiday season. Demonstrate to those around you how grateful you are to have them in your life. A smile, a "thank-you" and a touch can help show them how you truly feel. And try to remember this when asked to mentor a student or resident, or contribute to your organization or medical staff or a committee at the CMS. Be grateful and be involved. May you have a meaningful holiday season. With gratitude.



Howard Axe, MD
President, Chicago Medical Society

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Get More Value from LinkedIn

10 easy tips **By Lonnie Hirsch and Stewart Gandolf, MBA**

LinkedIn is the premiere social media website for professional networking.

IF THERE'S ONE social media platform that medical doctors, hospital and healthcare executives should be using to showcase themselves, it's LinkedIn. LinkedIn is mainly for and about professionals and business networking. And as the trend toward hospital employment for doctors grows steadily upward—along with many other changes in healthcare delivery dynamics—LinkedIn is one online space to park your CV.

Most of what LinkedIn has to offer is free with a basic account. Some more aggressive users may want to upgrade to a Business, Business Plus or Executive account. The cost for the extra bells and whistles ranges from about $20 to $75 per month, which is reasonable, but only when you have a well-established "basic" account and are ready to move to the "power user" category. Paid ads are another option, but only for certain situations.

Think of LinkedIn as a dynamic process, and not a static page. The primary fuel of networking is in activity and interaction. And the single most important way to get more value and benefit from LinkedIn is in making regular changes.

This "secret" is no surprise. Like many other social media platforms, it is the connections and interactivity that propel the process of networking. The LinkedIn system recognizes when change occurs and often that triggers a notice to others. What's more, change is important to search engines and the algorithms of stronger search listings.

Call them updates or revisions—adding (or subtracting) content is what causes others to notice your pages. Here are ten tips to bring more activity to your profile and get more value from your LinkedIn pages. There's no cost involved, except for a bit of time.

1 **Refresh your descriptive Summary**. Likely you've done something new, attended a conference, been a presenter or earned an award. Add the new details, remove the dated ones, and occasionally rewrite the description to be relevant and timely.

2 **Update your photograph.** Use a photo that is less than a year old. Take a new photo if needed. Switch between a "business casual" photo and a formal pose from time to time.

3 **Add titles** to your Reading List. LinkedIn makes this easy to do, complete with book cover.

4 **Join LinkedIn Groups** or start your own. Consider LinkedIn's suggestions for Groups You May Like and/or search for other options.

5 **Integrate LinkedIn and Twitter.** List your Twitter account on your LinkedIn profile and use #in and #li to send tweets to your LinkedIn page.

6 **Rearrange the sections** of your profile. New on LinkedIn is the ability to present your profile sections in the order you choose. (Click on draggable handles and drop in your preferred order of presentation.)

7 **Make contact** or contribute comments. Add your note to the discussions of others. Better yet, begin a conversation. Send brief notes of thanks, congrats, etc.

8 **Recommend others** (and vice versa). LinkedIn notices the connectivity between and among individuals.

9 **Add connections.** You may not know it, but you likely have friends, colleagues and college alumni who are already LinkedIn members. (LinkedIn will tell you who is listed.) It's easy to check your list, make invitations or invite non-members to join in.

10 **Post your presentations.** LinkedIn and SlideShare work together. Include the PowerPoint or other visual materials from your most recent talk or professional presentation.

Lonnie Hirsch and Stewart Gandolf, MBA, are Founding Partners for Healthcare Success Strategies, a full-service healthcare marketing company. You can find them at www.healthcaresuccess.com.

Your Practice Management Colleagues

MEMBERSHIP in the Chicago Medical Society's Practice Manager Section is an excellent way to expand your professional networking horizons. Practice managers employed in the offices of CMS physician members enjoy a discounted dues rate of only $99 per year. The nonmember rate is $395. To download a membership application, please go to *www.cmsdocs.org* or call 312-670-2550.

How to Get the Most Out of a First Patient Visit

Six important things to do **By Susan Keane Baker**

A **FIRST PATIENT** visit is the best opportunity you ever have to develop a mutually rewarding relationship. Most patients arrive with high hopes for a positive experience. It's up to you to manage the first visit in a way that leaves your patient convinced that he or she made the right decision in choosing you.

Create some positive anticipation through advance contact. Send a letter that answers the questions patients want to know. "How do I get there? Is it difficult to find parking? Is there a charge for parking? Which entrance should I use? Is there a long wait? What happens while I am there?" Or you might call to confirm an appointment and make that call patient-focused by asking "Are there any questions I can answer for you now?"

Be glad to see your new patient. You, and everyone on your team, should know when someone is a first-time patient. Make the time to introduce the first time patient to others. Find out what his or her past experiences have been in healthcare settings.

Assess expectations. Ask "Can you tell me three things that are most important to you in your relationship with us?" Your patient will think about what she liked and disliked most in her previous relationship. It's the same phenomenon you experience when you hire a new employee. If the person who held the position before loved to gossip all day and took lots of personal phone calls, a desire to focus on work will be an important characteristic for you in evaluating job applicants. If the person who held the position before was chronically late, punctuality will rise right to the top of your "most desired characteristics" checklist. When you ask your patient about her top three expectations, it's likely that you will be able to satisfy two, if not three, of them. If you can't meet all three, it's an opportunity for you to manage her expectations. "I hope two out of three will work for you. I wish that we could provide prescription refills on the weekends, but our policy is that because physicians don't have access to your medical record when they take weekend call, they don't order refills then. However, we do routinely ask patients if they need any prescription refills when they are here."

Explain your rules and systems early. If you explain a rule before a patient violates it, that's education. If you explain a rule after a patient violates it, that's perceived as scolding.

Find something to like about your patient. Compliments must be sincere. Don't bother with admiring the patient's shoes unless you are truly interested. Notice pins. They are often added to attire because they hold special meaning. "Can you tell me about the pin you are wearing?" will convey that you are interested in your patient as a person. If you are a specialist, compliment the patient's choice of primary care practitioner. Compliment good health habits or lifestyle choices. "I wish more of my patients understood the importance of eating well."

Help patients remember what to do after the visit. Written or audiotaped instructions are essential, no matter how simple the information might be. Consider providing a checklist of items that the patient is to follow through. You help your patient be successful by providing the information he or she needs to take the next step. "Schedule mammogram 504-555-3300, ext. 2453" Leave space for appointment dates, and patient notes.

The impressions that patients form during their first encounter are long lasting. How do you want them to feel about you and your organization? With a little bit of planning, you can create the experience that will accomplish your goal.

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"Written or audiotaped instructions are essential, no matter how simple the information might be."

"My doctor told me to stop having intimate dinners for four. Unless there are three other people."

–ORSON WELLES

Usability and Electronic Health Records

The importance of effective technology **By Enid Montague, PhD, and Abel Kho, MD**

UNDER the Health Information Technology for Economic and Clinical Health Act of the 2009 American Recovery and Reinvestment Act, the United States Department of Health and Human Services invested billions of dollars to expand the adoption of health information technology. The initiative has led to a widespread transformation of health care systems by promoting rapid adoption of electronic health records.

The goal of the HITECH Act was not limited to implementing EHRs—it extended to the concept of Meaningful Use, which is being released over three stages. Meaningful Use Stage 1 focuses on improved documentation, Stage 2 focuses on improved care processes, and Stage 3 will focus on improved outcomes. Increasingly, there is interest in understanding how to design systems that complement provider and patient needs and contribute to high-functioning healthcare systems. The Stage 2 Meaningful Use regulations address this for the first time by requiring that EHR vendors demonstrate how they have incorporated user needs (for example, usability) into the design of their products.

Practical Usability

What does this mean for physicians in Chicago? Usability is about making it easy for people to accomplish goals and do their jobs well while benefiting from technological advances that improve efficiency and effectiveness. After all, technology should make us smarter, faster and more capable. For example, a well-designed mobile phone calendar can help you schedule meetings efficiently and remind you of important deadlines. This tool can remember complex information like dates, times and locations far better than the average human brain, therefore freeing up mental energy for other tasks such as problem solving, empathy and creativity—activities technology doesn't do nearly as well as humans.

A tool designed with user needs in mind can increase productivity and satisfaction. However, a version of the same technology that does not include user needs can add time to a everyday activities and decrease productivity and satisfaction. If technology is not easy to use, people may find themselves working less effectively overall. Going back to the calendar example, imagine how frustrating it might be for a busy person to struggle to add dates and locations to a system that is poorly designed, requires too many steps, or shows you appointments that don't match the way you typically think about dates. If the calendar is very different from other calendars you're familiar with, you might get frustrated when you try to view dates and times. Poorly designed products can cause errors and are potentially unsafe. In practices, EHRs help physicians care for patients better. However, in some cases, these systems could benefit from usability studies so they can be updated to better assist physicians with their workflow.

Usability Research

Now you can see why usability research is so important. Healthcare is a complex system that involves many types of users, teams, needs, goals and environments and, of course, patients with equally diverse needs. Developing designs that work for everyone is not easy, and the lack of research on healthcare system user needs and capabilities poses a challenge to achieving optimal use.

To emphasize that point, the Agency for Health Care Research states, "Scant basic research has actually been conducted to better capture how clinical work (i.e., cognitive workflow, task distribution) is performed, who performs it (e.g., physician, nurse, therapists, administrative staff), and how it could be performed, with and without the support of health IT." Those working to increase this research are part of the discipline of human factors ergonomics engineering, which is concerned with understanding human, group and system needs, and capabilities and limitations.

Research initiatives are particularly important as lack of usability is cited as a significant barrier not only to the adoption of EHR systems, but to their effective use. To design better EHR systems, more research is needed about how physicians provide care while using new technologies. For example, human factors engineers are skilled at understanding thought processes and answering questions such as, "Exactly how many alerts can a person attend to reliably?" and, "Which aspects of a person's workflow can be automated, and which should remain under human control to avoid error?"' Designing while considering knowledge of human capabilities and work contributes to systems that are easier and more pleasant to use, and maximizes the potential benefits of EHRs. The important thing to think about is that technologies designed with user needs in mind help physicians focus their attention on the important goal of providing care.

Practically, understanding usability can help practices communicate needs to vendors and develop more effective EHRs, implementation and training programs. The result is more efficient, effective and safer use of EHR.

Participate in Testing

To prepare for the usability component of Meaningful Use Stage 2 and to learn about your HIT needs, you might consider participating in usability testing. This is particularly important for practices with diverse providers and patients or for those that have experienced decreased quality after implementation of an EHR. Formal usability testing can provide an individual or a practice with ideas to maximize use of EHRs and can improve HIT for the greater physician community.

As Chicago's federally funded resource for health IT assistance, the Chicago Health IT Regional Extension Center offers support for obtaining usability testing. We have the tools, testing facilities, and information on finding trained usability consultants to help you get started.

Contact Dr. Enid Montague at *enid.montague@northwestern.edu* or 312-503-6461 to receive information about usability, to learn about testing at your practice, or for a personalized consultation. For information on participating in one of our usability studies, visit *chitrec.org/research/usability-testing*.

Dr. Enid Montague is an assistant professor in the Division of General Internal Medicine and Geriatrics at Northwestern University and director of CHITREC's Research Initiative for Human Factors Research and Usability Testing. Dr. Kho is an internist and co-executive director of CHITREC.

Start with Your Staff

Look to your staff if you want to set a foundation for top-notch patient care **By Alina Baban**

PRACTICE managers constantly strive to provide ever-better care to patients by focusing on better patient communication and education. Still, keep in mind that every goal has a clearly defined foundation. Most managers err in making the patients the foundation of the practice. Yes, satisfied patients are the ultimate goal, but they are not the building blocks that will drive your practice to where you want it to be—your staff is. Here are three key elements to create a successful staff foundation:

1 Staff Morale. Only satisfied and happy staff members can take *excellent* care of patients. Standard patient care is expected and can be provided by any staff member. To stand out from the practice next door, your staff members must feel valued and understand the importance of their role. Remember to reward and thank staff members for the exceptional care they provide. A simple thank you note expressing your appreciation is important, and doesn't require much time.

2 Staff Development. Transition to a more structured training format. It's normal to feel too busy to train new staff members, and instead let them follow existing staff members around to learn their job. Take a look at other industries and note the amount of time and energy they spend on staff training. It doesn't make sense that the hotel or fast food industry spends more time training their staff members than we do in healthcare. What is the excuse for not providing as much training as the other industries? Overly busy schedules? Too busy focusing on patient care? Set aside the excuses and realize that staff development will lead to higher levels of competency, increased job proficiency, and overall better patient care.

3 Staff Accountability. Staff members are competent, well-intended, and responsible individuals, and should be held accountable for their actions. Accountability has to be measurable in order to be effective. Have each staff member list a couple of goals they want to attain, and ask them how you can help. Let your staff know they can hold you as well as each other accountable. As leaders, we are the example that drives the morale and development of the practice.

Once you realize that your foundation should be your staff, the goal of building a practice that delivers superb care becomes easy to attain. With staff morale, development, and accountability intact, you can build a strong and trusting foundation of staff that will drive your practice to the forefront of excellent patient care.

Alina Baban is chair of CMS' Practice Management Section.

Stroke in Native Americans

A new study shows a higher incidence rate in this population group

By Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

"Current and past smokers had more than 2 times and 1.5 times higher risk of incidence stroke respectively compared to participants who had never smoked."

CEREBROVASCULAR disease and stroke are the leading causes of long term disability in the United States. More than 900,000 hospital admissions are attributed to stroke related illnesses and it ranks as the fourth leading cause of mortality with annual costs of care and treatment estimated to be $18.8 billion. Recent trends demonstrate decreasing death rates for Caucasians and African American patients who have a stroke; however relatively little is known regarding stroke incidence, risk factors and mortality among Native Americans.

The *Strong Heart Study* is a population-based study of cardiovascular disease and its risk factors in 13 Native American communities in southwestern Oklahoma, central Arizona, and North and South Dakota. The initial exam of over 4,500 participants occurred in 1989-1992, and in 2004, 306 participants suffered a first stroke at an average age 66.5 years. The incidence of stroke increased with older age in both men and women in all communities. Overall the 30-day case fatality from the first stroke was 18 percent with a one year case fatality rate of 32 percent.

Those participants with incident stroke were older, had higher systolic and diastolic blood pressures, fasting glucose, HbA1c and were less physically active at baseline compared to participants who remained stroke free. Hypertension, diabetes, microalbuminuria and macroalbuminuria were more common in persons at baseline who developed a subsequent stroke, and those with incident stroke were more likely at baseline to be past alcohol users. Persons with higher levels of blood pressure and HbA1c had higher incidence of stroke than those with normal levels and baseline LDL cholesterol levels were not significantly related to stroke incidence. Current and past smokers had more than 2 times and 1.5 times higher risk of incidence stroke respectively compared to participants who had never smoked.

The most common subtype of stroke was cerebral infarcts (86 percent); hemorrhagic stroke occurred in 14 percent of subjects. Intraparenchymal hemorrhages were more common in the youngest age group (45 to 54 years of age) with relatively few cases of subarachnoid hemorrhages noted. Among those Native Americans who had a first stroke, the percentage of subtypes of strokes were similar to that noted in other large studies such as the Framingham study, Cardiovascular Health study and Atherosclerosis Risk in Communities Study.

Although the risk factors that predict stroke appear to be similar between Native Americans and other populations, this study (which was comparable to other studies in Caucasian and African American populations) suggests that Native Americans have a higher overall stroke incidence rate than Caucasians or African Americans. Another important finding was that both the 30-day and 1 year case fatality rates after first stroke were higher in both Native American women and men as compared to the comparable national data for Caucasians and African Americans.

Further studies are needed to examine the differences in stroke incidence and risk factors among Native Americans. Understanding the potential mechanisms to explain differences in stroke should lead to the development of more efficient and effective stroke prevention strategies in this group.

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

Q&A

Q: In complying with HIPAA regulations, do I have to obtain my patient's authorization to use or disclose his or her protected health information to an interpreter?

A: When you use an interpreter to communicate with your patient, you do not have to obtain an authorization if one of these conditions is met:

- The interpreter is a member of the covered entity's workforce—for example, a bilingual employee.
- The interpreter is a business associate.
- The interpreter is the patient's family member, close friend, or any other person identified by the patient as his or her interpreter for that health care visit.

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A Citywide Effort

Public health efforts have led to a 47 percent reduction in HIV in Chicago

By Bechara Choucair, MD

ON DECEMBER 1, World AIDS Day, people from around the globe unite in the fight against the human immunodeficiency virus. An estimated 33.3 million people in the world are living with HIV. The U.S. Centers for Disease Control and Prevention estimates that 1.1 million people in the United States are currently living with HIV; in Chicago the epidemic has affected our families, disparate populations and our children.

Thirty-one years ago, in 1981, the first case of acquired immune deficiency syndrome was reported in Chicago. Since then, 37,617 cases of HIV and AIDS have been reported in the city. Today, 22,172 people in Chicago are living with HIV. However, an estimated 20 percent of people infected with HIV are unaware of their status, suggesting that more than 27,000 people might be living with HIV in our city.

Fortunately, HIV is preventable. Effective counseling and testing are essential components to a comprehensive HIV prevention strategy, which is why the Chicago Department of Public Health is focusing its efforts around prevention. At the CDPH, our goal, which is aligned with the National HIV/AIDS Strategy goal, is to reduce new HIV infections in Chicago by 25 percent by 2015.

"Thirty-one years ago, in 1981, the first case of acquired immune deficiency syndrome was reported in Chicago."

So far, we've had great success. Our HIV prevention efforts have led to a 47 percent reduction in the number of new HIV infections since 2000. This decline is due in part to collaborative efforts between the CDPH and many local and national community partners. As one unit, we are committed to preventing the spread of HIV by implementing a comprehensive system of prevention, care and support services.

For example, on World AIDS Day, the CDPH organizes a citywide STI/HIV prevention effort to distribute 20,000 free condoms to Chicagoans during their morning commute. This is also a year-long project that allows us to distribute 10 million free condoms a year through city clinics, community-based organizations, community health centers and local businesses such as nightclubs, barbershops and churches.

The project is aligned with the National HIV/AIDS Strategy, the U.S Department of Health and Human Services and CDC's Enhanced Comprehensive HIV Prevention. It also is part of the National Female Condom Coalition and a partner with the Chicago Female Condom Campaign to increase access and availability to female condoms.

All of these efforts are working together to reduce the burden of disease in our city, but there is still much work to be done. We are faced with the same challenges observed nationally, such as racial disparities and a younger population affected by HIV and other sexually transmitted infections. In Chicago, non-Hispanic Blacks have an AIDS case rate that is four times greater than that of non-Hispanic Whites, an HIV infection diagnosis rate three times higher than non-Hispanic Whites and an HIV infection prevalence rate twice that of non-Hispanic Whites.

Hispanics have a considerably lower prevalence rate than non-Hispanic Whites and non-Hispanic Blacks, and a slightly higher AIDS diagnosis rate than non-Hispanic Whites. Compared to the U.S. population overall, the HIV prevalence rate is higher in Chicago for all racial/ethnic groups but the magnitude of difference varies. Most notable, is the difference for non-Hispanic Whites who have a prevalence rate five times greater than the rest of the U.S. population.

Men who have sex with men continue to be disproportionately affected by the epidemic. In 2010, two out of every three diagnoses were among homosexual males. Also, we are now seeing considerable differences in HIV trends by age group. A younger population is more affected by HIV than ever before. In the last decade (2001-2010), the number of HIV infection diagnoses actually increased for ages 13-19 (30 percent) with only small declines for ages 20-29, while the older age groups all experienced declines of more than 45 percent. Adolescents and young adults up to age 29 represented 38 percent of HIV infections diagnosed in 2010 alone.

The mission of CDPH's Division of STI/HIV/AIDS Public Policy and Programs is to use the best public health practices for the prevention and treatment of HIV and sexually transmitted infections. By continuing to build partnerships in the community and effecting systems of change, the CDPH aims to eliminate the spread of HIV and its related illness and death.

To learn more about our prevention efforts and to stay informed about the status of HIV in Chicago, visit our website at *www.CityOfChicago.org/Health* or follow us on Twitter @*ChiPublicHealth* and Facebook at *www.facebook.com/ChicagoPublicHealth*. As always, I am happy to respond to any emails at *Choucair@cityofchicago.org*. I am also available on Twitter @*choucair*.

Dr. Choucair is commissioner of the Chicago Department of Public Health.

Fresh, Innovative and Tasty Menu Items

They're coming to a restaurant near you! **By James M. Galloway, MD, MPH**

CHICAGO IS often noted as one of the best food cities in the world. Unfortunately, dining out may contribute greatly to the U.S. obesity epidemic. Americans spend nearly half of their food budget on meals away from home, which can lead to diets higher in calories, sodium, saturated fat, and cholesterol.

In light of this, Building a Healthier Chicago has developed the F.I.T. (fresh, innovative and tasty) City Initiative to encourage restaurants to include healthy offerings—and to recognize those that do. The program is a collaboration among the Chicago Medical Society, Chicago Department of Public Health, the Office of the Regional Health Administrator of the U.S. Department of Health and Human Services and Institute of Medicine Chicago focused on making Chicago the healthiest city in the nation. Many restaurants are already taking a deeper look into their menu items, so the time is right for the initiative to have an impact.

F.I.T. City is working with some of Chicago's top chefs, including Pam Smith, an internationally known chef and nutritionist and the lead for Disney's Food and Wine Festival, to promote the initiative and generate efforts to support the health of Chicago. The group has put together a set of criteria that restaurants can adopt to ensure healthy menu items. The F.I.T. City designation is given if a restaurant meets the following criteria:

- A minimum of two menu items, other than salad, whose main ingredients are fresh, non-deep fried selections of fruits and vegetables.
- A minimum of two menu items, at least one of which is an entrée, whose main ingredients include whole-grain selections.
- No menu items with artificial trans fat.
- Only plant-based cooking oils, containing predominantly monounsaturated or polyunsaturated fats (including oils such as olive, canola, peanut, grape seed, rice bran, corn, sunflower or safflower) are used for frying entrées and side dishes.
- A non-deep fried fruit or vegetable is offered as an option for all meals that include french fries or chips.

The initiative also recommends that restaurants support local sustainable agriculture, meat, and seafood. F.I.T. is working with restaurants, chefs, culinary institutions and community groups to implement this important work. Visit *www.healthierchicago.org*. To learn more about F.I.T. City, or recommend a restaurant that may want to participate, contact Lesley Craig at *Lesley.Craig@hhs.gov*.

Dr. Galloway is Assistant U.S. Surgeon General and Acting Director, Regional Health Administrator, Region V. He can be reached at: James.Galloway@hhs.gov.

The Medicare Recovery Audit Program

Top strategies to overcome a backdoor attempt to save the Medicare trust fund

By Leon Huddleston, MD, JD

EVERY YEAR the federal government struggles to obtain the revenue it needs to meet its funding obligations and priorities. In its October monthly budget review, the Congressional Budget Office projected that the federal budget deficit for fiscal year 2012 was $1.1 trillion and it will be nearly $900 billion in fiscal year 2013. This unsustainable trend makes true the adage: "If your outlays exceed your income, your upkeep will be your downfall." Congress has at long last attempted to heed this ominous declaration.

Congress passed—and several presidents signed—legislation that created an abundance of acronymically named federal programs designed to recoup money paid for legitimate and illegitimate medical claims. These programs include MACs, ZPICs, CERT and RACs. The list does not include programs conducted by the Department of Health and Human Services' Office of Inspector General. The OIG runs its programs through the Offices of Audit Services, Evaluation and Inspection, Investigations, and Counsel to the Inspector General. On June 8, 2010 President Obama announced that his administration would cut the improper payment rate in the Medicare Fee-for-Service program by half in 2012. The goal was to eliminate more than $20 billion in payment errors in 2012.

This article reviews the Recovery Audit Contractor program. The RAC program is broad in that it touches nearly every aspect of medical care and it is deep because of the methods the program uses to obtain data and determine improper payments. The Centers for Medicare and Medicaid Services has noted that the RAC program's goal is to eliminate improper payments and it has listed the recovery auditors on its website at www.cms.gov. This should give you the theoretical hope that the program's success will be its demise.

The CERT Program

CMS implemented its Comprehensive Error Rate Testing program in 2003 to measure the Medicare Fee-For-Service improper payment rate. The program monitors payment decisions made by claims processors. CERT considers any claim that was paid when it should have been denied or paid at another amount (including overpayments and underpayments) to be an improper payment. CERT evaluates a random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding and billing rules.

CERT obtains a random sample of claims stratified by service selected from all claims submitted to processing contractors (for example, MACs). The sample is comprised of claims paid or denied. In 2011 CERT sampled 51,000 claims (less than the previous year due to increased efficiency). The improper payment rate calculated from the sample reflects all paid claims for the year. Because CERT uses random claim selection, reviewers cannot label a claim fraudulent.

Once the medical records are received, CERT medical professionals conduct a review. The team may include physicians, nurses and certified coders. Before reviewing the documentation, medical reviewers examine the Common Working File and the CMS eligibility system to (1) confirm that the patient is an eligible Medicare beneficiary; (2) ensure the claim was not a duplicate; and (3) verify that Medicare was the primary insurer. CERT must ensure compliance with Medicare statutes, regulations, billing instructions, NCD, LCDs, and coverage provisions in the CMS instructional manuals. The Social Security Act is the primary authority for all coverage provisions and policies.

Recovery auditors cannot use claims history information to make a payment determination—each claim must stand on its own. Recovery auditors may use the claims history for data mining and to detect duplication and overutilization of services. They perform two types of reviews: automated (also known as non-complex), which involve no documentation requests and complex, which requires the review of medical records. Recovery auditors may re-open a claim for good cause. Reasons may include high error rates or potential overutilization based on data analysis.

In *Palomar v. Sebellius,* a recovery auditor re-opened a claim that was more than a year old. Under Medicare regulations, a claim can be re-opened if it is less than one year old. If the claim is more than one year, but less than four years old the claim can be re-opened only for "good cause."

Palomar went through the administrative appeals process and an administrative law judge found that Palomar was overpaid, but that the recovery auditor did not show good cause to re-open the claim. The decision was overturned by the CMS administrator. The district court found for the HHS. The Ninth Circuit ruled that given the goals of the RAC program and the Secretary's regulation, the decision to re-open a claim is final and not appealable. The court stated further that the issue of good cause for re-opening a claim could not be raised after an audit's conclusion and the revision of a paid claim for medical services.

Once a claim has been re-opened CERT assigns error categories to each claim. They are labeled:

- No documentation
- Insufficient documentation
- Medical necessity
- Incorrect coding (different codes, billed service as unbundled)
- Other—unallowable service, etc.

CERT notifies the claims processing contractors about the improper payment. The contractors are only allowed to recover the actual overpayments. Projections made to the universe of claims by CERT cannot be the basis for recovering projected overpayments nationally.

The 2011 Medicare FFS improper payment rate was 8.6 percent or $28.8 billion. This is out of $336.4 billion paid in FY 2011. Most of the improper payments were in the form of Part A payments for acute inpatient hospital care. They tallied approximately $10 billion. A large portion of the 2011 improper payments (over 20 percent) were inpatient claims that were denied but would have been payable if billed in the outpatient setting. The RAC program focuses on essentially four claim types: Part A (acute inpatient services); Part A (excluding acute inpatient services); Part B (outpatient services); and Durable Medical Equipment, Prosthetics,

Orthotics, and Supplies. DMEPOS suppliers have the highest rate of improper payment rate at 61 percent though Part A claims have the highest dollar amount of improper payments at $15.1 billion.

RAC auditors have homed in on inpatient admissions because they represent the greatest cost to the Medicare Trust Fund. An inpatient is one who is admitted to a hospital for bed occupancy to receive inpatient hospital services for 24 hours or more. Medicare will cover an inpatient stay only if the hospital care is deemed medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. Hospitals must meet all documentation requirements noted in the LCDs, NCDs, and issued by the processing contractors.

The issue is whether or not the patient is sick enough to require the intensity of the inpatient setting. Furthermore, CMS has determined that certain surgical procedures should be done in the inpatient setting. This means that many other procedures must be done in the outpatient setting. Even so, there are exceptions to the inpatient-only procedure rule. The physician's clinical judgment is considered as well.

RAC auditors have seized upon short inpatient stays because they tend to violate the inpatient admissions rules that services be provided in the proper setting. Statistics have shown that the frequency of claim errors is positively correlated with decreasing length of stay—the shorter the inpatient stay the more likely it is to be inappropriate. For instance, stays of one day or less had an improper payment rate of 34.4 percent, whereas, two day stays had an improper rate of 17.3 percent, and three-day stays had a rate of 11.8 percent. The concern is that providers may trend toward placing patients in 23-hour observation when those patients should, instead, be admitted as inpatients.

CMS has identified a number of services and settings that should be reconsidered. For instance, joint replacements without documentation indicating functional limitations and the exhaustion of conservative treatment have been denied. CMS has noted also that the placement of cardiac stents and cardiac pacemakers should be performed in outpatient settings unless there is a good medical reason for the patient to be admitted. In addition, all improper payments for cardiac pacemakers occurred because dual-chamber pacemakers were placed instead of single-chamber pacemakers. These factors underline the need for providers to consider Medicare coverage guidelines in addition to the best practices guidelines of their various societies and their own clinical judgment.

Inpatient care is not the only setting that the CMS is scrutinizing. Services provided in skilled nursing facilities are being denied primarily because of insufficient documentation to support the patient's stay. Patients should be admitted for nursing care and therapy services, not for custodial care. Home health services had an improper payment rate of 7 percent. As with the denial of care in nursing facilities, home health services are denied because of insufficient documentation and medical necessity errors. If home health agencies do not submit therapy notes, the physician certification of homebound status, and the Outcome and Assessment Information Set, their claim for services provided will be denied.

Those who provide DMEPOS items have suffered the greatest losses under the RAC program. More than 60 percent of their claims were denied by recovery auditors. Many DMEPOS providers fail to submit complete medical records and a physician signature, which may help to ensure payment. The documentation supplied by the DMEPOS supplier is not enough to warrant payment. Recovery auditors are questioning beneficiaries' need for oxygen and glucose monitoring supplies, nebulizer machines, power mobility devices (power wheelchairs) and, positive airway pressure devices.

CMS is now working to increase its pre-payment medial review by using enhanced analytics.

There are three demonstration programs designed to reduce improper payments:

1. Recovery Auditors Prepayment Review

Recovery auditors recovered $939.4 million in improperly paid claims in fiscal year 2011. The demonstration project will allow RACs to review claims before they are paid. This, of course, is more onerous than a post-payment audit because the provider never receives the payment that may later be disputed. Prepayment review will therefore affect hospitals' and physicians' cash flow, making it harder to maintain a healthy practice.

2. A/B Rebilling Demonstration

This demonstration is limited to a select number of hospitals that will be able to re-bill denied claims that would have been payable in outpatient settings. The stated purpose of this project is to allow reimbursement for medically necessary services, while protecting beneficiaries, encouraging proper inpatient admissions and reducing appeals. It appears that CMS recognizes that the denial of all reimbursement for medically necessary services could make the agency responsible for the denial of future services.

3. Power Mobility Devices Prior Authorization

A limited demonstration project is being established to determine if prior authorization for power mobility devices can reduce fraud and improper payments. Since this is not a random sampling (as with CERT) and a relatively small number of power mobility devices are received, the program may be used to detect fraud.

To offer further evidence of the depth of RAC audits, the recovery auditor for Region C has been authorized to inspect physician billing of office visits. This kind of scrutiny had not been allowed previously. The recovery auditor, Connolly Inc., will be authorized to review claims from Oct. 1, 2007 forward. CMS has taken this action because it is suspicious of physicians who bill the higher-level E&M code 99215, even though in May 2010 the OIG reported that fewer than 1,700 physicians consistently bill at this level out of 442,000 physicians who billed E&M codes. Physicians whose electronic medical record systems allow them to cut and paste or auto-fill the patient's record should be aware that HHS and the Department of Justice believe the systems can be used to up-code office visits and allow physicians to bill more than they should.

These concerning trends will lead to more audits that will have to be appealed.

Appeal of RAC Audits

The RAC audit appeals process is the same for the original Medicare program, which was fee for service. The process does not apply to Medicare Advantage (Part C) programs. Section 1869 of the Social Security Act and 42 C.F.R. Part 405 sub-part I outlines the appeal process for Medicare Part A and B claims.

There are five levels of appeal as listed below.

1. Redetermination by a CMS contractor

When a Medicare claim is denied, the redetermination is performed by contractor staffers who were not involved in making the initial claim determination. If the redetermination is unfavorable for the appellant, the appellant may request reconsideration.

2. Reconsideration

The reconsideration is performed by a Qualified Independent Contractor. The QIC will conduct an independent review of the CMS contractor's initial determination, including the redetermination, which may include a review of medical necessity by a panel of physicians or other qualified healthcare professionals. If the appellant once again fails to prevail, the appellant may appeal the QIC's decision to an administrative law judge within 60 days of the reconsideration.

3. Adminstrative Law Judge Hearing

If at least $130.00 remains in controversy after the QIC's decision, the appellant may request an ALJ hearing within 60 days after the QIC's decision. The minimal amount in controversy changes annually based on the percentage increase in the medical care component of the Consumer Price Index.

4. Appeals Council Review

If the ALJ's ruling has failed to satisfy both parties, the matter may be brought before the Appeals Council for review. CMS or one of the contractors may refer a case to the Council if they believe that the ALJ's decision contains an error of law that is material to the outcome of the claim or if the outcome presents a broad policy or procedural issue that may affect the public interest. CMS may request the Council to review on its own motion if CMS participated in the ALJ proceedings, and if in its view the ALJ's decision was not based on the preponderance of evidence or the ALJ abused his or her discretion.

No minimum monetary amount is necessary for a review to occur. The request for a review, however, must be submitted in writing within 60 days of the ALJ's ruling. The Appeals Council's decision should be expected within 90 days thereafter and it qualifies as the final decision of the Secretary for judicial review purposes.

5. Judicial Review in U.S. District Court

If at least $1,350 remains in controversy after the Appeals Council's decision, the dissatisfied party may request a judicial review in federal district court. This must be done within 60 days after receipt of the Council's decision. The amount in controversy required for a judicial review is increased annually based on the increase in the medical care component of the Consumer Price Index for all urban consumers.

Recommendations for Mounting a Defense

The good news in all of this is that physicians and hospitals win almost half of the recovery audit appeals. According to an analysis by CMS for fiscal year 2010 physicians and hospitals appealed 5 percent of their cases and 46 percent of those cases were overturned in favor of the providers.

The starting point for a RAC defense is to first determine if the overpayment claim is appropriate. If the answer is yes, the provider should learn from its mistake and probably forgo an appeal. If the answer is no, the provider must weight the risk against the benefit of pursing an appeal. The provider should considering the following:

1. Was the claim coded properly?

Recovery auditors have successfully obtained repayment from providers because of coding errors such as the following:

- Incorrect code
- Unbundling
- Incorrect discharge status
- Non-covered, non-allowed services
- Multiple error code values
- Incorrect number of units

Providers can successfully defend recovery audits if they abide by CMS billing guidelines.

2. Was the care medically necessary?

RACs have focused on the correct setting of care and whether or not a procedure was necessary at all. If a procedure was necessary, but performed in the wrong care setting, the claim will be denied. Treating physicians should be involved in the defense of those claims with which they are associated.

Attorneys who want to mount a successful RAC appeal should look to the Medicare Appeals Council rulings for guidance on developing a strategy.

King's Daughter Medical Center (Appellant) v. RAC Auditor CGI Federal, Inc.

One issue in this hearing was CMS' contention that the ALJ's unfavorable decision contained errors of law and was not consistent with the preponderance of evidence. In particular, CMS alleged that the ALJ gave presumptive weight to the treating physician's medical opinion contrary to CMS policy. The appellant provided medical services for a beneficiary over a 24-hour period that immediately followed a left heart catheterization and angioplasty and stenting of a right coronary artery. Prior to then, the patient had complained of chest pain and received a diagnosis of unstable angina. A RAC audit determined that the services were not covered because the medical record did not establish the need for acute care hospitalization at the inpatient level.

On review of the medical record, the ALJ noted that the patient had a history of diabetes, hypertension, COPD, and chest pain. In addition, the medical record documented the patient's current crescendo angina/unstable angina, severe peripheral vascular disease resulting in the insertion of two stents in the femoral artery and CT of the thorax. The ALJ determined, based on multiple medical factors, that the inpatient hospitalization subsequent to the surgery was medically necessary.

CMS homed in on the ALJ's statement "based on the overall record, the undersigned gives *greater weight* to the position of the admitting physician and finds the inpatient admission of the Beneficiary was medically appropriate...." The Appeals Council held that the ALJ did not afford presumptive weight to the admitting physician's opinion but afforded his opinion greater weight based on the ALJ's consideration of the entire record. Attorneys defending a recovery audit may be able to assert that the ALJ should give greater weight to the admitting physician's medical opinion if the record does not present any evidence of a violation of CMS policy.

Indiana University Health Methodist Hospital v.

National Government Services

This hearing involved the Appeals Council's decision to overturn an ALJ's determination that the provider was liable for non-covered services and not without fault for the overpayment under section 1980 of the Social Security Act. The appellant billed Medicare for services rendered to a beneficiary after he was admitted for acute renal failure, dehydration, and viral gastroenteritits. More than one year after the services were rendered, the recovery auditor denied the claim, stating that the patient could have been treated in an outpatient setting. The denial was upheld on redetermination and by the QIC. The ALJ affirmed the lower determinations.

The Appeals Council performed its review. It noted that there are no binding statutes, regulations, or NCDs that establish criteria for coverage and payment of inpatient services; however, the Council affirmed the ALJ's ruling that the beneficiary's care could have been provided in the outpatient setting. The Council overturned the ALJ's ruling that the appellant was liable for the cost of the care. The Council reasoned that the medical care provided was necessary and appropriate; therefore, the services furnished to the beneficiary qualified for Medicare coverage under Part B as outpatient services. The Council relied on the Medicare Benefit Policy Manual for its decision. The Council's ruling and its reference to the Manual should provide attorneys with strong arguments during their appeal.

Challenging CMS

Some entities have now gathered together to challenge CMS' refusal to abide by its own policies.

The American Hospital Association in concert with several medical centers have filed suit against HHS Secretary Kathleen Sebelius, alleging the Medicare program has refused to pay hospitals for hundreds of millions of dollars worth of care even though all parties agree that the treatment was reasonable and necessary as the Medicare Act requires. The AHA has put forth several arguments. It asserts that CMS violates it policies when it does not pay hospitals for the care they provide because CMS acknowledges that services not paid under Medicare Part A must be paid under Part B. The AHA maintains that CMS Payment Denial Policy should be set aside on the grounds that it is contrary to federal law, arbitrary and capricious and invalid for failure to undergo notice and comment. Furthermore, the AHA requests that CMS be required to repay hospitals for reasonable and necessary services whether they were inpatient or outpatient.

Creating Protective Protocols

Physicians should develop a process to help ensure that they do not provide services that may not be reimbursed because they are not deemed reasonable and necessary. For example, at Provena St. Joseph Center for Wound Care and Hyperbaric Medicine in Joliet, we have developed a protocol over the past two years based on Medicare LCDs and NCDs. Our clinic offers a range of state-of-the-art treatments for patients with diabetic wounds, including hyperbaric oxygen therapy and the placement of bioengineered skin substitutes. These treatments are effective, but expensive. Medicare LCDs and NCDs lay out the diagnoses that qualify for these services. Because these are not emergency treatments, we are able to ensure that the proper pre-treatment testing and documentation is done before proceeding. If the patient does not qualify for treatment based on Medicare guidelines, we do not provide the treatment. This simple process has helped ensure we will not suffer any loss if we are audited. However, this approach is unlikely to work for those physicians who have urgent or emergent decisions to make.

Recommendations for Physicians

The recovery audit program is a permanent part of the regulatory scheme. The stated goal of the program is to eliminate improper payments. Currently, the program is not designed to detect fraud. Medical necessity is at the core of the program and usually concerns the setting of care. Physicians must decide if they wish to appeal a recovery audit. They should consider the expense versus the reward. Physicians and hospitals have had moderate success in winning recovery audits on appeal. Attorneys and those involved in the appeals process should look to the Medicare Appeals Council's rulings to develop a defense strategy. And if physicians appeal a greater percentage of their cases, they may chasten the recovery auditors into denying only the most egregious claims.

Dr. Leon Huddleston is the medical director of the Provena St. Joseph Center for Wound Care and Hyperbaric Medicine in Joliet. He also holds a faculty appointment at Rush University Medical Center and is an attending physician at Advocate South Suburban Hospital. In addition, Dr. Huddleston is a 2012 Graduate of Depaul University College of Law.

Legislative Mandate

THE MEDICARE Fee-For-Service improper payment rate was first measured in 1996. After the Office of Inspector General estimated the improper payment rate from 1996 through 2002, Congress passed the Improper Payments Information Act in 2002. The primary objective of the Act was to enhance the accuracy and integrity of federal programs by requiring executive branch agency heads to review their programs annually to identify those that may be susceptible to significant improper payments. The Secretary of Health and Human Services, through the Centers for Medicare and Medicaid Services, identified the Medicare FFS program as at risk for significant improper payments.

In 2010, Congress amended the Act when it passed the Improper Payments Elimination and Recovery Act, which shifted its focus from simply obtaining information about overpayments to recovering those overpayments and eliminating them if possible. To address improper payment issues, CMS developed the Comprehensive Error Rate Testing program to define the improper payment rate.

The Escalating Rise of Exemptions

More schools—and their students—are falling below recommended vaccination levels

By Cheryl England

IN A CONCERNING trend, more schools in the state of Illinois than ever are falling below recommended vaccination levels. A recent report from the Illinois State Board of Education shows that in the 2011 – 2012 school year, 417 schools out of 5,500 plus had total immunization rates below 90 percent, which is the recommended rate for squelching outbreaks of preventable diseases. When looking at individual immunizations, exemptions have also been on the rise for the last few years. For example, last year, the sub-ninety percenty immunization rate for measles was measured at 124 schools as compared to a mere 31 schools as recently as 2003. Similarly, the number of schools below 90 percent for polio has risen from 27 to 100 since 2003.

The raw numbers aren't very comforting either with non-compliance ranging from a high of 30,280 students who did not receive diphtheria, pertussis and tetanus shots to a low of 3,053 students who did not receive Haemophilus influenzae type b vaccinations either due to religious or medical objections. "In a way, we are victims of our own success," says Lisa Kritz, Project Director for the Chicago Area Immunization Campaign, which is part of the Illinois Maternal and Child Health Coalition. "Before vaccines, childhood diseases were scary and very real."

Now for the Good News

There is a lot of good news in all of this, however. First, the numbers are not the be-all, end-all. Some of the non-compliance with vaccinations can be chalked up to medical objections from physicians or children who are on a vaccination schedule but not yet fully compliant. Data entry errors can occur and some students may be up-to-date on vaccinations but simply lack the paperwork to prove it.

And, overall, Illinois is doing a good job of keeping childhood vaccination rates high. While a handful of schools can skew the numbers, vaccination rates remain high in Illinois schools, at around 96 percent. Even more fortunately, Illinois does not allow the vaguely defined Personal Belief Exemption that some 20 other states do. For example, in California, obtaining a personal belief exemption has, in the past, been amazingly easy. Parents have only been required to sign their name to a two-sentence standard exemption statement on the back of the California School Immunization Record or provide a signed written statement—a process that is often easier than getting a vaccination for a child.

As a result, the number of parents choosing to exempt their children in California from school immunization requirements has increased significantly over the past decade. The number of kindergartens with 10 or more students enrolled that have personal belief exemptions has more than tripled over the past decade. In 2010, California had about 11,500 kindergarteners with personal belief exemptions, which represented a whooping 25 percent increase over the previous two years. A new law that will take affect in 2014 aims to make the process a bit more onerous, by having parents sign a statement saying that they have received information about the benefits and risks in vaccinating a child.

Legislation in Illinois

The state of Illinois, too, is passing legislation to help educate parents about vaccinations in their schools. Starting in 2013, schools will be required to publish their immunization rates every December. The hope is that parents will work to get the immunization rates up for their children's

schools.

Religious exemptions, too, are rising. For example, religious exemptions for the measles shot grew from about 3,400 in 2000 to more than 6,000 in the 2011–2012 school year—nearly a 100 percent increase. And, the exemptions are not hard to get—various websites offer model letters for parents to use.

The increase also reflects growing unease among some parents about the safety of vaccinations, even though vaccinations have been scientifically proven to rarely cause serious complications. Part of the fear certainly stems from the scientifically unfounded study by Andrew Wakefield, a former British surgeon and medical researcher in 1998 that claimed that the mumps-measles-rubella or MMR vaccination (or other vaccines containing the preservative thimerosal) could cause autism. While the physician who authored the study has since had his medical license removed and the study has been debunked by numerous scholarly and scientific sources, the stigma still remains. "It *is* news to say that a vaccine causes autism, but unfortunately it is *not* news to say that it doesn't," says Kritz. "And vaccinations can be scary for parents," she continues. "Your child is the most beloved being you have in your world and when you hear scary or frightening things about vaccines, it can make you reluctant to vaccinate your child."

More Efforts to Help Raise Vaccination Rates

Other efforts are also helping to increase the rates of immunization for school-age children. Currently, 74.1 percent of children under the age of three are appropriately vaccinated but Kritz thinks

Tips for Talking to Parents

Most likely, by now you've run into a parent that is hesitant to vaccinate their child. Here's a list of 14 arguments that you can use to convince them that it is in both theirs and their child's best interest to vaccinate.

1 The flu is a serious respiratory disease that can bed deadly. Healthy infants and toddlers are especially vulnerable.

2 Whooping cough (pertussis) is an extremely dangerous disease for children, which is not easily treated and can result in permanent brain damage or death.

3 Unvaccinated children can pass diseases on to babies who are too young to be immunized.

4 Unvaccinated children pose a threat to children and adults who can't be immunized for medical reasons such as those with leukemia and other cancers or people with immune system problems.

5 Without immunizations, your child may have to be excluded from school or child care.

6 Medical and legal authorities have scientifically proven that the measles-mumps-rubella vaccine or other vaccines containing the preservative thimerosal does [ital.]not[ital.] cause autism.

7 Vaccinations are usually free or low cost for children when families cannot afford them.

8 Pediatric vaccines are responsible for preventing 10.5 million diseases per birth in the U.S.

9 Before the vaccine for chickenpox, about 12,000 people were hospitalized for the disease every year. About 100 people died from the disease. Since the vaccine was licensed in 1995, millions of doses have been given to children in the United States.

10 Haemophilus influenzae type b diseases were a major problem a few years ago until a vaccine was developed. Over several years, cases of the disease went form 20,000 to less than a few hundred. Unvaccinated children are still at risk for Hib meningitis and other serious illnesses.

11 Immunizations have reduced most common childhood diseases to very low levels in the United States. However, some of these diseases are still common in other parts of the world. Travelers can bring these diseases into the U.S. Without immunizations, these infections could spread quickly here. Of the 692 cases of measles reported during 2001-2010, a total of 604 (87 percent) were import-associated.

12 Reactions to vaccines may occur, but they are usually mild. Severe reactions to vaccines are very rare. Symptoms of a more serious reaction includes very high fever, generalized rash, and a large amount of swelling at the point of injection.

13 The Federal Drug Administration tests new vaccines for up to ten years before issuing the vaccine a license. All vaccines must be safe and proven to work well in children.

14 The concept that your child will be protected from a vaccine-preventable disease because other children are vaccinated is known as herd immunity. Herd immunity refers to the type of immunity that occurs when the vaccinated portion of the population provides protection against a disease to the unvaccinated individuals. Those who are too young or too sick to be vaccinated depend on the "herd" to keep disease away from them. Relying on herd immunity is risky. The more parents that think this way, the fewer vaccinated children we will have and the more likely a serious disease will return and infect all of those unvaccinated.

Vaccine-Related Resolutions

AT THE RECENT interim meeting of the American Medical Association's House of Delegates, three resolutions centering on vaccines were put forth. Two of the three were adopted and the other was referred for decision. Here are the resolutions:

Pharmacist Administration of Vaccines

This Resolution asks (1) that the AMA recognize the role of the pharmacist as an essential member of the medical home model health team and the potential role that pharmacists may play in increasing immunization rates in this country; (2) that our AMA reaffirm its commitment that such endeavors are physician-led and that pharmacists administration of immunizations is only proper when any of the following criteria are satisfied:

a) The pharmacist has an order from a physician licensed to practice medicine in the state where the immunization is to be administered.

b) The pharmacist has a collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered.

c) The state where the immunization is to be administered has designated a state of emergency, which necessitates the rapid immunization of the population in order to respond to the public health state of emergency. Administration by pharmacists should be limited to the specific vaccine required to respond to the emergency and only for the duration of the emergency declaration;

(3) that our AMA support that a state's educational requirements of pharmacists who administer immunizations be developed from input by both the state's boards of medicine and pharmacy; (4) that the AMA oppose any federal or state legislation allowing pharmacists to administer immunizations without a licensed physician's order or collaborative agreement, or during a designated state of emergency; (5) that the AMA draft model legislation which supports a medical home model and requires a physician's written or standing order, or a collaborative practice agreement between a physician and a pharmacist for the administration of immunizations, and to outline educational and safety requirements which must be satisfied in order for a pharmacist to administer immunizations; and (6) that the AMA distribute this model legislation to state and specialty societies.

Status: Referred for decision

Medicare Part B Coverage of TDAP

This Resolution asks that the AMA urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

Status: Adopted

Mandatory Immunization for Long-Term Care Workers

This Resolution asks that the AMA (1) support a mandatory annual influenza vaccination for every long term care health care worker who has direct patient contact unless a medical contraindication or religious objection exists; and (2) that the AMA recommend that medical directors and other practitioners encourage caregivers (both professional health care workers and family caregivers) to obtain these vaccinations; and (3) the AMA recommend vaccinations be made available and offered at no cost to staff working in long-term care settings.

Status: Adopted

that number can—and should—be increased. "If we address the infant immunization issue," she says, "we probably wouldn't have the school problem."

She is also keenly aware that the ten deaths in California in 2005 from pertussis have increased the awareness among parents for the need for childhood vaccinations. "Those deaths opened up people's eyes that these dangerous diseases do exist and we can't let down our guard," she says.

And a variety of groups also offer education for parents and provide handouts for physicians to give their patients. Example websites include the Centers for Disease Control and Prevention at *www.cdc.gov,* the Immunization Action Coalition at *www.immunize.org,* the American Academy of Pediatrics at *www2.aap.org,* Text4Baby at *text4baby.org,* and the Chicago Area Immunization campaign at *www.ilmaternal.org.* Local organizations such as the Chicago Area Immunization campaign also host community education and outreach events and distribute flyers to places where parents are likely to go including beauty salons and grocery stores. In addition, they get local representatives from Medicaid to reach out to their clients in social services.

In addition, many groups are advocating with the legislature to tighten the process for religious exemptions. "If a person's religion really prevents them from immunizing their child, that's one thing," says Kritz. "But for someone to use a religious exemption when they don't really have that belief is an abuse of the system. If too many people do not immunize their children, then the school system becomes a Petri dish."

And it's just that Petri dish analogy that alarms healthcare providers so much. One outbreak of a childhood disease has the potential to spread like wildfire, especially if the school children have siblings at home that may be too young for vaccinations or have medical conditions that prevent vaccination. Similarly, elderly people can easily become a victim of many of these diseases. Clusters of unvaccinated people across the country, not just children in schools, are weakening the so-called herd immunity that occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity thus threatening to resurrect preventable, but potentially fatal, childhood diseases.

Influenza Update: It's Not Too Late to Vaccinate Patients

December offers many opportunities for vaccinating your young patients

By Kenneth L. Soyemi, MD, MPH

IT HAPPENS every winter—an outbreak of the influenza type A or B virus in varying severity, commonly known to your patients as "the flu". The attack rates during these outbreaks may be as high as 10 percent to 40 percent over a five- to six-week period. Two unique features of influenza are the epidemic nature of the disease and the mortality that results in part from pulmonary complications.

For the 2012-13 influenza season, physicians should begin offering vaccinations as soon as the vaccine is available. Vaccination of all patients aged 6 months and older continues to be recommended (for more on vaccination issues with children, please see "The Escalating Rise of Exemptions" on page . It is also important to continue to offer seasonal vaccinations and schedule immunization clinics throughout the influenza season, which includes the month of December and later.

Five companies produce seasonal trivalent inactivated influenza vaccine formulated for the 2012-13 influenza season. They are: Sanofi Pasteur (Fluzone, Fluzone High-Dose, Flu zone Intradermal), Novartis Vaccines (Agriflu and Fluvirin), GlaxoSmithKline (fluarix) CSL, Biotherapies (Afluria), and ID Biomedical Corporation of Quebec (FluLaval). Med Immune Inc. is manufacturing the live, attenuated seasonal influenza vaccine FluMist.

2012-2013 Advisory Committee on Immunization Practices: The five principle updates

Five principle updates have been provided by the Advisory Committee on Immunization Practices, which is a section within the Centers for Disease Control and Prevention. They are:

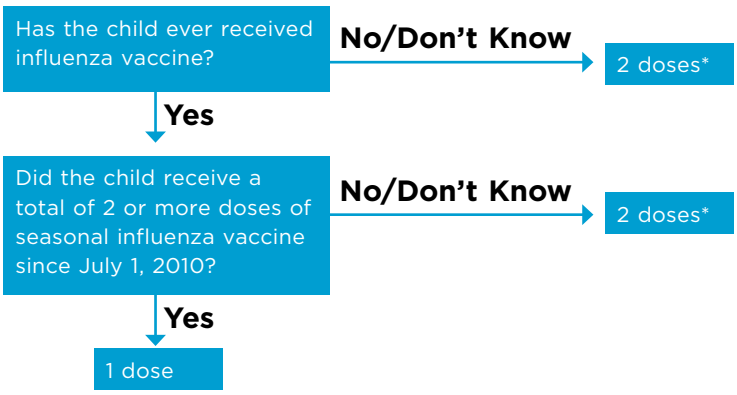


FIGURE 1

Influenza Vaccine Dosing Algorithm for Children Aged 6 Months through 8 Years

* Doses should be administered at least four weeks apart. †For simplicity, this algorithm takes into consideration only doses of seasonal influenza vaccine received since July 1, 2010. *Source: Advisory Committee on Immunization Practices United States 2012–13 influenza Season*

1 The composition of the 2012-13 trivalent influenza vaccine includes the following three influenza virus strains: A/California/7/2009 (HlN1)-like; A/Victoria/361/2011 (H3N2)-like; and B~Wisconsin/l/201O-like (Yamagata lineage) antigens. The trivalent inactivated vaccine and live attenuated influenza vaccine (LAN) will contain these three antigens. Note that influenza A (H3N2) and B antigens differ from the respective 2010-11 and 2011-12 seasonal vaccine antigens. The influenza A (HlN1) antigen has not changed.

2 Children aged 6 months through 8 years who last received seasonal (trivalent) influenza vaccine before the 2010-11 season, but did not receive a vaccine containing A/2009(H1N1) antigen [either seasonal vaccine since July 2010 or monovalent 2009(H1N1) vaccine], will not have received this antigen. These children should thus receive two doses this season, even if two doses of seasonal influenza vaccine were received before the 2010-11 season. (See Figure 1.)

The ACIP does not recommend the U.S.-licensed CSL Biotherapies' TN, Afluria, for children younger than age 9 because of reports of increased risk of fever and febrile seizures among young children in Australia. Those reports were associated with receipt of an influenza vaccine produced by CSL Biotherapies that was formulated for use during 2010 in the Southern Hemisphere.

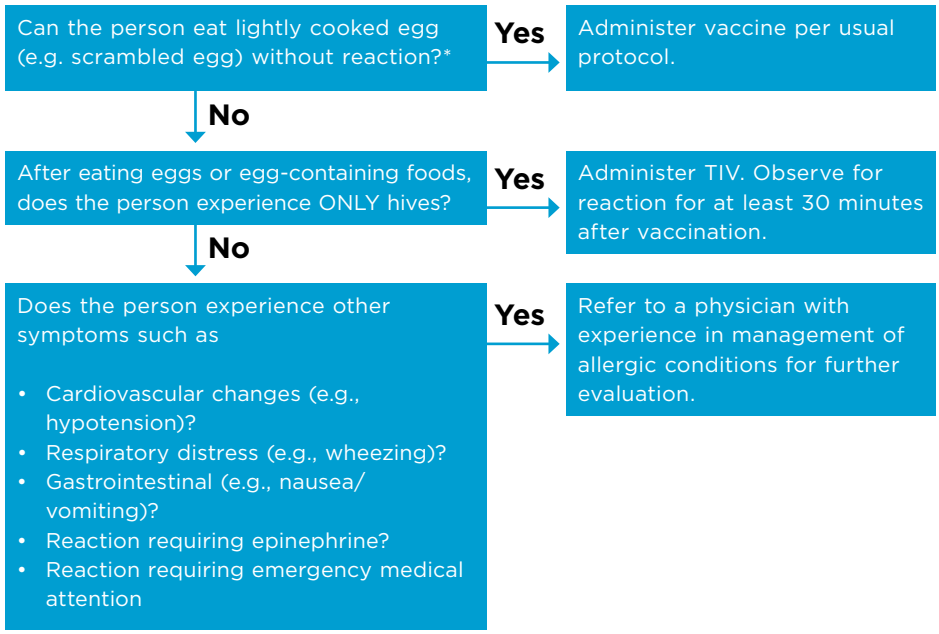
3 Surveillance for U.S.-licensed influenza vaccines during the 2010-11 season detected safety signals for febrile seizures among young children after TN administration. Further assessment determined that the increased risk occurred on the day of vaccination and the day after vaccination (0- to 1-day risk window) among children aged 6 months through 4 years. The risk was greater when children received concomitant 13-valent pneumococcal conjugate vaccine (PCV13) and peaked at

FIGURE 2

Influenza Vaccination Recommendations for Patients Who Report Allergy to Eggs

Patients with egg allergy might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy.

Source: Advisory Committee on Immunization Practices United States 2012–13 influenza season



approximately age 16 months.

Following evaluation of data regarding febrile seizures during the 2010-11 and 2011-12 influenza seasons and consideration of the risks and benefits of vaccination, no policy change was recommended for use of TN or PCV13 during the 2011-12 influenza season, and no change was recommended for use of these two vaccines during the 2012-13 influenza season.

4 Individuals who are allergic to eggs and who experienced hives only after exposure to egg should receive influenza vaccine with the following additional safety measures: TIV rather than LAIV should be used; vaccine should be administered by a health care provider who is familiar with the potential manifestations of egg allergy; and vaccine recipients should be observed for at least 30 minutes for signs of a reaction after administration of each vaccine dose. Patients who have had severe reactions to egg including angioedema, respiratory distress, lightheadedness, or recurrent vomiting, or who have required emergency medical intervention, are more likely to experience serious side effects to egg proteins. Such individuals should be referred to a physician with expertise in management of allergic conditions for further risk assessment.

5 In February 2012, the Food and Drug Administration approved a new seasonal quadrivalent LAIV, FluMist Quadrivalent (Med Immune). This vaccine is not anticipated to be available until the 2013-14 influenza season, at which time i t is expected to replace the seasonal trivalent FluMist formulation. Inactivated quadrivalent influenza vaccines currently are in development.

4 Influenza vaccine without thimerosal (as a preservative) will be available in limited supply during the 2012-2013 influenza season. The supply of this vaccine will be increased as manufacturing capabilities are expanded. Elimination of thimerosal in other vaccines has already been achieved and has resulted in substantially lowered cumulative exposure to thimerosal. The ACIP states that individuals for whom inactivated vaccine is recommended may receive any age- and risk-factor-appropriate vaccine preparation, depending on availability.

"Five companies produce seasonal trivalent inactivated influenza vaccine formulated for the 2012-2013 influenza season."

Additional Issues and General Recommendations for Patients

1 Either TIV or LAN can be used when vaccinating healthy, non-pregnant patients between the ages of two to 49 years old.

2 Vaccination of children younger than the age of 9 who are receiving seasonal influenza vaccine for the first time can begin as soon as vaccine becomes available. This practice increases the opportunity for both doses to be administered during the same influenza season and before the onset of influenza activity.

3 Children from the ages of 6 months to 35 months should receive only a 0.25 mL dose of a split-virus vaccine formulation. Currently only Sanofi Pasteur provides this presentation for physicians to use.

5 The first and second doses of vaccine do not have to match; TIV or LAIV can be used to complete the two-dose requirement. Doses should be separated by at least four weeks.

For questions, contact your local health department.

Dr. Soyemi is a medical epidemiologist and assistant medical director at the Illinois Department of Public Health in Chicago. Trained originally in pediatrics, he now works in the Office of Health Protection/ Division of Infectious Diseases, covering the entire population of Illinois. He may be reached at sheyi66@hotmail.com.

Welcome to the Chicago Medical Society!

REPRESENTING OVER 17,000 physicians, the Chicago Medical Society is one of the largest and most active county medical societies in the country. There has never been a more important time to be a member of the CMS and Illinois State Medical Society. When you join our two organizations, you become part of a dedicated network of Illinois physicians who are working together to achieve a unified healthcare front and fight against unfair insurer reimbursement practices, restrictions on physician autonomy and the erosion of valuable legislation that protects physicians' practices. CMS and ISMS can help enhance your practice, improve your bottom line, and protect your autonomy as a physician.

As a member of CMS and ISMS you will have access to the wealth of resources both organizations offer as well as access to the extensive expertise of its staffs. CMS and ISMS offer physicians the opportunity to learn about trends in the practice of medicine through committee participation, policy development, educational seminars, and publications. In addition, membership provides networking opportunities, membership services, and a strong, solid voice in state and national policy-making bodies on issues of concern to physicians. Read on to discover the many benefits of membership.

Legislative Advocacy

The CMS' strong legislative programs build coalitions of engaged physicians and establish productive relationships with lawmakers and other decision makers both locally and statewide. Through our Grassroots Advocacy Center, Legislative Mini-internship Program, Legislative Breakfasts, and Governing Council, we work continuously to positively shape public policy on behalf of physicians and their patients. We also collaborate with the ISMS, and its influential Governmental Affairs Division, to prevent harmful legislation from becoming law, and to implement pro-medicine legislative proposals at the county, state, and federal level. Our scope is ambitious and comprehensive, benefiting physicians globally and on a day-to-day basis, with tangible results and savings.

Our policy and legislative components include:

Shaping Legislation

CMS provides a launching pad for pro-medicine and patient initiatives; your active participation is key to our success in Cook County, Springfield, and Washington, DC. Against a rapidly changing healthcare landscape, lawmakers are making rapid-fire decisions about funding, reimbursement, medical liability, ACOs, and public health, among other areas. Physicians have the unique perspective and insight to advise elected officials, explaining how specific legislation will positively or adversely affect the medical profession, our patients and day-to-day practice. Working together, our organizations introduce and influence legislation at the county, state, and federal level. Who better than our team of experts to guide elected officials and key decision makers?

Relationships with Legislators

CMS leaders engage lawmakers on a regular basis. Each year we travel to Washington, DC, where we meet with approximately one-third of the Illinois Congressional Delegation. We also relay your concerns in Chicago and Springfield, proposing solutions on healthcare delivery, Medicare and Medicaid, medical liability, and looming workforce issues. This past year we engaged the following legislators and aides: Senators Richard Durbin; Mark Kirk; Harry Reid; and Representatives Timothy V. Johnson; Luis Gutierrez; Adam Kinzinger; Mike Quigley; Robert Dold; Danny K. Davis; Jan Schakowsky; Judy Biggert; and Eric Cantor.

Mentorships for Lawmakers

The CMS Mini-Internship program matches you for a day with an elected official while you make daily rounds, perform surgery, or care for patients in the clinic or hospital. The goal is to show legislators firsthand the complexities and hassles you encounter each day as a practicing physician. Many legislators have said they come away with a new appreciation and respect for the practice of medicine. Not only do they witness the impact of legislation on physicians and healthcare delivery, but our members also acquaint themselves with the responsibilities of legislators, and learn how to communicate their needs to them. The Mini-Internship program also informs lawmakers and civic leaders that CMS is a valuable source of information and guidance on health policy issues, which they should use in their deliberations. For details on the CMS Legislative Mini-Internship Program, please contact Christine Fouts 312-670-2550, ext. 326, or *cfouts@cmsdocs.org*.

Breakfast Talks with Legislators

CMS Legislative Breakfasts bring you face-to-face with your elected representatives and civic leaders, in hospitals or other locations of your choice. One example is a breakfast with State Senator Heather Steans (7th Dist.) at Swedish Covenant Hospital. Members gave the North Side Chicago Democrat their perspectives on defensive medicine, insurance reform, Medicaid reimbursement, medical education, and loan forgiveness. They used this time to discuss a study by CMS member Russell Robertson, MD, which found more than half of Illinois medical residents leave the state due to medical liability costs and loan repayment issues.

The Legislative Breakfast program complements the Mini-Internship program. At your request, CMS staff works with District leaders and hospital medical staff to arrange these breakfasts—all you do is choose the representative. For details or to schedule a breakfast in 2012-2013, please contact Christine Fouts 312-670-2550, ext. 326 or *cfouts@cmsdocs.org*.

Grassroots Advocacy Center

This new CMS website function informs members of new and pending legislation, encouraging them to engage with their congressional representatives. The site provides contact information, links, sample letters, and guidance on communicating effectively with legislators.

Governing Council

We recognize the necessity of a strong representative Society that engages all Cook County physicians. CMS recently expanded its grassroots Governing Council, giving new seats to specialty societies and hospital medical staff organizations. This structural change gives our "affiliated" groups a voice and creates a platform for all 17,000 physicians in the county region. We encourage them to actively shape Society policies and objectives, through resolutions, and to communicate with our leaders in this democratic forum.

Together we stand united, fighting for core principles and goals.

CMS also will collaborate on issues important to our affiliated constituents and CMS members. We offer valuable resources and services, such as studying specific issues they bring to us.

Authoring Resolutions

As the legislative body for both our organizations, the ISMS House meets once a year to set objectives on key issues, ranging from scope-of-practice and reimbursement reform, to public health and graduate medical education. The resolutions members submit to the CMS Governing Council directly shape these objectives. ISMS also works directly with the Illinois General Assembly to introduce and influence legislation promoting and protecting medical practices and individual physicians.

Member Discounts

CMS and ISMS membership offers you exclusive, time- and money-saving benefits. By taking advantage of these discounts and services, you can earn back more than the investment of your dues dollars. Our members have access to billing and collection services, medical products and supplies, health, life, disability insurance, group practice insurance, banking and investment services, and more. The money you save through your societies will help keep your practice more profitable.

Access to Events and Educational Programs

CMS and ISMS regularly host seminars, CME programs, webinars, conferences, meetings, and educational workshops on a variety of topics essential to running the business side of your practice. You'll find programs on topics such as:

- Implementing electronic medical records
- Proper coding, billing and collection
- Managing Medicare
- Practice management techniques
- Understanding and implementing legislative and policy regulations
- And much, much more

Events are held throughout the county and state. Please view the calendar at *www.cmsdocs.org* or check the Calendar of Events section of this magazine for details.

Reimbursement Assistance

The ISMS Division of Member Advocacy supports physicians—especially those in solo practice, partnership, or small group settings—who face increasing financial pressure due to ongoing changes in the healthcare delivery system. We recognize that physicians like you are under constant pressure to streamline your business operations while continuing to provide access and quality care to patients. It is often a struggle to implement changes in stringent federal and state regulations and grapple with health plans that use confusing, inconsistent, and unfair payment practices. ISMS offers hands-on support to members in a variety of areas to ensure a healthy bottom line for their practices.

- Reimbursement assistance, which can help you recoup thousands of dollars by showing you how to appropriately respond to health plans through efficient appeals processes and claims reconsideration.
- Direct assistance with resolving reimbursement issues.
- Numerous workshops and seminars that teach physicians and their staff how to maximize reimbursements.
- Various toolkits to help you better manage your finances.
- Assistance with federal and state pre- and post-payment audits and compliance.
- Information on healthcare issues, mandates, and new policies to keep members informed about day-to-day reimbursement issues.
- Pro-active work with public and private payers to prevent onerous provisions from getting into contracts in the first place.

For more information, please contact the ISMS Division of Member Advocacy at *www.isms.org.*

New Initiatives

As always, CMS strives to create new programs of value to its members as the landscape changes. Some of our latest initiatives include:

- **Women Physicians Forum**—The forum looks at the unique needs and interests of women physicians in Cook County. As the local counterpart of the Illinois ISMS Women Physicians Forum, the group is structured to focus on three key areas: (1) representing and advocating on behalf of women physicians; (2) networking; and (3) offering services specific to women physicians. The Women Physicians Forums provide the means for a strong representative voice on behalf of the growing number of women in medicine.
- **Committee for Academic Physicians**—Formed to improve CMS' representation of physicians involved in academic medicine, this committee addresses the unique regulatory and financial issues that affect academic physicians, and provides a forum to discuss them. The committee is responsible for researching the feasibility of policies, activities and services that ultimately enable CMS to better serve the needs of academic physicians.
- **Young Physicians Group**—This group focuses on the concerns of physicians under 40 years of age or within the first eight years of professional practice. The YPG major goal is to strengthen the value of CMS young physician membership by (1) enhancing young physician practice of medicine, including the transition into practice; (2) facilitating the participation of young physicians in policy development and other activities of the CMS; and (3) promoting young physician leadership throughout organized medicine.
- **Council on Hospital Medical Staff Leadership**—In response to the growing demands on medical staff leadership, CMS formed a Council on Medical Staff Leadership, which is designed to be a valuable resource to you and your hospital. The Council is composed of medical staff presidents, presidents-elect, secretaries, and representatives of the AMA's Organized Medical Staff Section and focuses on issues affecting hospital medical staffs.

Contact Us

Through our advocacy efforts, our physician leaders and staff strive toward a common goal—that you spend more time treating patients and less time navigating the obstacles that threaten your autonomy and undermine your practice of medicine. Recognizing the diverse needs of our prospective members, we offer specialized memberships for physicians, practicing residents, medical students, and practice managers. For additional information on the benefits of membership or to apply, visit *www.cmsdocs.org* or call us 312-670-2550.

Decisions, Decisions

Highlights from the American Medical Association's Interim House of Delegates meeting

IN EARLY November, delegates from the Illinois State Medical Society and the Chicago Medical Society participated in the American Medical Association's Interim House of Delegates. Below are some highlights of the adopted resolutions. For a full list, visit the AMA's website at *www.ama-assn.org*.

Sequestration Budget Cuts

This Resolution asks that the AMA urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and healthcare for service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.

Generic Medications and Pay for Delay Practices

This Resolution asks that the AMA support federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.

Mandatory Physician Enrollment in Medicare

This Resolution asks (1) that the AMA support every physician's ability to choose not to enroll in Medicare; and (2) that the AMA seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians.

Student Loans and Medicare/ Medicaid Participation

This Resolution asks that the AMA seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt and replace it with system of garnishing Medicare and Medicaid reimbursement payments for the repayment of delinquent student loan payments.

Eliminate ICD-10

This Resolution asks, that in order to alleviate the increasing bureaucratic and financial burden on physicians, the AMA vigorously advocate that CMS eliminate the implementation of ICD-10 and instead wait for the adoption of ICD-11. The AMA will immediately reiterate to CMS that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication needs to be sent to all in Congress and displayed prominently on our AMA website.

Use of Prevention and Public Health Fund Dollars for Activities Unrelated to Prevention and Health Promotion

This Resolution asks (1) that the AMA support budget allocations from the Prevention and Public Health Fund at no less than the levels adopted in the Affordable Care Act of 2010; and (2) that the AMA actively oppose policies that aim to cut, divert, or use as an offset, dollars from the Prevention and Public Health Fund for purposes other than those stipulated in the Affordable Care Act of 2010.

Decoupling Social Security from Medicare

This Resolution asks (1) that the AMA support abrogation of any connection between Medicare and Social Security benefits as proscribed in *Hall et al v. Sebelius*; (2) that the AMA support the plaintiffs in *Hall et al v. Sebelius*; and (3) that the AMA support legislation that makes *Hall et al v. Sebelius* moot.

RAC Audits of E&M Codes

This Resolution asks (1) that the AMA oppose RAC audits of E&M codes with the CMS and explain to CMS and Congress why these audits are deleterious to the provision of care to patients with complex health needs; (2) that if the AMA is unsuccessful in reversing the audits, that the AMA urge CMS and elected officials to require physician reimbursement for time and expense of appeals; and (3) that the AMA urge CMS and elected officials to provide statistical data regarding the audits, including the specialties most affected, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal.

Mandatory Immunization for Long-Term Care Workers

This Resolution asks that the AMA (1) support a mandatory annual influenza vaccination for every long term care healthcare worker who has direct patient contact unless a medical contraindication or religious objection exists; and (2) that the AMA recommend that medical directors and other practitioners encourage caregivers (both professional and family caregivers) to obtain these vaccinations; and (3) the AMA recommend vaccinations be made available and offered at no cost to staff working in long-term care settings.

Improved and Standardized Instructions for Drug Labels

This Resolution asks that the AMA encourage state Boards of Pharmacy to adopt the newly revised standards contained in the United States Pharmacopeia general chapter on prescription container labeling, which offers specific guidance on how prescription labels should be organized in a patient-centered manner.

Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment

This Resolution asks that the AMA (1) encourage the adoption of age birth year-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control and Prevention recommendations; and (2) encourage increased resources for CDC and state Departments of Public Health for the development and coordination of Hepatitis C Virus infection educational and prevention efforts.

Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations

This Resolution asks that the AMA encourage the National Institute for Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority and refugee populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations in order to increase access to care and appropriate treatment.

Harm Reduction Strategies for Patients at Risk of Opioid Overdose

This Resolution asks that the AMA (1) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (2) encourage the continued study of and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

PSAs to Educate Children and Adults Never to Use Medications Prescribed to Other Individuals

This Resolution asks that the AMA work with interested stakeholders, federal agencies and pharmaceutical companies required by Risk Evaluation and Mitigation Strategy legislation to develop Public Service Announcements for TV and other media to educate children and adults about the dangers of taking medications that are prescribed for others:

- Never to use medications prescribed to other individuals, especially controlled substances such as opioid analgesics, benzodiazepines and stimulants; and
- That the use of non-prescribed medications may result in injury or death to anyone for whom they are not prescribed; and
- That taking other people's medications is usually illegal.

Expansion of the National Diabetes Prevention Program

This Resolution asks that the AMA (1) support evidence-based, physician-prescribed diabetes prevention programs; (2) support the expansion of the NDPP to more CDC-certified sites across the country; and (3) the NDPP should be a Medicare benefit and be covered by all private insurers.

Support for Breast Reconstruction Public Education Initiatives

This Resolution asks that the AMA support education for physicians and breast cancer patients on breast reconstruction and its availability.

Pharmaceutical Compounding Company Oversight

This Resolution asks that the AMA: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and, (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.

Preservation of Residency Training Positions

This Resolution asks that the AMA oppose the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.

Prescription Refill Schedules

This Resolution asks that the AMA encourage insurers and pharmacy organizations to develop and implement prescription refill schedule strategies so that travel barriers are reduced for patients requiring multiple medications.

Evidence-Based Use of Services

This Resolution asks that the AMA support physician-led, evidence based efforts to improve appropriate use of medical services, and educate members, physicians, hospitals, health care leaders and patients about the need for such efforts.

Transparent Development of Clinical Coverage Protocols by Private Carriers and Benefit Management Plans

This Resolution asks that the AMA work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write/revise them; that those processes seek input from relevant national physician organizations; and that such clinical coverage protocols be easily and publicly accessible on their websites and that the AMA advocate that when private insurance plans and benefit management companies make changes to clinical coverage protocols, they must inform all insured individuals and participating providers in writing no less than 90 days prior to change(s) going into effect.

Medicaid Expansion

This Resolution asks that the AMA, at the invitation of state medical societies, work with them and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA.

Medicare Quality and Resource Use Reports

This Resolution asks that the AMA continue to work with CMS to improve the design, content, and performance indicators included in the Quality and Resource Use Reports for physicians, so the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers; and (2) that the AMA continue to advocate, educate and seek to delay implementation of the VBM program.

Designation of Electrodiagnosis/ Other Services as Separate Category in Provider Networks

This Resolution asks that the AMA oppose the re-designation of services traditionally provided by broader medical specialties as a separate specialty category for inclusion into a payor's provider network unless compelling evidence shows that such a redesignation will improve patient care and support the ability for all appropriately trained neurologists and physiatrists to perform electrodiagnosis on patients within their provider network.

Responsibility for Transparency

This Resolution asks that the AMA oppose any legislation that deems the physician the responsible party to inform patients of their anticipated healthcare costs where the practitioner does not set reimbursement rates.

Opposing Assigning Dual-Eligibles into Mandatory Managed Care

This Resolution asks that the AMA (1) demand that CMS require all states to develop forms and related processes to facilitate opting out of managed care programs by Medicare-Medicaid dual-eligible individuals, and related processes and that those forms and directives be available no less than 120 days before the effective date of a state's dual eligible managed care program implementation; and (2) that the AMA advocate to continue to revise, limit the size, and limit the expansion of the dual-eligible managed care pilot process until it demonstrates improved accessibility, quality and cost efficiencies.

Medical Staff Bylaws as Binding Contracts

This Resolution asks that the AMA pursue the enactment of federal legislation that will recognize medical staff bylaws as a binding contract between the medical staff and the governing board of a hospital or health care delivery system.

Protect Your Practice

HIPAA violations are on the rise as civil monetary penalties skyrocket

PHYSICIANS AND practice managers take heed: a new era in HIPPA privacy and security enforcement has begun in earnest. "Covered entities" must report a breach to affected individuals within 60 days of discovery. If the breach affects more than 500 individuals, the HHS and the media must be notified. "Don't let the government's lax enforcement of HIPAA security before 2009 lull you into being non-compliant. The threat of enforcement and liability exposure to your practice is real," said Tracey A. Salinksi, partner in Arnstein & Lehr LLP, in cautioning members of the Chicago Medical Society.

Speaking at CMS on Nov. 7, attorney Salinksi reviewed the HITECH Act, and enforcement ramifications for medical practices. Both covered entities and their business associates face new obligations and stiffer penalties for non-compliance. Health insurance exchanges, regional health information organizations, e-prescribing gateways, and electronic health record vendors that contract with covered entities fall under the business associate category. The Act also opened the door for a new wave of government enforcement, giving state governments the authority to file suit in federal district court on behalf of state residents for HIPAA violations.

Several developments in 2011 are helping fuel tough HIPAA enforcement:

- Healthcare data breaches are on the rise, with 392 breaches reported between September 2009 and January 2012 involving more than 500 individuals. Roughly 51 percent were due to theft (paper records—24 percent, laptop—23 percent, desktop computers—15 percent and portable electronic devices—15 percent). More than 42,000 breaches involved fewer than 500 individuals. A total of 7.8 million patients were affected.
- Preliminary results of a pilot HIPAA audit program show many violations. The Office of Civil Rights launched the pilot in late 2011 to assess compliance with privacy and security rules, identify best practices, and discover risks and vulnerabilities not found through complaint investigations and compliance reviews.
- After only 20 audits, the pilot identified top problem areas: 65 percent involved security issues, 26 percent involved privacy issues, and 9 percent involved breach issues. Auditors found that smaller providers are less compliant than larger ones.

Before the HITECH act, statutory maximum civil monetary penalties for privacy and security rule violations were $100 per violation up to a maximum of $25,000 per year per violation type. Today, the statutory maximum is a whopping $1,500,000.

Salinksi shared enforcement highlights: The OCR fined Cignet Health Center $4,300,000 in civil monetary penalties for denying patients access to their medical records within HIPAA-specific time frames and for failure to respond to, and cooperate with, OCR's investigation into alleged violations. Massachusetts General Hospital was fined $1,000,000 for failure to safeguard records of 192 patients, when an employee left paper records containing protected health information on a subway while commuting to work. The records were never recovered. At UCLA Health System, 850 unauthorized employees repeatedly accessed and viewed electronic PHI of two celebrity patients, resulting in OCR fines of $865,000. Other providers have been fined for a culture of non-compliance, failure to conduct risk analysis of the confidentiality of PHI on portable media, and failure to implement policies and procedures to limit access to electronic PHI to authorized users.

Healthcare providers should have in place a carefully designed, delivered, and monitored HIPAA compliance program.

Compliance Tips

Privacy Tips

- Know your business associates and have written compliance agreements in place. Look for indemnification from business associates and return of documents upon termination.
- Verify the identity of individuals requesting protected health information from your office.
- Know who is and is not a proper personal representative.
- Develop and distribute notice of privacy practices.
- Know patient access rights under HIPAA. Review and document access denials.
- Know new Illinois laws regarding disclosure records of deceased patients.

Administrative Tips

- Develop, follow and update HIPAA policies and procedures.
- Write up policies and then be sure to implement them.
- Take complaints seriously. Follow up on complaints and mitigate them.
- Train new hires (mandatory) and document their training.
- Implement annual training for your entire workforce and document it.

Security Tips

- Track protected health information.
- Know where iPads, iPhones, laptops and other mobile devices are and where they are going.
- Conduct and document a risk assessment or perform an internal self-audit. The OCR posts audit guidelines on its website.
- Encrypt emails to patients or send emails through secured portals.
- Place EHRs on a segregated network.
- Implement and adhere to a data backup plan.
- Keep your technology up-to-date.
- Change passwords periodically and prohibit the sharing of passwords.
- Regularly monitor user activity.

A New Kind of Collaboration

Legislative advocacy from your medical societies can make a world of difference

By William N. Werner, MD, MPH

IT'S HARD TO MISS the shift that has taken place in recent years in the way patients and policymakers think about healthcare. Physicians used to stand alone in the public consciousness as the only individuals with the training and experience to treat patients. But as costs rise ever faster and the physician shortage deepens, members of other health care professions often seek to fill perceived gaps in the healthcare system, and patients and lawmakers desperate to control costs wonder whether these allied health professionals may be the answer.

Most physicians work with a wide variety of allied health professionals on a daily basis, from nurses and physician assistants to physical therapists and many others. Physicians count on every member of the healthcare team to practice at the top of their licenses, providing all the care they are licensed to provide—and patients count on them to know when they have reached their professional limits.

The only way to accomplish this is through close collaboration. That's why the Illinois State Medical Society has partnered with the Illinois Nurses Association, the Illinois Society for Advanced Practice Nursing and several other health care professional organizations to produce *Advanced Practice Nurses' Authority to Diagnose and Prescribe.* This comprehensive guide is designed to help physicians keep track of the various types of advanced practice nurses and their legal authority to provide care and treatment, and is available as a free download on www.isms.org.

Unfortunately, some policymakers have been swayed by arguments that physician shortages and health care disparities could be alleviated if other individuals were allowed to provide medical care beyond the scope of their training. Each year, the Illinois General Assembly considers a variety of bills aimed at giving non-physicians expanded authority, and in recent sessions non-physicians have become even more aggressive. For example:

- Currently, individuals who want to practice midwifery in Illinois can become advanced practice nurses certified as nurse midwives and work under a collaborative agreement with a physician or be credentialed and granted appropriate hospital staff privileges. *However, independent midwives who are not trained as nurses also have a long history of seeking licensure as "certified" professional midwives. They have repeatedly pushed legislation that would allow them to provide unsupervised prenatal, delivery, post-partum, and pediatric care—including the administration of prescription drugs and the performance of surgical procedures like episiotomies.*
- Current Illinois law dictates that before a physical therapist treats a patient, the patient must first be seen by a physician, who will provide a referral if physical therapy is needed. *However, legislation has been introduced that would remove this referral requirement and allow physical therapists to treat patients without a physician diagnosis. Physical therapists are not able to order tests or prescribe drugs, nor are they trained to read x-rays or other diagnostic procedures.*
- Physicians, usually those specializing in psychiatry or internal medicine, can prescribe medication to treat mental illness, many of which have potentially disabling and deadly side-effects. *In spite of this, psychologists, who are not physicians and are not medically trained, have sought legislation to allow them to prescribe drugs for patients. Some psychologists believe that with some token pharmacologic coursework they are qualified to prescribe psychiatric medications, but much more advanced training is needed to properly manage a patient's use of prescription drugs, which may include powerful psychotropic medications.*
- Physicians are trained to make safe and effective use of all the tools available to diagnose and treat disease and provide other kinds of health care. *However, naturopaths have repeatedly pushed proposals that would license them to prescribe drugs, provide obstetric care and perform "minor office procedures." These individuals are not medically trained, yet want to be licensed as "doctors."*

"Physicians count on every member of the healthcare team to practice at the top of their licenses, providing all the care they are licensed to provide; patients count on them to know when they have reached their limits."

The medical team is a valuable and effective force for patient care, but with the patient's life and health at stake, a fully trained and licensed physician must always be in the driver's seat. Anything less is potentially harmful to patients, not to mention the cost containment that is often used to justify expanding other professionals' scope of practice.

ISMS is dedicated to being the voice for physicians in the Illinois General Assembly, and we have worked vigorously to protect the safety of our patients by opposing each of these legislative overreaches. We have been successful so far, but we expect to see more scope-of-practice legislation in the 2013 session, and will need your support to fend off bad bills that put Illinois patients at risk.

Our legislative advocacy is not limited to fighting bad bills, however. We are dedicated to ensuring that each legislator who serves in the General Assembly understands the issues that physicians face, and that takes significant time and effort—especially given the high number of new legislators elected in 2012.

ISMS is here to lead the healthcare team in Illinois, just as our members lead healthcare teams in their practices. As you protect your patients and ensure that the other professionals you work with are practicing within their limits, with your support, we will continue to do the same statewide.

William N. Werner, MD, MPH, is President of the Illinois State Medical Society.

Member Resolutions Spark Debate

CMS committees to join in recommending policies and taking action **By Elizabeth Sidney**

THE CHICAGO Medical Society policymaking and legislative process swung into action on Nov. 5 with grassroots member testimony at CMS' downtown headquarters. The meeting marked the first Resolutions Reference Committee discussion of the 2012-2013 year. Member physicians considered proposals to enforce the rules of the road for bicyclists and to mandate care continuity during patient transfers among others. Generating intense discussion, one resolution protested mandatory board re-certification, and another called for all physicians to be certified in basic life support.

As of press time in late November, several resolutions were headed to the CMS Governing Council for full debate while others were sent to the Public Health and Physician Advocacy Committees for further study. Ultimately, the resolutions will inform policy and action at the Illinois State Medical Society, by proposing legislation that benefits patients and physicians. All members are invited to weigh in on resolutions by attending committee and Council meetings. For information, please contact the CMS at 312-670-2550.

Basic Life Support: A Life Skill

The sponsor of this resolution, Dr. Vemuri S. Murthy, a practicing anesthesiologist and CMS district trustee, proposed new CMS and ISMS policy encouraging physicians to use basic life support training modules. On a stronger note, he argued that both medical societies should recommend that BLS certification become a requirement for staff membership privileges.

Taking a mixed view, some Committee members expressed concern that doctors would have difficulty maintaining their competence in CPR, and face potential liability issues as well if certification is mandated. They also pointed out that BLS certification is usually restricted to certain medical specialties and that Bylaws requirements differ from hospital to hospital. Those opposed also argued that, ultimately, the resolution contradicts CMS policy that supports the autonomy of the medical staff and opposes interference with its ability to self-govern.

Dr. Murthy's resolution also garnered spirited support, with some arguing the issue isn't one of certification, but of basic life support skills and knowledge; even boy scouts are trained in CPR. They noted that AMA policies support both BLS and Advanced Cardiac Life Support beginning in medical school and in residency.

While opposing the idea of a mandate, the Committee voted to strengthen and broaden the AMA policy by encouraging all physicians to train themselves in BLS.

Recommendation: CMS and ISMS should adopt policy encouraging all doctors and members of the medical staff to learn CPR and recommend certification for all hospital staff.

Rules of the Road for Bicyclists

Is strict enforcement of the rules of the road for cyclists the best method of preventing bicycle-automobile injuries and death, as proposed by orthopedic surgeon and CMS trustee Dr. Michael R. Treister? Dr. Treister and others cited the growing incidence of bicycle-auto injuries in Chicago as well as in other major U.S. cities. They reported on existing and proposed legislation that addresses licensure of bicyclists and related conversations with Chicago and State of Illinois leadership on this problem. When bicyclists flout the traffic laws and cause accidents, it ultimately becomes a public health and medical issue.

The resolution asks CMS to urge the Mayor of Chicago, the Chief of Police and the City Council to begin a campaign of strict enforcement, while publicizing the importance of obeying the rules of the road. The sponsor called for a mandatory city vehicle sticker program for bicycles that could be revoked for infractions of the rules. The resolution also requests ISMS to promote public education campaigns and strict enforcement, along with a statewide license plate system for bicycles with revocation for infractions of the rules of the road.

On the other side of the debate, the Committee heard from a physician who described himself as a frequent cyclist. He said he found the resolution accusatory, pointing out that motorists often drive in bike lanes and text while driving, causing accidents of their own. He argued the language raised problematic issues, such as rules of the road for children.

While the Committee agreed the resolution's intent was timely and within the purview of CMS, it recommended additional study, along with rewording of the language to incorporate the views of those who felt the presumption of guilt was entirely on the bicyclist.

Recommendation: The CMS Public Health Committee will study the resolution, and hold a teleconference with members of the Resolutions Reference Committee and other stakeholders. All interested members are encouraged to participate.

Patient Transitions and Continuity of Care

The sponsor of this resolution, retired internist Dr. Sanford Franzblau, called for statewide legislation mandating continuity of care for patients discharged from a hospital to a nursing home. He relayed that such patients often suffer from critical medication delays and interruptions that can result in morbidity and mortality.

In response, the Committee noted the fairly stringent policies adopted by organized medicine on transitions and care continuity, which place responsibility on the attending physician and on the nursing home. There is no specific state legislation that addresses transitions of care or penalties for lapses. Moreover, medications delays are usually not the fault of a single person, but a system-wide problem.

Some Committee members argued for reaffirmation in lieu of existing policy while others called for referral for study into state licensure. The final recommendations, which will be presented at the Feb. 19 Council meeting, will be forwarded to ISMS and its Governmental Affairs Committee.

Recommendation: The CMS Physician Advocacy Committee will further consider this resolution. Members of the Resolutions Reference Committee and other stakeholders are encouraged to participate.

Do Not Resuscitate vs. Do Not Treat

Should a Do Not Resuscitate order be

overridden if the treating physician believes a patient can be restored to a reasonably full and active lifestyle? The sponsor, internist Dr. Sheldon Schwartz, argued that "Do Not Resuscitate" and "Do Not Treat" have no clear differentiation in meaning for critically and chronically ill patients. He proposed allowing the opinion of the attending or treating physician should be enough to override a DNR if the physician believes the patient can be restored to a reasonably full and active lifestyle.

The Committee agreed unanimously that overriding the DNR would interfere with the doctor-patient relationship, and is contrary to what the patient or family wanted. Also, "Do Not Resuscitate" and "Do Not Treat" are not identical in meaning, a point specifically addressed in AMA policy. Moreover, AMA policy also states that physicians should not permit their personal value judgments to obstruct implementation of a patient's refusal to have CPR.

Ultimately, the Committee agreed the resolution contradicts everything that physicians stand for.

Recommendation: The resolution should not be adopted.

Adequate Payment for Primary Care Doctors

Pediatrician Dr. Anthony C. Delach proposed that ISMS introduce legislation that would require adequate and timely reimbursement for primary care physicians, and for those primary care givers practicing evidence-based, continuous preventative medicine.

While agreeing with the sponsor's goals, Committee members cited ample existing policies supporting the intent of this resolution.

Recommendation: The Council should reaffirm existing CMS, ISMS, and AMA policies.

Chicago Chapter of the Society of Physician Entrepreneurs

Should CMS sponsor an organization devoted to physician innovation and entrepreneurship as proposed by anesthesiologist Dr. John E. Vazquez? SoPE is a physician-led non-profit, 501(c)6 member organization helping doctors to commercialize their ideas, inventions or discoveries, providing educational programs, networking venues and services, including access to sources of financing that can assist them in bringing their ideas to life. SoPE chapters are located in several cities, and the local medical societies aid and encourage their existence and member participation.

While Committee members found the concept of a chapter of physician entrepreneurs interesting, they expressed concern over CMS sponsorship of such an entity. Some felt the relationship would commercialize the Medical Society. Better options might be encouraging a chapter's creation or forming a CMS section for physician entrepreneurs. To qualify as a CMS section, the chapter would have to be formed for educational and networking purposes.

Recommendation: Obtain a legal opinion and report back with final recommendations at the Feb. 19 Council meeting.

Medication Management in Assisted Living Facilities

The sponsor of this resolution, geriatrician Dr. Rajeev Kumar, called upon ISMS and AMA to introduce or support statewide and federal legislation, respectively, that would mandate the management and administration of medications in assisted and sheltered living facilities. Dr. Kumar, who is also a nursing home medical director, reported that these facilities are not stringently regulated by the state, thus posing medication safety hazards, especially when the majority of people living in these facilities have dementia, even if mild.

The primary ramification of such legislation would be cost, said the Committee, ultimately pricing many consumers out of the market. The law would raise staffing issues and new licensure requirements as well.

Some Committee members argued that patients and families have a choice; they are responsible for determining the level of care they want and how much they are willing to spend. The sponsor replied that costs can be prohibitive, but the issue is not just a matter of cost. The Committee agreed more information is necessary to make a recommendation to the Feb. 19 Council, that if approved, would then be forwarded to ISMS for policy and legislation.

Recommendation: The CMS Public Health Committee will research licensure, cost, staffing and related issues. Members of the Resolutions Reference Committee and other stakeholders are welcome to participate.

Protect Physician Certification

Should ISMS introduce legislation preventing hospitals and insurance companies from requiring board recertification for physicians? The sponsor of this resolution, family practitioner Dr. Makis Limperis, pointed out that judges and attorneys take their certification exam only once, but hospitals and insurance companies are starting to require physicians to re-take the board certification exam.

Those in family practice, like the sponsor, are more affected than their colleagues in the specialties, Dr. Limperis stated. Meanwhile, DOs are not subject to the same requirements, thereby posing a double standard. Continuing medical education, rather than testing, is the best way to ensure physicians are up-to-date on the latest knowledge, Dr. Limperis explained. With the state angling to increase licensure fees, he argued that medical societies should demand, in exchange, a law preventing institutions from requiring specialty board re-certification for physicians.

Offering mixed opinions, the Committee cited existing AMA policy that opposes the use of maintenance of certification as a condition of employment, licensure, or reimbursement. However, AMA policy does accept the practice of re-certification.

The sponsor replied that while AMA opposes the use of Maintenance of Certification against doctors, the organization doesn't defend them. He called for legislative action in Illinois, rather than simple reaffirmation of existing AMA policy.

Committee members agreed the issue is far-reaching because when physicians become members of specialty boards they agree to MOC requirements.

Some members proposed referring the resolution to the ISMS Governmental Affairs Council, where the sponsor might explain how his resolution proposes new policy, and what kind of legislation might be introduced.

Recommendation: The CMS Physicians Advocacy Committee will distinguish those aspects of the resolution that represent new policy and consider the implications of the legislation called for by the sponsor. Members of the Resolutions Reference Committee and other stakeholders are encouraged to participate in the discussion.

Calendar of Events

DECEMBER

8 Illinois Residency Program Directors Meeting Hosted by the Illinois State Medical Society, this event will update attendees on the latest residency training news. Topics for this CME activity include: Building a Team; Navigating the Next Accreditation System; and Thinking Strategically about the Future of Graduate Medical Education. *8:00-9:00 a.m.; Maggiano's Banquets, 111 W. Grand Ave., Chicago. For more information, please contact Ruby at 312-670-2550, ext. 344; or* rbahena@cmsdocs.org.

19 CMS Executive Committee Meeting The Executive Committee meets once a month to plan CMS 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 at 312-670-2550, ext. 344; or* rbahena@cmsdocs.org.

19 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 at 312-670-2550, ext. 344 or* rbahena@cmsdocs.org.

JANUARY

16 Chicago Gynecological Society OB/GYN Jeopardy Residents from Chicago-area institutions will compete against each other as well as compete against program directors and CGS members. *6:00-9:00 p.m.; Maggiano's Banquets, 111 W. Grand Ave., Chicago. For more information or to RSVP, please contact Amanda at 312-670-2550, ext. 325 or aworley@cmsdocs.org.*

18 Winter Networking Event Please join the CMS's Medical Student District, Resident District, and Young Physicians Group at this annual gathering. Heavy appetizers and open bar included. Registration begins in mid-November. *8:00-10:00 p.m.; Rock Bottom Brewery, One W. Grand Ave., Chicago. For information, please contact Christine at 312-670-2550, ext. 326 or* cfouts@cmsdocs.org.

23 CMS Executive Committee Meeting The Executive Committee 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.; Chicago Medical Society, 33 W. Grand Ave., Chicago. For more information, please contact Ruby at 312-670-2550, ext. 344 or* rbahena@cmsdocs.org.

FEBRUARY

4 Resolutions Reference Committee Meeting This Committee meets quarterly to consider resolutions referred by the CMS Governing Council and to make recommendations on those resolutions. *7:00-9:00 p.m.; Chicago Medical Society, 33 W. Grand Ave., Chicago. For more information, contact Liz at 312-670-2550, ext. 335 or esidney@cmsdocs.org.*

11-13 AMA National Advocacy Conference At this yearly event, the AMA holds forums and educational programs on physician advocacy, while allotting time for members to visit legislators on Capitol Hill. *Registration opens in December. For more information, please contact Laura Villagomez at 312-464-5606 or* laura.villagomez@ama-assn.org.

19 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 and all members. *6:00-9:00 p.m.; Maggiano's Banquets, 111 W. Grand Ave., Chicago. Free for members. To RSVP, please contact Ruby at 312-670-2550, ext. 344 or* rbahena@cmsdocs.org.

20 CMS Executive Committee Meeting The Executive Committee 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 at 312-670-2550, ext. 344 or* rbahena@cmsdocs.org.

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classifieds

Personnel Wanted

Chair, Department of Medicine, Mercy Hospital and Medical Center, Chicago, IL 60616. Responsible for the overall direction and management of the Department of Medicine. Department includes 12 sections and an Internal Medicine Residency Program. Board-certification and administrative experience preferred. Forward CV to: Jere Freidheim, MD, 2525 S. Michigan Ave., Chicago, IL 60616.

Ob-gyn physician needed (part-time or full-time) for family planning clinic in the Chicagoland area. Please fax resumes to 847-398-4585 or email to *administration@officegci.com*.

Physicians needed in all specialties, including but not limited to anesthesia, urology, ob-gyn, gastroenterology, family medicine, and dermatology, for a family practice in the Chicagoland area. Part-time or full-time schedules available. Please fax resumes to 847-398-4585 or email *administration@officegci.com*.

Physician Care Services is seeking full-time and part-time physicians for home visits to the elderly in the Chicagoland area. Scheduling, malpractice insurance, MA, company car provided. Quarterly bonus program. Please email CV to *skookich@mpihealth.com* or fax 708-336-7420.

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.

Office/Building for Sale/Rent/Lease

Medical office building for rent; 1006 N. Western Ave., Chicago 60622; elevator to second floor. Contact: Chris Davis 312-286-9186; or Dr. Helio Zapata 956-566-2383.

For sale: Successful, longstanding family planning clinic in the Chicagoland area. Asking price $3.2 million. Please fax inquiries to 847-398-4585 or email *administration@officegci.com*. Serious inquiries only.

New medical office sublease in the Glen in Glenview. Available any day except Friday. Two exam rooms, conference room, and lab. Newly furnished, with HS Internet. One to three-year sublease. Call Cindy 847-404-3153.

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 in Downtown Winnetka Professional Center. Two available suites can be rented separately or together for up to six operatories. Approximately 1,000 square feet each. Private office, reception desk, and large shared reception room. Ideal satellite location. Call 847-446-0970 or email *ssdental@sbcglobal.net* for details.

Welcome New Members!

The Chicago Medical Society welcomes its newest members elected in November 2012. We are now 10 voices stronger!

Student District

Henry R. Del Rosario
Andrew J. Ernst
Carolyn H. Goldschmidt
Stein Ingelovetsen
Cameron Loudill
Patrick O. McCaffrey
Margaret Russell
Daniel Schmitt
Jason Stoklosa

Resident District

David J. Krodel, MD

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 Rd., Suite 300, Skokie, IL 60077-4462; *shj@sjesser.com; www.sjesser.com*.

Advertiser Index

Learning the Ropes of Running a Business

Pediatrician's skills go beyond medicine, extending into business **By Cheryl England**

Pediatrician Dr. Virginia DePaul has her hands full caring for her private practice's patients, running a business, presiding over a community association, handling hospital appointments and caring for her children as well.

DR. VIRGINIA DePaul didn't start her career in medicine planning to run a business, but now her long days include not only caring for her young patients but also handling the practice management side of the 10-physician North Suburban Pediatrics clinic. "As the managing partner," she says, "I manage the finances, hire and fire staff, and oversee contracts with insurance companies—basically everything but the electronic health record systems, which I leave to one of our younger, more tech-savvy physicians."

In fact, Dr. DePaul says that one of her proudest achievements is in managing the practice. "When I became the managing partner, the group was in some financial difficulties mostly due to some very non-productive relations with IPAs," she says. "I was able to be very effective in improving the group's financial condition. Also in the past 10 to 15 years, we've brought in some excellent young physicians—we are a very vibrant pediatric group due to the quality of our physicians."

In addition to her duties at Northern Suburban Pediatrics, Dr. DePaul also holds hospital appointments at three area hospitals—Evanston Northwestern Healthcare, Children's Memorial Hospital and Northwest Community Hospital. As if that weren't enough, in 2005 she joined the Board of Directors of the Children's Community Physicians Association—the pediatric independent physician association affiliated with Children's Memorial Hospital—and moved up through the ranks to her current position as president of the group. "The CCPA allows pediatricians to get discounts on multiple products such as vaccinations and contract with multiple insurance carriers," she explains. "That's really important in helping to keep us solvent since we don't have the high income levels that other specialties do."

So why did Dr. DePaul choose the less lucrative field of pediatrics? "Actually, it was a big decision to even go to medical school at the time," she says. "I don't come from a wealthy background so the expense was a bit daunting. I knew I was leaning toward pediatrics, but after working with adults I was sure of it," she says with a laugh.

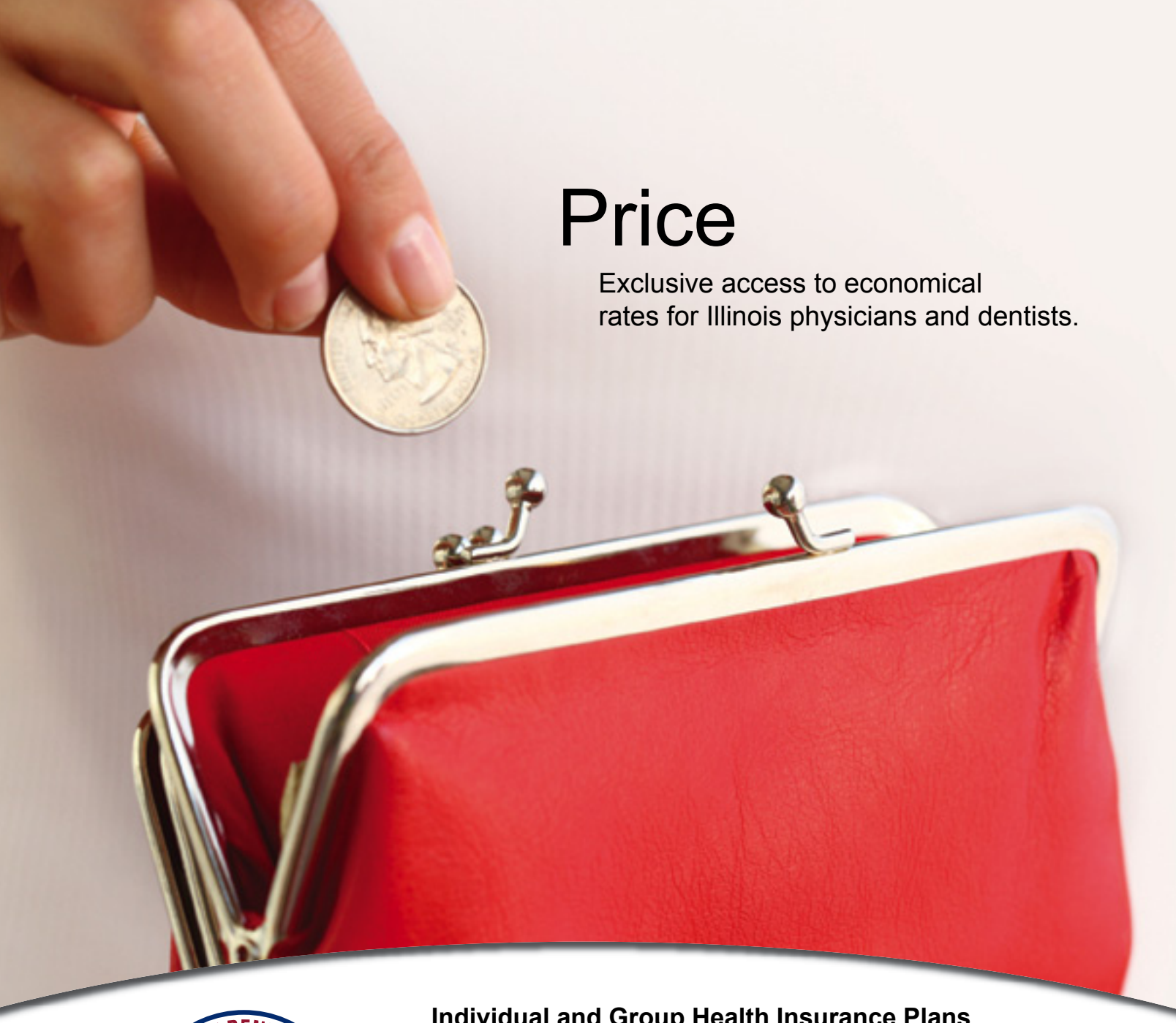
Also, she was very affected by a young patient she had during residency who began as a healthy child but developed terminal cancer while under her care—quite an experience for a young resident. "I took him from diagnosis to passing," she says. "I became very close to the family. I've had other similar cases since then but there was something about that particular family and that particular child that left me with a warm, but sad, feeling."

Now as a more experienced pediatrician, Dr. DePaul notes her appreciation of the Illinois State Medical Society and, more importantly, the Chicago Medical Society. "The ISMS and CMS do a good job of advocating within the state legislatures on issues of concern to physicians," she says.

In what little spare time she has, Dr. DePaul takes care of her three children and attends their sporting events. Melanie, 20 and Kevin, 18 are both college students and competitive gymnasts; Beverly, 16 is still in high school and plays soccer. "I also manage my own home, including cleaning." she says. When Dr. DePaul actually sleeps is anyone's guess!

Dr. DePaul's Career Highlights

DR. DEPAUL has made a lifetime of living and working in Chicago. She received her BS from DePaul University in 1976, double majoring in biology and medical technology, which aids in managing the laboratory at Northern Suburban. She earned her MD from the University of Illinois College of Medicine in 1981 and did her residency in pediatrics at the Michael Reese Hospital and Medical Center, holding the position of chief resident there from 1984 to 1985. In addition to her private practice and hospital appointments, she is also an instructor in pediatrics at Northwestern University. She is also a member of the American Academy of Pediatrics, the Chicago Pediatric Society, and the American Society of Clinical Pathologists.



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