

Chicago

MEDICINE

Quality Control?

Docs feel squeeze as insurers push high-performance networks

PAGE 10

+
What's the Future Under the Affordable Care Act?

Facing HIPAA Complaints

Medicaid Expansion: Ramifications of Supreme Court Decision

November 2012 | www.cmsdocs.org





I am ISMIE.

Loyal.

Dependable.

Supportive.

Virginia M. DePaul, MD, Pediatrician, Policyholder since 1985.

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

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

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

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

ISMIE

Mutual Insurance Company

The Physician-First Service Insurer®

Protecting the practice of medicine in Illinois



FEATURES

10 Quality Control?

Docs feel squeeze as insurers push high performance networks. By Bruce Japsen

12 A Bipartisan Outlook

What's the future for physicians under the Affordable Care Act? By Bruce Japsen

PRESIDENT'S MESSAGE

2 Time to Step Up

By Howard Axe, MD

FRONT OFFICE

4 Unprecedented Physician-owned ACO to launch in Chicago

Docs have equal stakes. By Scott Warner

5 Physician Engagement Key to Alignment

Trust is crucial. By Aimee Greeter and Rick Langosch

6 Moving Forward with Meaningful Use

Planning for 2014 by Theresa Walunas, PHD, and Abel Kho, MD, MS

PRACTICE MANAGEMENT

8 The Paid Time Off Bank Model

Is this model right for your office? By Alina Baban

ACADEMIC MEDICINE

14 Urological Men's Health Review

It's time to recognize that it's manly to be healthy. By Laurence A. Levine, MD

LEGAL

18 HIPAA Complaints

Is your practice prepared if the federal government comes calling? By Kate L. Bechen, JD

20 Friedman v. Sibelius

A cautionary tale for health care administrators. By Carolyn Fitzhugh McNiven, JD

PUBLIC HEALTH

22 Stroke in Asians and Pacific Islanders

Risk factors similar but prevalence rates differ among Asians and non-Asians. By Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

24 Shaping Healthy Behaviors with PlayStreets

Program brings sports, fun, and fitness to local communities. By Bechara Choucair, MD

RESIDENT/FELLOW

25 The Simplicity of Difficult

Training in Malawi adds unique dimension. By Devin D. Mehta, MD

LEGISLATIVE ADVOCACY

26 Help Preserve Patient Choice in Medicare

No easy solution to problem. By William N. Werner, MD, MPH

NEWS & EVENTS

28 Medicaid Expansion Ruling to Top List of Effects

Other ramifications and repercussions of Supreme Court decision. By E. Sidney

WHO'S WHO

32 Reaching the Multitudes

Medical epidemiologist Dr. Kenneth Soyemi makes his mark on public health care. By Scott Warner

Time to Step Up

WE'RE DOCTORS, we don't want to pay for anything," a colleague said recently while we were discussing membership in organized medicine. Sad to say, this was not the first time I've heard such responses from non-member physicians, and I'm sure some of you recall similar ones.

This way of thinking came up again in a conversation I had several years ago with my neighbor's son as we stood on the driveway. He told me about his new job as a bagger at the local grocery store. He was upset that he had to join a union and pay dues. He wasn't aware of the benefits he would receive, only aware of the cost coming out of his paycheck.

What do these examples tell us? While we are not automatically made union employees, we physicians overlook the benefits of belonging to an organization that represents and fights for us. And in this column, I want to take a closer look at membership and examine how not joining affects each of us and our profession.

With the Illinois legislature returning to Springfield for the fall veto session, a critical issue—renewal of the Medical Practice Act—is coming up. As many of you know, the Act historically has been renewed for ten-year increments, up until the last several years; the latest renewal was for only 13 months. One of the reasons for more frequent renewal has been a push by legislators and the Illinois Department of Public Health (IDPH) to raise the physician licensure fee from \$300 to \$600 every three years. This would be the first fee increase in 25 years. But something important is never mentioned when legislators talk about raising the fee: the fact that over the years the legislature has raided this fund to the tune of \$8 million and diverted monies to the general fund. There might not be a need for additional licensure revenue if the fee income hadn't been diverted from its intended purpose. The fee increase is the equivalent of a tax increase on physicians in Illinois. I'm not aware of the legislature requesting a fee increase on other licensed professionals.

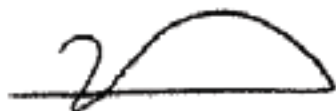
This is where the Chicago Medical Society (CMS) and Illinois State Medical Society (ISMS) are needed. Unless physicians speak up, this "tax" on our profession will become a reality. Both CMS and ISMS are working in Springfield to block the fee increase, as we did successfully last year, for the benefit of ALL Illinois physicians.

If made fully aware of the professional and financial benefits, I think many reluctant physicians would join organized medicine. Communicating value was the purpose of our Partnership for Membership Growth program, which exposed non-members to the work being done on their behalf to improve the climate of medicine. As part of this effort, CMS and ISMS hosted numerous educational programs and will continue to provide timely and relevant programming.

We are working to persuade employed physicians to join together and insist that their employers include organized medicine dues as part of their benefits package. While one shouldn't expect the hospital or employer to make a physician's best interests their primary focus, employers should be reminded that they, too, benefit from organized medicine. After all, hospitals will have to pay the increased licensure fees sought by IDPH, and will have to address declining reimbursements if the SGR is not repealed and replaced. Unfortunately, the current situation is such that non-member physicians reap the benefits of organized medicine without contributing financially to our efforts. As a result, those physicians who do join are required to pay a disproportionate share for our benefits and services, unlike union members.

While we have historically enjoyed a strong voice in Springfield, our strength might fade if medical societies can't attract and retain members. Organized medicine is not a trade union, and membership is voluntary. For this reason, every physician has an obligation to their profession and their patients to join and support our efforts to protect and maintain the doctor-patient relationship.

Now is the time to exercise your voice and encourage non-members to share the load. As the saying goes, "together we are stronger."



Howard Axe, MD

President, Chicago Medical Society

Chicago

MEDICINE

EDITORIAL & ART

EXECUTIVE DIRECTOR

Theodore D. Kanellakes

ART DIRECTOR

Thomas Miller | @thruform

CO-EDITOR/EDITORIAL

Elizabeth C. Sidney

CO-EDITOR/PRODUCTION

Scott Warner

CONTRIBUTORS

Howard Axe, MD; Aimee Greeter, MPH; Rick Langosch, FHFMA; Abel Kho, MD, MS; Theresa Walunas, PhD; Alina Baban; Bruce Japsen; Laurence A. Levine, MD; Kate L. Bechen, JD; Carolyn Fitzhugh McNiven, JD; Neelum T. Aggarwal, MD; Shyam Prabhakaran, MD; Bechara Choucair, MD; Devin D. Mehta, MD; William N. Werner, MD, MPH

CHICAGO MEDICAL SOCIETY

OFFICERS OF THE SOCIETY

PRESIDENT

Howard Axe, MD

PRESIDENT-ELECT

Robert W. Pantan, MD

SECRETARY

Kenneth G. Busch, MD

TREASURER

Phillip B. Dray, MD

CHAIRMAN OF THE COUNCIL

Kathy M. Tynus, MD

VICE-CHAIRMAN OF THE COUNCIL

Adrienne L. Fregia, MD

IMMEDIATE PAST PRESIDENT

Thomas M. Anderson, MD

CHICAGO MEDICINE

515 N. Dearborn St.

Chicago IL 60654

312-670-2550

www.cms.org

Chicago Medicine (ISSN 0009-3637) is published monthly for \$20 per year for members; \$30 per year for nonmembers, by the Chicago Medical Society, 515 N. Dearborn St. Chicago, Ill. 60654. Periodicals postage paid at Chicago, Ill. and additional mailing offices. Postmaster: Send address changes to Chicago Medicine, 515 N. Dearborn St., Chicago, IL 60654. Telephone: 312-670-2550. Copyright 2012, Chicago Medicine. All rights reserved.

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

—Dr. Reavis Eubanks



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

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

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

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

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

Visit www.athenahealth.com/ChicagoMed or call 800.981.5085

*ambulatory segment for practices with 11-75 physicians

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

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

Unprecedented Physician-owned ACO to Launch in Chicago

Docs have equal stakes **by Scott Warner**

THE FIRST-of-its-kind 100% physician owned Chicago Accountable Care Organization (ACO) will soon debut in Chicago.

Formed entirely by practicing physicians, the Independent Physicians ACO of Chicago aims to increase the quality of care, while reducing overall health expenditures for patients who have Medicare fee-for-service benefits.

“And it will also give independent physicians a chance to survive and compete in the challenging health care market,” said John Venetos, MD, ACO board member.

Only Just Begun

“So far 100 physicians have joined from ten different hospitals, and we’ve only just begun,” Dr. Venetos said. He

anticipates the new ACO will officially begin on Jan. 1.

Dr. Venetos explained that the new ACO has a unique feature in that it is owned equally by all of its physicians with no hospital or other entity as owners.

The ACO has partnered with an organization sponsored by a major insurance company that will share resources and coordinate patient care by:


- Assisting physicians in guiding their patients to timely, appropriate and comprehensive care that focuses on care coordination, expanded access and increased communication using innovative information systems.
- Providing the tools that transform a physician practice to offer a care model that focuses on the whole person and their family in all aspects of their

health care.

- Developing patient data profiles that assist patients and providers in determining their health care needs and current health status.
- Offering outreach methods that include a website and care reminders to assist patients and their families with achieving and maintaining wellness.

Sustainable Solution

“It is time for independent physicians to unite and establish an industry-leading organization that can create a sustainable health care solution for the future,” Dr. Venetos said.

He encourages physicians to contact him to find out more about the Independent Physicians’ ACO of Chicago. Call 847-975-1114 or email samv5161@aol.com. 

We do what no other medical liability insurer does. We reward loyalty at a level that is entirely unmatched. We honor years spent practicing good medicine with the Tribute® Plan. We salute a great career with an unrivaled monetary award. We give a standing ovation. We are your biggest fans. We are The Doctors Company.

We created the Tribute Plan to provide doctors with more than just a little gratitude for a career spent practicing good medicine. Now, the Tribute Plan has reached its five-year anniversary, and over 22,700 member physicians have qualified for a monetary award when they retire from the practice of medicine. More than 1,300 Tribute awards have already been distributed. So if you want an insurer that’s just as committed to honoring your career as it is to relentlessly defending your reputation, request more information today. Call our Chicago office at (800) 748-0465 or visit www.thedoctors.com/tribute.



Tribute Plan projections are not a forecast of future events or a guarantee of future balance amounts. For additional details, see www.thedoctors.com/tribute.

Physician Engagement Key to Alignment

Docs' trust is crucial by Aimee Greeter, MPH, and Rick Langosch, FHFMA

DURING THIS unstable time in health care, the way of the future appears to be physician alignment. Indeed, many health care entities are choosing to consolidate with private physician practices or align themselves with physician practices or health systems as a way to secure their futures. Alignment is not easy, however, and the process can be wrought with confusion and turmoil, particularly when the initiative involves a practice and a health system. For physician practices, the involvement of its doctors throughout the process should be maximized to ensure the best possible outcomes. Here are three critical steps in the alignment process that call for active physician engagement.

- Selecting outside assistance.
- Deciding on the alignment model.
- Serving as the “face” of the practice during negotiations with the health system.

Outside Assistance

First, it is important to ensure that physicians are included in the selection process of any outside assistance, including consultants and legal counsel. Advisors will be acting as representatives of the practice, and as a result, must have the full trust of the physicians. One way to ensure this trust is for the physicians to select those who will be assisting them during this process. While the practice administrator may create a short list of possible representatives, it is imperative that physicians make the final selection on their advisors. Typically, this decision is preceded by conference calls, video conferences, or in-person meetings where physicians interview potential candidates and make an informed decision.

Alignment Model

Next, physicians must be involved in the selection of the alignment model. A number of viable physician/hospital alignment structures are currently being used across the nation. Employment is one option. Also gaining popularity are various forms of professional service agreements, often referred to as PSAs. Even more moderate forms of alignment, such as clinical co-management or service line management agreements, are becoming popular alternatives to full employment.

Because of the myriad options that exist, physicians must first define their goals and desired outcomes, and what they hope to achieve as a

result of alignment with a health system partner.

Next, they must understand what options exist relative to the alignment structure, and which options best fit their stated goals. It is the physicians who must make the ultimate decision on which model they will pursue in earnest.

This level of involvement minimizes the chance that physicians will experience “buyer’s remorse,” feeling unsatisfied with the depth of the alignment relationship once it is in place. Engagement throughout the process is one way to avoid this pitfall!


Practice Representation

Finally, one or two physician representatives should be physically present during key negotiations with the health system as the deal structure is being developed. While the physicians do not have to actively participate in the negotiations dialogue, having them present and adding appropriate “color commentary” on key issues highlights the importance of these matters. Having the physicians take a stance on controversial items may ultimately increase the odds that the health system will agree to the practice’s proposed terms (or at least help the health system move off their original position).

“It is important to ensure that physicians are included in the selection process for any outside assistance, including consultants and legal counsel.”

Conclusion

In summary, physician engagement throughout the alignment process ensures a successful transaction, both in the immediate and long term. The trend of viable hospitals/health systems employing or aligning closely with its physicians is very apparent. The pendulum has swung back over the past 15 years when many hospitals approached physicians for alignment and then sought to transition them back to the community as entrepreneurs. The “pendulum” (outright employment) now occurs for nearly 50% of all doctors and an estimated 65% for those physicians finishing up medical school/fellowships.

For more information on engaging your physicians during the alignment process, please contact Aimee Greeter at agreeter@cokergroup.com or Rick Langosch, service line leader-practice management at Coker Group, rlangosch@cokergroup.com. 

Moving Forward with Meaningful Use

Planning for 2014 by Theresa Walunas, PhD, and Abel Kho, MD, MS

Would you like more information about how you can achieve Meaningful Use? Join CHITREC for a workshop. Learn more and sign up at www.chitrec.org/events.

MEANINGFUL USE (MU) Stage 2 has been finalized. Last month we provided an in-depth overview of the changes between Stage 1 and Stage 2 and how they might impact your practice. This month we review more details for program implementation and discuss how you can plan for the electronic health records (EHR) incentive programs and avoid Medicare penalties.

Stage 2 Changes that Can Be Implemented in Stage 1 for 2013

Even while you're working on meeting Meaningful Use Stage 1, it's not too early to begin thinking about MU Stage 2. No one is required to meet the Stage 2 measures until 2014, but some measures can be adopted in 2013 if they benefit your practice.

It is a good idea to review the new requirements for these measures and determine whether early adoption makes sense for you. See Table 1 for the major changes in Stage 2 that don't involve alterations to the measure

thresholds—other changes were discussed in the October issue.

Another 2013 consideration for physicians participating in the Medicaid incentive program: patient volume calculation has changed. Now you will be able to include any encounter with patients enrolled in Medicaid at the time of service, even without the requirement of Medicaid payment liability.

In addition, Children's Health Insurance Program (CHIP) patients can be included in patient volume when CHIP is offered as part of a Medicaid expansion under Title 19 or 21—which is the case in Illinois. This should be a significant benefit to many pediatricians who are generally not eligible for the Medicare incentive program.

What's Coming in 2014?

2014 will be a big year for EHR Incentive programs. The implementation of Stage 2 requires that EHR vendors be recertified to demonstrate compliance with Stage 2 measures and that physicians participating in the incentive programs upgrade their EHR to the Stage 2 certified version.

That means you'll be working with your EHR vendor to plan an upgrade path and timeline for your practice so you can meet MU Stage 2 requirements. Also, 2014 marks a change in how information is reported. For the Medicare incentive program, practices will

Table 1
Stage 2 Changes That Can Be Implemented In Stage 1

Measure	Stage 1 Requirement	Stage 2 Requirement
Computerized Physician Order Entry (CPOE)	Denominator: unique patients with at least one medication in their medication list	Denominator: number of orders in the reporting period
Vital Signs	Age Limits: Age 2 for blood pressure, height and weight Exclusion: All three elements not relevant to scope of practice	Age Limits: Age 3 for blood pressure, none for height and weight Exclusion: Blood pressure can be separated from height and weight
Test of Electronic Transmission of Key Clinical Information	Required	Requirement Removed for 2013

Table 2

Medicare Payment Adjustments For Non-Meaningful Users Starting In 2015

% Physicians at MU	2015	2016	2017	2018	2019	2020+
<75% Physicians are at MU	99%	98%	97%	96%	95%	95%
>75% Physicians are at MU	99%	98%	97%	97%	97%	97%

have the option of submitting batch data for all participants in the practice instead of submitting the data individually, which decreases the time it takes to report. For Medicaid, practices will still have to attest using the tools provided by the state of Illinois.

To accommodate the EHR upgrade, all incentive program participants will only be required to report on MU in a three-month window in 2014, regardless of when they started the program, in which program they are participating, and what stage they are working on.

This means participating providers have less reporting and more of a chance to comfortably meet MU standards.

In addition, Clinical Quality Measure (CQM) data will be submitted electronically, starting in 2014, through a streamlined process intended to align federal programs and reduce reporting burden. Participants in the Medicare incentive program will report CQMs in defined calendar quarters. Participants in the Illinois Medicaid EHR incentive program should follow the reporting requirements defined by the Illinois Department of Healthcare and Family Services (HFS) for CQM reporting.

Avoiding Medicare Payment Penalties in 2015

To drive MU of EHRs, Congress established penalties to Medicare payments, starting in 2015, to physicians who don't demonstrate adoption and MU of EHRs. While you might be nervous about this possibility, you can relax and know that if you take the right steps, you will receive your full payments.

To avoid penalties, all physicians are required to attest to MU by Oct. 1, 2014, which means you must start a three-month reporting period no later than July 1, 2014. And you must continue to demonstrate MU every subsequent year in order to avoid payment adjustments (Table 2).


The Medicare penalty applies to those who don't achieve meaningful use, regardless of whether you participate in the Medicare or Medicaid incentive

programs. Although the timeline is aggressive, the application of penalties is not absolute. Physicians can apply for hardship exceptions by July 1 in any year, if certain conditions apply.

“Another 2013 consideration for physicians participating in the Medicaid incentive program: patient volume calculation has changed. Now you will be able to include any encounter with patients enrolled in Medicaid at the time of service, even without the requirement of Medicaid payment liability.”

A word of warning for Medicaid program participants: while the Adopt Implement Upgrade (AIU) year— the year you first start using a certified EHR—counts towards receiving incentive payments, it does not qualify for demonstrating MU to avoid the Medicare payment penalties. If you see both Medicare and Medicaid patients and wish to avoid the penalty in 2015, you must demonstrate AIU no later than 2013 so you can report on your first MU year in 2014.

The coming of MU Stage 2 and the Medicare payment penalties will bring challenges, but with good advance planning, any practice can succeed. If you have questions or would like assistance, CHITREC is here to help. Feel free to contact us at info@chitrec.org and we'd be happy to help you prepare to meet MU.

Dr. Kho is an internist and co-executive director of the Chicago Health IT Regional Extension Center (www.chitrec.org). Theresa Walunas is the director of operations of CHITREC and an advisory group member of the Regional Extension Center's community of practice on Meaningful Use. CHITREC is federally funded to directly assist providers in Chicago achieve meaningful use of electronic health cords. 

The Paid Time Off Bank Model

Is this model right for your office? by Alina Baban, Chair, Practice Manager Section

H EALTH CARE organizations are regularly faced with the decision of choosing the right model to compensate their employees for paid time off. Two models are commonly used; the traditional model, which separates time-off according to categories of vacation, sickness, or personal time, and a general bank of paid time off (PTO). More health care organizations are shifting away from the traditional model to a PTO-bank model. WorldatWork, a not-for-profit organization that provides education, conferences, and research focused on global human resources, conducted a survey in 2010 that analyzed paid time off models in the United States. The survey found that even though traditional systems were more common

“PTO models can give your practice a competitive advantage if constructed wisely.”

outside of health care organizations, PTO models were steadily increasing and made up 80% of models implemented in health care organizations. What does this mean for practice managers? It means that before we uproot our traditional models and follow the trend toward PTO-bank models, we need to look at the advantages and disadvantages of a PTO model, and decide what works best for our individual practices. The decision to switch is not easy, and may not be right for every practice, but PTO models can give your practice a competitive advantage if constructed wisely.

Advantages of PTO Bank Model

It will minimize administrative work. Practice managers no longer have to track the why of an absence, but just worry about the when. It not only makes tracking easier, it also relieves managers from making judgments about how employees

use their down time. It eliminates the occasional doubts that may creep into our minds, but stay tightly sealed behind our lips.

PTO allows employees to take time off at their own discretion, which creates greater equality and a more appealing benefit package. Employees who never use sick time are rewarded with the ability to use the days allocated in their PTO bank as they wish.


When an effective PTO policy is in place, practice managers have more control over absences than they would with the traditional time off model. Many unscheduled absences can be eliminated if a two-day notice is required. Let's face it; some employees feel entitled to payment for the sick days granted to them on a yearly basis, which can account for some unplanned absences. Switching to a PTO model will decrease those absences, and create more stability in the schedule.

Disadvantages

There could be a potential cost increase to the practice. Some states, such as Illinois, require payment of vacation and personal days following termination. Traditional paid time off separates sick days, which are not legally required to be paid at termination. If staff turnover is high in your organization, your practice will incur additional charges for the PTO days that require payment.

When all PTO is viewed as vacation time, employees may have difficulty managing their time. Some employees may not be as willing to use their time off for sickness, which means they may come to work sick.

To determine which paid time off model is right for your practice, you must closely analyze your absenteeism patterns and costs. If your practice has a high number of employees with unplanned absences, a PTO bank model may help significantly decrease those absences. Creating a solid paid time off policy can create a more competitive benefit package, and ultimately show your employees you value their time.

Ms. Baban is co-founder and chief operating officer of Medical Device Provider, Inc., executive office manager for Medical Arts Unlimited, Corp., a comprehensive medical practice, and president of Precision Provider Services, Inc., a management consulting company. She also cares directly for patients as an allergy/immunotherapy surgical technician, and holds certification in medical coding and billing. Ms. Baban's background includes an undergraduate degree in biology and chemistry from the University of Illinois at Chicago. She is currently pursuing a master's degree in healthcare administration. 

Meet Your Practice Manager 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 discounted dues 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.

“As physicians, we have so many unknowns coming our way...

One thing I am certain about is my malpractice protection.”

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians:
our choice of a liability partner.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

I believe in fair treatment—and I get it.



To learn how we can help you lessen the uncertainties you face in medicine, scan the code with your smartphone camera.



Professional Liability Insurance & Risk Management Services

ProAssurance Group is rated **A (Excellent)** by A.M. Best.
www.ProAssurance.com.



CMS Insurance Agency, Inc.

For more information, please call our staff at 312.670.2550.

Quality Control?

Docs feel squeeze as insurers push high-performance networks by Bruce Japsen

AS THE NEW federal health care law pushes insurance companies to spend more on health care while providing better medical service, they are narrowing their lists of doctors and hospitals and demanding higher quality standards.

For some physicians and hospitals, it could mean they are on the outside looking in on a trend sweeping the health insurance industry that sends more patients and consumers to what these health plans deem are the best performers.

And for their patients, it can mean fewer choices of medical care providers. But the hope of health plans like Blue Cross and Blue Shield of Illinois, UnitedHealth Group, among others, is that consumers will be left with better medical care from the narrow list of higher-rated doctors and hospitals at a lower price.

The message to doctors and hospitals is that network participation will be based on quality measurements, which is a dramatic departure from the norms of the past when cost largely ruled the day. Doctors will not be kicked out of health plan networks if they are poor performers, but they could end up with fewer patients, insurers say.

"This is a phenomenon that is increasing in both demand but also in terms of sophistication in how we are measuring, evaluating and compensating," said Dr. Sam Ho, chief medical officer of Minneapolis-based health insurance giant UnitedHealth Group, parent of United Healthcare of Illinois.

"You have an opportunity if you are compared to benchmarks. You will be in our competitive high-performance networks and have access to more patients," Dr. Ho said, referring to physicians and other providers.

Pressure to Change

The move toward more narrow networks is brought on by continuing pressure from employers, taxpayers, and insurance companies to control costs. The thinking is that a narrow network is more easily controlled and includes the best providers who get the care right the first time.

In addition, insurance companies will be under more pressure to keep a lid on medical expenses under new rules established by the *Affordable Care Act* signed into law two years ago by President Obama.

The law requires state-regulated health plans, essentially those that sell policies to individuals and small businesses, to spend at least 80% of premium dollars on medical care. This new requirement, which has already taken effect, is squeezing the profits of health plans. And so these insurance companies are using quality measurements and related new standards to narrow their networks, or essentially trim back choices of doctors and hospitals to control costs by limiting the size and scope.

Both UnitedHealth and Illinois Blue Cross, for example, are creating new insurance products with narrow networks that will be offered to consumers on the state-regulated exchanges that begin operating in each state in 2014. At that time, millions of Americans without health insurance will gain subsidies to buy coverage under the law.

"Narrow networks can provide greater value to the individual consumer," said Steve Hamman, vice president of network management at Blue Cross and Blue Shield of Illinois, the state's largest health insurance company with more than 7.3 million health plan members.

Hamman said one of the insurer's narrow network plans is BlueChoice, which offers a wide number of choices but attempts to avoid duplication.

The BlueChoice product is 10-15% less costly to the individual policyholder than plans with a broader network, Hamman said. "If you can channel more members to a pharmacy, physician, and hospital system—you get a greater discount in exchange," Hamman said.

For example, there are about a half dozen academic medical centers in Chicago, but as of November, BlueChoice included the University of Chicago Medicine, Loyola University Medical Center, and NorthShore University HealthSystem. Patients cannot, for example, get the same level of benefits from Northwestern Memorial Hospital or Rush University Medical Center because they are not in the BlueChoice narrow network.

Benchmarks Must Be Met

Under a narrow network, providers of medical care will have to meet certain benchmarks for both inpatient and outpatient care. Health plans say they are using national independent quality measures such as "HEDIS" that have input from organized medical groups and researchers.

For example, a doctor who does a better job making sure his female patients are screened for breast cancer is more likely to be in the insurance company's narrow network than the doctor whose patients are not getting their regular screenings. Doctors are compared to a peer control group, insurance companies say.

In addition, hospitals that have fewer patient readmissions within 30 days of a patient's initial procedure will also have a better chance of being in the narrow network, or what UnitedHealth calls its "high-performance network."

UnitedHealth executives report their measures have helped reduce re-admissions of commercially insured patients to less than 8% of enrollees. Meanwhile, enrollees in UnitedHealth's Medicare Advantage plans are re-admitted to the hospital less than 14% of the time.

By comparison, 20%—or one in five—patients in traditional Medicare are re-admitted to hospitals within 30 days because of complications, errors, and other problems. Because of the high-re-admissions in traditional Medicare, the federal government in October of this year began penalizing hospitals for high patient re-admission rates.

"We are ahead of the curve," Dr. Ho said. "It is a quality and a cost-efficiency indicator. Nobody wants to be in the hospital unless they have to be."

UnitedHealth said doctors are not kicked out of its networks if they don't perform as well as physicians who are considered of higher quality. Rather, they can remain an option for patients in a higher-cost network.

Loyalty a Factor

"Nobody is going to be excluded from any network," Dr. Ho said. "There are many patients and providers who are going to stay loyal to their hospital or doctor and

they will have an opportunity to buy-up.”

Some doctor groups are leery of the concept and urge physicians and their patients to monitor closely how physicians are rated.

“Too often, there are serious accuracy problems with the physicians ratings used by health insurers to develop tiered or narrow networks,” said Dr. Jeremy Lazarus, the president of the American Medical Association. “The AMA remains concerned with the accuracy of evaluation techniques used by insurers to assess individual physicians.”

The AMA and other doctor groups urge transparency by insurance companies in how the ratings are conducted, citing concerns about the methodologies used to make insurers’ preferred choices list.

“Patients should always be able to trust that insurers are providing accurate and reliable information on physicians, yet some insurers offer economic evaluations of individual physicians that are more often wrong than right,” Dr. Lazarus added. “Transparent, accurate information is critical when patients select a physician through a tiered network. Patients deserve to know that insurers are offering physician ratings that have a high risk of error and should not be the sole basis for selecting a physician.”

Some physicians and organized medical associations also worry doctors could be penalized simply for caring for a population that tends to need more care, such as seniors. That, these physicians say, could negatively impact ratings of the doctor or hospital merely because the repeat visits are for sick patients rather than a reflection of the quality of care provided.

“Narrow networks are a health plan strategy to control costs,” said Dr. Glen Stream, president of the American Academy of Family Physicians. “We believe they would have better leverage in controlling total costs if they put resources into fortifying their primary care network and providing community support for better care coordination.”

Will Docs Come Around?

But health plans say they are confident doctors will come around to the narrow networks. Blue Cross and Blue Shield of Illinois reports that health care systems in Chicago are on board with the narrow network and some are in discussions with the insurer to co-brand a network by lending the provider’s name to an

insurance product.


Illinois Blue Cross’ Hamman would not disclose which health systems were likely to co-brand an insurance product with Illinois Blue Cross but he said the insurer is talking to several medical care providers.

“We are heavily exploring the concept of co-branded products with health systems,” Hamman told *Chicago Medicine* magazine. “The concept of being a micro-network is starting to gain a lot of interest,” he added.

In addition, UnitedHealth said doctors who are in the narrow “high-performance network” will have an opportunity to reap more patients and therefore increase their income.

“If you really want to have the most accessible source of patients and consumers, you will be in the network where insurance products will be offered at a much more affordable price point,” Dr. Ho said.

“Doctors can benefit.”

Bruce Japsen is an independent Chicago health care journalist and a contributor to the New York Times and health care writer for Forbes. He was health care business reporter at the Chicago Tribune for 13 years and is a regular television analyst for WTTW’s Chicago Tonight, CBS’ WBBM radio 780-AM and 105.9 FM and WBEZ’s 848 program. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com. 

A Bipartisan Outlook

What's the future for physicians under the Affordable Care Act? by Bruce Japsen

No matter the fate of the *Affordable Care Act* and how it is carried out, physicians will face changes that will bundle their payments and push them toward new reimbursement models that are likely to require expert advice on everything from contracts to regulatory legalese.

In a bipartisan hour-long podcast sponsored by the Chicago Medical Society and the Health Law Section of the American Bar Association, a forecast outlining such future change known as Obamacare, offered doctors advice, consultation, and tips on how to prepare for life with or without the landmark legislation.

Dr. Donald Palmisano, a Louisiana surgeon and former American Medical Association president, who is an outspoken critic of the Obama administration's health law, and former Obama health care advisor and Affordable Care Act supporter Dr. Stephen Ondra, senior vice president and chief medical officer at Northwestern Memorial Hospital in Chicago, addressed 60 attorneys and doctors on a conference call last month.

The information provided by Drs. Palmisano and Ondra on the podcast comes as attorneys, physicians, other medical care providers and those who work with them brace for dramatic change following this past summer's decision by the U.S. Supreme Court to uphold much of the Affordable Care Act.

"For the first time in the health care industry, there will be winners, there will be big winners, there will be small winners and there will probably be some losers," said Dr. Ondra, who worked for the White House as senior health care advisor to Obama's administration.

"Enter with eyes that are wide open. (The law) will be both changed and refined."

Doctors as Employees?

While both doctors disagreed with tenets of the sweeping federal health legislation, both said physicians should prepare for a future where the law, as well as economic forces in the private sector, will push doctors toward being employees rather than being independent and self-employed.

Dr. Palmisano cited recent surveys of doctors, including one by The Physicians Foundation that showed physicians are working fewer hours and treating fewer patients than four years ago. Meanwhile, more doctors are selling their practices to larger groups or hospitals and going to work for someone else rather than spending money to upgrade their practices with the latest technology for electronic medical records. For example, more than one-third of physicians polled in the

Physicians Foundation survey said they did not have the funds they needed to put electronic medical records in their practices.

Just one-third of doctors are projected to be independent by 2013, the Physicians Foundation survey showed. In 2000, almost 60% of physicians were independent.

"They may consider joining a hospital or large medical clinic," Dr. Palmisano said.

Once physicians become hospital or clinic employees, they may lose autonomy that includes access to their patient records and files, Dr. Palmisano said. Therefore, these newly employed physicians may be unable to have or control outside business or consulting relationships with device or drug companies or other businesses.

"The prudent thing to do is hire a lawyer specialized in contract negotiation," said Dr. Palmisano, who in addition to being a long-time New Orleans area general surgeon is also an attorney and was one of the AMA's key point people in the doctors' groups many battles with health insurance companies over patients rights legislation and liability reform.

"Doctors need to know their rights should they go to work for someone else," Dr. Palmisano added. "AMA has an excellent brochure that deals with contracting. It goes through many issues that many physicians will want to know about."

Depending on the makeup of Congress and given federal budget constraints, both Dr. Palmisano and Dr. Ondra believe that there could be changes in the health law. Doctors may then want to get out of their employment relationship. Therefore, doctors should have an out in their contract with a future prospective employer, Dr. Palmisano said.

Know How You Part

"Always have a break-up clause in there," Dr. Palmisano said of a potential employment relationship with a hospital, clinic, or health system. "It's not that you are bad or they were bad. You just need to know how you part."

In joining a larger organization, doctors that become employees may find themselves taking on more financial risk.

The Affordable Care Act, for example, encourages so-called "Accountable Care Organizations," or ACOs, and patient-centered medical homes. Such new forms of health care delivery are also being encouraged by private health insurance companies.

To be sure, most major insurers such as UnitedHealth Group, Aetna, Inc., Humana, Inc. (HUM), and most Blue Cross and Blue Shield plans have various efforts underway whereby they pay primary care physicians who coordinate services

with specialists, pharmacists, or other providers of medical care. State Medicaid programs do the same and the Obama administration has pilot medical-home projects in the Medicare program for seniors using medical homes.

The health law as well as demands by private insurers and employers is placing a greater emphasis on a team approach to medical care that makes more doctors accountable for medical errors and quality improvement.

Most major health insurance companies are already paying more bundled payments to doctor practices, rewarding them if they work together to keep patients healthy and out of the more expensive hospital setting.

In Arkansas, for example, Dr. Ondra said both government and private insurance companies like Blue Cross and Blue Shield of Arkansas are moving predominantly to bundled payments.

Payers are moving from a fee-for-service model, “where the more you do, the more you are paid” to a “value-based system where there is risk sharing,” Dr. Ondra said. It’s a move from volume to “value-based care,” Dr. Ondra added.

The government-led ACO program under the *Affordable Care Act* works with the Medicare health insurance program for the elderly, contracting with doctors and hospitals through an ACO which, in turn, pushes high quality, and less expensive care rather than today’s payment system that often leads to excessive care by paying for each treatment or procedure that isn’t always better. The providers in an ACO are responsible for managing the care of the health plan enrollees and are financially rewarded if the enrollees, or patients, stay out of the more expensive hospital.

Already, more than 150 new groups of medical care providers across the country, including Chicago’s Advocate Health Care, have been attracted to Medicare’s ACO effort.

If the providers in the ACO achieve better outcomes, they divvy up money saved with the government’s program known as the “Medicare Shared Savings Program.”

No matter how the *Affordable Care Act* may be changed following the general election, value-based care and bundled payments through ACOs will become common no matter who is in Congress or the White House.

Shift to Value-Based Care

“If you look at the political right, left (and private insurers)... everybody is moving to value-based care in some form,” Dr. Ondra said.

“Health care is going to continue to change,” Dr. Ondra added. “Value-based incentives to reimburse physicians will increase. That is coming from all directions.”

Dr. Palmisano urged doctors to pay close attention to the kinds of relationships and measures that are going to be used through ACOs and bundled

payments.

In October of this year, for example, Medicare began penalizing hospitals for patients who are re-admitted to their facilities within 30 days after discharge. Dr. Palmisano said it is unclear whether that could result in financial repercussions to a physician.

Dr. Palmisano said pilot programs and studies should be conducted to track patients who are not re-admitted.

“If you re-admit patients within 30 days after discharge . . . there is less payment to you,” Dr. Palmisano said. “That may save money at the hospital level, but what about the patient? Who is tracking the patient?”

Dr. Ondra said doctors should prepare for quality measures and bundled payments by “getting experience at how to improve health.”

If you have a population of patients that tend to be sick, work at ways to keep them healthy and out of the hospital. “Mitigate the loss you are exposed to,” Dr. Ondra said.


Don’t Count on Government

Both Dr. Ondra and Dr. Palmisano agreed that innovations to improve health care within the framework of the *Affordable Care Act* will not come from the government.

Though many physicians such as Dr. Palmisano were upset that the law did not include medical liability reform and caps on noneconomic damages, the law does include demonstration projects such as private courts and panels designed to reduce the cost of liability and lead to improved “conflict resolution.”

They both urged physicians to be wary of the new rules and not be caught off guard.

“Hopefully, it will be both changed and refined,” Dr. Ondra said of the potential for future changes to the *Affordable Care Act*. It will be changed and refined over time. “This will have to come from the bottom up.”

Editors note: This story was based on an hour-long conference call and subsequent podcast hosted by the Chicago Medical Society and the American Bar Association’s Health Law Section that was attended by more than 60 interested doctors and attorneys from across the country. The teleconference was moderated by Julian Rivera, an ABA member and partner at the law firm McCarroll of Austin, Texas. Physicians with questions can e-mail Mr. Rivera at jrivera@brownmccarroll.com. The story written based on the podcast was by Bruce Japsen, an independent national health care journalist based in Chicago and contributor to Chicago Medicine. Japsen also writes health care stories for the New York Times, the Medicare News Group and has a health care policy and business blog for Forbes at www.blogs.forbes.com/brucejapsen. Japsen can be reached at brucejapsen@gmail.com. 

“Physicians should prepare for a future where the law, as well as economic forces in the private sector, will push doctors toward being employees rather than being independent and self-employed.”

Urological Men's Health Review

It's time to recognize that it's manly to be healthy **by Laurence A. Levine, MD**

MEN'S HEALTH has emerged as the new buzzwords in medicine. Attention to this concept as a new medical subspecialty comes as a result of baby boomers living longer and demanding a higher quality life. Men have traditionally had limited contact with physicians until the "wheels fell off." There are many reasons for this delay in seeking care, which include social taboos, embarrassment, fear, and the desire to avoid appearing vulnerable or weak. This article focuses on the urological aspect of men's health, including: hypogonadism, erectile dysfunction, and prostate disorders.

Hypogonadism

Male hypogonadism is defined as a reduction in testosterone production in association with clinical symptoms. There are two types of hypogonadism: primary, which refers to testicular failure, and secondary due to hypothalamic and/or pituitary dysfunction. It can be multifactorial, and is most commonly associated with aging, stress, chronic illness, and medication. Most important, this is not a rare problem. In fact, a recent demographic study screened over 2,100 men for hypogonadism (defined as total morning testosterone levels less than 300 ng/dL). Almost 39% of those over age 45 satisfied this criterion.

All components of testosterone decrease with age, beginning in a man's early 30s. By extrapolating this figure to the adult male population in the United States, it appears that over 14 million men are hypogonadal.

The significance of hypogonadism to overall health is best represented by four large, longitudinal studies that demonstrated a higher mortality rate in men with low testosterone. These studies consistently showed that men with the lowest levels of testosterone had a higher risk of early death.

In a meta-analysis of 820 studies, all causes of mortality were found to be higher in older subjects, but also in those with lower testosterone levels. The meta-analysis concluded that, due to study heterogeneity, low testosterone is likely a marker of general health, but the higher mortality rates in these men may be associated with other comorbidities.

The important HIM study (Hypogonadism in Men) demonstrated the higher risk of hypogonadism in men with commonly encountered comorbidities, including: hypertension, hyperlipidemia, diabetes, obesity, asthma, HIV/AIDS, and those on chronic opioids.

The relationship between low testosterone and metabolic syndrome has been recognized as

a complex bidirectional process that is related to visceral adiposity, hypertension, dyslipidemia, hyperglycemia, and insulin resistance. Several studies have demonstrated that men with low testosterone are three times more likely to have or to develop metabolic syndrome, and are at higher risk for cardiovascular disease. In fact, testosterone replacement has been shown to improve metabolic syndrome components, including: lower fasting glucose, HbA1c, fasting insulin, waist circumference, BMI, cholesterol, and prevalence of metabolic syndrome after one year.

Testosterone has historically been associated with sexual function, but today we recognize that it may be the single best indicator of a man's health status, as it is associated with so many important organic functions, including: preservation of bone mineral density, erythropoiesis, muscle mass, cognitive function, energy, and general sense of well-being.

The role of testosterone in sexual function is not completely understood, but it does appear that this hormone is necessary for nitric oxide synthase activity, and necessary for nocturnal, but not sexually induced, erections. Up to 40% of men with erectile dysfunction who do not respond to PDE5 inhibitors (sildenafil, tadalafil, vardenafil) and have low testosterone have been found to recover their response to the erectogenic agents when testosterone is replaced.

The diagnosis of hypogonadism remains a challenge for the practitioner. Various guidelines have been issued by many societies around the world. The general consensus is that total testosterone levels of less than 300 ng/dL and free testosterone below 50 ng/dL are consistent with hypogonadism, and warrant treatment.

How Should We Determine a Patient's Testosterone Level?

The best time to obtain a blood test is in the morning hours (8 a.m.-12:00 noon), when testosterone is apt to be highest. This diurnal variation tends to be less of a concern in older men, since it flattens with aging. In my practice I obtain total testosterone any time of day when screening for low T. Remember—it's hard enough to get men to come see the doctor. If this test yields borderline results or is below normal, then repeat the total testosterone in the morning with free testosterone, luteinizing hormone, and estradiol. If the total testosterone is below 150, then prolactin, serum ferritin, and pituitary MRI assessment would also be in order.

An interesting study recently demonstrated that the predictability of total testosterone for normal

free testosterone fell off between 300 to 400 ng/dL. Therefore, patients who are in the low-normal range of total testosterone (<400 ng/dL) may not have normal free testosterone, the biologically active component of this hormone. It was recognized recently that the androgen receptor can have significant genetic variability, as manifested by the number of CAG repeats. A higher number of CAG repeats is associated with a less sensitive androgen receptor. The clinical presentation of this situation occurs when the patient presents with clear symptoms of hypogonadism but has a low-normal or normal total and/or free testosterone. Unfortunately, assessment of CAG repeats is not commercially available. My recommendation is that if the patient is symptomatic and has borderline T levels (<400 mg/dl), then it is reasonable and safe to offer a short course of testosterone replacement to determine the clinical response.

How Should We Screen for Low Testosterone?

Screening by age alone (say over 45 years) would seem too broad and costly. Screening by symptoms would be reasonable, but there are no pathognomonic symptoms. Currently, the best approach to enhancing our identification of hypogonadism appears to be screening those men with specific and common comorbidities, those who are at greatest risk of having low T, as suggested by the 2010 Endocrine Society Guidelines. This would include men with type II diabetes, obesity, osteoporosis, moderate to severe COPD, HIV, kidney failure, and chronic opioid use. The symptoms associated with hypogonadism are well recognized but, as noted, are non-specific, including: loss of libido, diminished erections, mood change, easy fatigability, loss of muscle mass and strength, and occasionally regression of secondary sexual characteristics. A variety of questionnaires can help during the screening process.

The benefits of testosterone replacement have been well demonstrated in a variety of studies. They include increased energy and mood, improved body composition by reducing fat mass while increasing lean body mass, and possibly increased muscle strength. Additional benefits are restoration of libido and erectile function and increased bone mineral density, which may reduce future hip and spine fractures.

Treatment options with testosterone in the United States include intramuscular injections, transdermal patches, transdermal gels, gingival patches, axillary solutions, and pellet implants. Oral tablets containing methyltestosterone are not recommended, as they can have significant adverse effects on liver function and can cause liver disease. Intramuscular injection therapy may be associated with higher risk of gynecomastia, polycythemia, and fluid retention because of the frequent supraphysiologic and hypophysiologic

levels that occur with this treatment option.

Problems occur with other forms of testosterone treatment, but are markedly less frequent with gels, patches, and pellet implantation, because testosterone levels remain stable and within normal range. Men receiving testosterone must undergo proper baseline evaluation and monitoring, which would include: CBC, PSA, digital rectal exam, and periodic estradiol assessment. The incidence of

“Hypogonadism is not a rare disorder. It is under-recognized, under-diagnosed, and as a result, under-treated.”

polycythemia is generally less than 5% with topical applications of testosterone.

One of the greatest fears preventing physicians from initiating testosterone replacement is the concern that testosterone causes prostate cancer. Yet multiple studies have uncovered no clear evidence that TRT increases the risk of prostate cancer. In fact, recent reports demonstrate that men successfully treated for prostate cancer, by radical prostatectomy in particular, and who have non-detectable PSA, can be successfully treated with testosterone replacement with very low risk of prostate cancer recurrence.

In summary, hypogonadism is not a rare disorder. It is under-recognized, under-diagnosed, and as a result, under-treated. Androgen deficiency has a significant impact on physical, psychological and sexual function, since it increases the risk for bone loss, metabolic syndrome/diabetes, cardiovascular disease, obesity, and mortality.

Measurement of total testosterone, preferably in the morning, is the starting point for hypogonadism screening. There is substantial clinical evidence supporting the safety of testosterone replacement therapy for lowering lipid levels, the risk of cardiovascular and prostate cancer, as well as the restoration of sexual function, improved mood, increased bone mineral density, and improved metabolic syndrome and type II diabetes parameters.

Erectile Dysfunction

Erectile dysfunction is certainly not a rare problem. In fact, the Massachusetts Male Aging Study in 1994 demonstrated that 52% of men over age 40 had some evidence of erectile dysfunction, which increased in severity and prevalence with aging. An erection is a complex neurovascular event that must occur in the proper psychosocial and hormonal environment.

Historically, ED was thought to be primarily a psychological problem. We now recognize that in 80-90% of patients, ED is primarily organic, and contributed to by certain risk factors that accelerate vascular aging. These “erection busters” include high blood pressure, dyslipidemia, diabetes,

smoking, low testosterone, depression, and obesity. Erectile dysfunction is also a frequent sequelae following treatment of prostate cancer with either surgery or radiation.

ED primarily occurs as a result of vascular changes, where oxidative stress results in endothelial cell injury. Studies have demonstrated that men presenting with ED may be signaling serious underlying disease that has not been diagnosed, including: diabetes, hypertension, dyslipidemia,

“Erectile dysfunction significantly affects the self-esteem, self-confidence, and quality of life for men and their partners. It usually has an organic basis and may signal or accompany serious systemic illness, including: diabetes, hypertension, cardiovascular disease and neurologic disorders. ED is usually easy to diagnose and treat.”

cardiovascular disease, and neurologic disorders. Therefore, questions about sexual function should be part of every systems review for adult males. Multiple studies have suggested that ED be considered as a marker for acute myocardial infarction, or for coronary artery disease. In fact, one important study demonstrated that men who presented with chest pain and documented coronary artery disease had an ED prevalence of 49%, and that 67% had ED symptoms before their coronary symptoms, at a mean interval of 39 months before the onset of their coronary symptoms.

Diagnosing erectile dysfunction should be quick and efficient. A basic history is obtained, and a physical examination is performed focusing on evidence of proper virilization, satisfactory pulses in the femoral area, a penile exam ruling out the presence of Peyronie’s disease, and a testicular exam. Lab studies should include serum glucose, lipid, and testosterone.

When the interview is direct and physician initiated, the whole process may take as little as five to seven minutes. By taking control, we are less likely to be caught at the end of our consultation with the schedule-busting, “Oh, by the way doc, I have ED.”

Treatment options for erectile dysfunction are well recognized and should take a stepwise approach. When an organic cause of erectile dysfunction is suspected, first line therapy includes oral erectogenic agents (sildenafil, tadalafil, vardenafil), vacuum constriction devices, hormone replacement with testosterone if indicated, and couples or psychosexual therapy. When these approaches either fail, are contraindicated, or result in complications, second line therapy includes intracavernosal injection therapy with

vasodilating agents, or intraurethral alprostadil. Finally, men who fail all these approaches and wish to have an erection on demand, much as they did as younger men, should consider surgical penile prosthesis implantation. Penile implants have been around for over 40 years, with more than 600,000 devices placed in the United States. Mechanical failure rates with the newer inflatable devices are estimated to be 10-15% at 10 years follow-up, and with improvements to these devices and better surgical technique, infection rates are now reported in the 1-2% range. Before beginning ED treatment, lifestyle changes may result in improved sexual function, particularly in the obese or diabetic patient who goes on a proper regimen of weight loss and exercise. Smoking cessation should be always encouraged in our patients, and worsening erectile dysfunction can be used as an effective “stick” to encourage this behavior.

Studies in young men who have ED and then subsequently stopped smoking have shown that some will recover normal erectile function. Older men are less likely to see spontaneous recovery, but should be encouraged to stop smoking, as this will certainly reduce accelerated progression of their vascular disease.

In summary, erectile dysfunction significantly affects the self-esteem, self-confidence, and quality of life for men and their partners. It usually has an organic basis and may signal or accompany serious systemic illness, including: diabetes, hypertension, cardiovascular disease and neurologic disorders. ED is usually easy to diagnose and treat, and effective treatments are available for all types of ED.

Prostate Disorders—Benign & Malignant

The primary role of the prostate is sexual. It produces the fluid that provides nutrients for sperm, and serves as a vehicle that enables sperm to travel outside the body. Half of all men have benign prostate hyperplasia (BPH) identifiable by biopsy by the time they are age 60; each year an estimated nine million men seek some form of treatment for symptoms caused by BPH. The most common irritative and/or obstructive symptoms reported include: frequent urination, urgency, nocturia, hesitancy, weak stream, and double voiding. Potential complications of advanced BPH include: urinary retention, kidney damage, UTI, bladder stones, and bladder damage.

A variety of treatment options are used for this distressing disorder, including watchful waiting for the patient who is not bothered by symptoms and has clear urine, minimal post-void residual, normal feeling prostate, and normal PSA. For those bothered by their symptoms, oral agents including a variety of alpha blockers and 5-alpha-reductase inhibitors can be used. The alpha blockers (terazosin, alfuzosin, silodosin) tend to work better in the non-bulky prostates. The 5-alpha-reductase inhibitors (finasteride, dutasteride) are effective agents,

but patients must be informed of potential sexual side effects, in which a very small percentage may have permanent changes in their sexual function, even after stopping the drug. Recently, tadalafil, a PDE5 inhibitor, was approved for treatment of lower urinary tract symptoms associated with BPH. When these approaches fail or are contraindicated, minimally invasive procedures including microwave (TUMT) and radiofrequency needle ablation (TUNA) can be performed in the office. More sophisticated outpatient approaches have begun to replace standard transurethral resection (TURP) with a laser that can either vaporize or resect the prostate.

Finally, when the prostate is just simply too big, an open prostatectomy can be performed, but this is quite unusual at this time.

Prostate Cancer

Prostate cancer is the most commonly diagnosed cancer in American men, with over 215,000 new cases reported in 2010. It is also the second most common cause of death from cancer in men, with over 32,000 deaths reported in 2010. Prostate cancer tends to have a familial association. Men who have a first degree relative with prostate cancer have a two times greater risk of cancer; for African-American men with a family history of prostate cancer, the increased risk is threefold.

The big controversy that has emerged over the last several years concerns when and whether to begin screening for prostate cancer with PSA blood tests.

The general consensus of the American Urological Association: physicians should discuss the possibility of performing screening with patients, typically starting at age 50 for men with no family history, but closer to 40 for those men with a family history of prostate cancer or who are of African-American heritage. This consensus is in contradistinction to the recent U.S. Preventive Services Task Force recommendations, which reported that there was no advantage in performing screening PSA blood tests on an annual basis, as there was no reduction in prostate-cancer-associated death. This argument goes on, as the data used by the USPSTF did appear initially to show no advantage to PSA screening, but with the maturing of these studies, there was clear evidence that there was a 20-40% reduction in prostate-cancer-related death in those men who underwent annual screening.

Historically, a PSA less than 4 ng/ml was considered normal, but a large-scale study known as the Prostate Cancer Prevention Trial found that prostate cancer can be found in men with PSAs below 0.5. Therefore, we should think of the PSA level in terms of a continuum of cancer risk rather than a definitive cut-off point for predicting the presence or absence of cancer. In my own experience as a resident in the early 1980s at the beginning of the PSA era, 60% of men who were

identified with prostate cancer by digital rectal exam already had metastatic disease. The clear advantage to PSA screening is early diagnosis, where 95% of prostate cancer is identified by a change in PSA, which allows early identification of organ-confined disease. The complexity of this argument is unfortunately beyond the scope of this article, but will certainly be ongoing within the medical literature.

Treatment options for localized prostate cancer include open, laparoscopic, or robotic surgery. It is certainly true that the robotic approach allows the most rapid postoperative recovery, but there is no clear evidence this approach provides better cancer control, improves urinary continence, or preserves erectile function over other surgical approaches. Brachytherapy has been suggested for low-grade (Gleason < 7), low-volume prostate cancer, and external beam radiation therapy has been used with newer modalities to reduce the likelihood of local injury to the bladder and bowel.


What has emerged most recently is a program of active surveillance. Clearly, not all prostate cancers are the same, and many grow very slowly and probably do not require aggressive treatment, particularly in older men with low-grade and low-volume cancer.

One of the proposed guidelines to employ active surveillance includes: PSA of less than 10 ng/mL, Gleason score of less than 7, tumor stage of T1c or T2a, life expectancy of 15 years or more, and biopsy that shows fewer than three positive cores and with less than 50% involvement per core. The patient who elects active surveillance must undergo PSA blood tests every three months for two years, and if stable, every six months thereafter.

Prostate biopsy is recommended at one year. Patients whose PSAs have a more rapid doubling time of less than three years, or have changes in their physical examination, or on repeat biopsy have a Gleason score of 7 or more, should move forward with definitive treatment.

Using this approach, many men with slow growing cancers can avoid invasive treatment of their prostate cancer, which will allow them to avoid the associated side effects of these treatments, including erectile dysfunction and urinary incontinence.

In conclusion, this article reviewed several important clinical disorders that clearly affect men and should be evaluated as part of every primary care physician's approach to the adult male. With emerging interest in men's health, not only by health care providers, but also within the lay population, we are likely to see more men interested in optimizing their quality of life.

Dr. Levine is professor of urology at Rush University Medical Center. He may be contacted at 312-563-5000 or via email drlevine@hotmail.com. For a list of references, please contact esidney@cmsdocs.org or call 312-670-2550, ext. 335. 

HIPAA Complaints

Is your practice prepared if the federal government comes calling? **by Kate L Bechen, JD**

W **E** **A** **R** **E** seeing an up tick in complaints, investigations and enforcement actions under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Under HIPAA, patients can file a complaint with the Office for Civil Rights (“OCR”) if they believe their privacy rights have been violated. While this right is not new, it is getting more attention as a result of stepped-up enforcement actions in the health care industry and increasing concern over patient privacy. Another fact behind the growing interest in HIPAA enforcement is the Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”).

When OCR receives a patient privacy complaint, an investigator determines whether the allegations, if true, would constitute a violation of HIPAA or HITECH. If “yes,” OCR issues a letter to the provider listing the complainant’s allegations, explaining OCR’s enforcement authority, the investigation process, potential penalties, response deadlines, contact information for the OCR investigator, and a document request list. OCR does not investigate the truth of the allegations until after receiving the provider’s response.

Smaller practices without an internal legal department should contact their attorney upon receipt of a letter from OCR. Involving your attorney from the start ensures a complete, timely and appropriate investigation, response, and follow-up. The standard response deadline is 14 days from the date of the letter.

Every complaint letter should be taken very seriously, even if the allegation is unfounded. Complaint letters will include a data request addendum which may vary slightly depending on the nature of the alleged breach. Nearly all complaint letters include the following data requests:

- Name, title and telephone number of provider’s contact person for the investigation (this could be the privacy officer or attorney).
- Position statement in response to allegation.
- Copy of HIPAA policies and procedures covering use and disclosure of protected health information (“PHI”).
- Mitigation policy and procedures.
- Copy of any internal complaint filed by complainant.
- Description of investigation.
- Remedial action taken, if any.
- Additional relevant information.

Often the provider has already performed a breach investigation, but sometimes the complaint letter is the first notice of the alleged breach, especially in the case of frivolous complaints. While each investigation is unique, there are several steps that every provider


should take to investigate the alleged breach.

- Follow any and all applicable policies and procedures.
- Determine if and when the breach occurred.
- Determine which individuals were involved and what PHI was affected.
- Determine the length of time the PHI was unsecured and who had access during that time.
- Perform a risk assessment to evaluate potential risks to affected individuals.
- Thoroughly document the entire investigation process.

Once the investigation concludes, determine what, if any, mitigation efforts are necessary.

- If PHI of more than just the complainant was disclosed, determine if/when/how the additional individuals should be contacted.
- Consider offering credit monitoring services.
- Consider whether compensation of affected individuals is appropriate (only do so in consultation with an attorney).
- Determine when HHS should be notified of the breach (this will depend on the number of patients involved).
- Determine whether media must be notified of the breach.
- Determine whether employees involved in the breach should be disciplined and/or terminated.
- Schedule training sessions to address the breach and discuss new policies and procedures implemented to prevent future breaches.
- Consider reaching out directly to the patient.

OCR’s subsequent review of the provider’s response may take several months, depending upon the complexity of the issues and the investigator’s workload. OCR’s primary concern is to make sure any breach is appropriately addressed and any harmful effects properly mitigated. A prompt, thorough, well-documented response goes a long way toward avoiding formal enforcement action. Even in situations where the provider realizes, as part of the investigation, that a complete overhaul of its HIPAA policies and procedures is necessary, OCR is generally receptive to prompt corrective action. That said, don’t be lax in annually reviewing your HIPAA policies and procedures, and make sure an attorney or experienced privacy officer has reviewed and updated your policies since the adoption of HITECH.

The author practices in the law firm of Michael Best & Friedrich LLP, in Milwaukee. She may be reached at klbechen@michaelbest.com. 

“Every complaint letter should be taken very seriously, even if the allegation is unfounded.”



CHICAGO
MEDICAL
SOCIETY

presents these exciting
travel programs
for 2013



OCEANIA CRUISES.....

SPLENDORS DOWN UNDER

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

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

MAYAN MYSTIQUE

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

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

BALTIC TREASURES

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

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

PEARLS OF THE MEDITERRANEAN

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

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

Prices are per person, double occupancy

For additional information and a color brochure, contact:



800-842-9023 or 952-918-8950

Friedman v. Sibelius

A cautionary tale for health care administrators by Carolyn Fitzhugh McNiven, JD

EXCLUSION from federal health care programs by the Department of Health and Human Services (HHS) effectively ends a physician's career. Not only can physicians not submit claims for reimbursement to federal health care benefit programs like Medicare and all federal employee health programs, physicians may find that their medical license is in jeopardy depending on the rules of their jurisdiction. In short, an enormous amount is at stake for a physician who is facing potential federal health care program exclusion. A recent Court of Appeals decision, *Friedman v. Sebelius*, provides both good and bad news for physicians on the topic of exclusion.

First, the bad news: the decision established that HHS may look to the facts underlying a conviction rather than the type of conviction in making its exclusion decision. This ruling has potentially far-reaching consequences for all providers, including physicians in particular. Appreciation of its significance depends upon an understanding of how exclusion works. Section 1128 of the Social Security Act (“the Act”) grants the Secretary of HHS (“the Secretary”) the authority to exclude individuals and entities from participating in, and thus receiving benefits from, federal health care programs. The Secretary delegates this exclusion authority to the Office of the Inspector General for Health and Human Services (“HHS-OIG”), the primary law enforcement arm of HHS. HHS can only exclude pursuant to the Act, if the conduct involved—namely, the acts or crimes that the individual is accused of or convicted of—is of a certain specified type. Obviously, one of those types of circumstances is where the alleged conduct involves fraud in a federal health care program. Whether HHS must exclude (i.e., exclusion is mandated by the Act) or may exclude (i.e., exclusion is up to the Secretary's discretion) depends on the nature of the conduct at issue.

What constitutes fraud in a federal health care program obviously can be interpreted narrowly or broadly. *Friedman* essentially established that the Secretary has the power to interpret her authority broadly, to exclude based on conduct even where no “fraud” type of crime was alleged. This holding is significant because it could be read to include any conduct that even arguably caused a loss to a federal health program and even when the individual the Secretary sought to have excluded was not charged with or alleged to have committed, or been convicted of any intentional fraud (i.e., knowing and intentional deception) in a federal health program. Prior to *Friedman*, individuals

convicted of misdemeanors for things other than crimes involving fraud, deception, or theft had at least a plausible argument that their “sort” of misdemeanor did not provide the Secretary a basis to exclude. Indeed, the guilty pleas that were the basis for exclusion in *Friedman* involved prosecution based upon the individual's roles as responsible corporate officers, not on any personal acts they allegedly committed, and related to their employer-company's promotional practices.

“No Authority”

The excluded individuals in *Friedman v. Sebelius*, who included a physician, argued precisely that the Secretary had no authority to exclude them because their convictions were not for a fraud or fraud-type of crime and did not involve personal bad acts on their part. This case arose out of an earlier criminal case that received quite a bit of publicity, *United States v. The Frederick Purdue Company*. In that case the government charged not only the company, but also four key executives—including one physician who was the company's medical director—in relation to promotion of OxyContin, a popular prescription pain medicine. The federal criminal investigation that resulted in Purdue's ultimate conviction for felony misbranding arose out of what can only be described as a firestorm of negative publicity surrounding the promotion of OxyContin as a purportedly less addicting medication and the ability of drug addicts to mimic the effects of heroin by crushing and snorting and/or injecting OxyContin powder.

Three top Purdue executives—Michael Friedman, the president; Howard R. Udell, Purdue's top lawyer; and Dr. Paul Goldenheim, Purdue's former medical director—were charged with misdemeanor misbranding based not upon their own personal acts, but rather upon the responsible corporate officer doctrine (RCOD), which makes an individual who supervises an area of a company where crimes are conducted, even if he (the responsible officer/supervisor) had no personal knowledge or involvement in the crimes themselves. Although they entered guilty pleas to mislabeling in violation of the Federal Food Drug and Cosmetic Act, they did not admit (nor were they accused of) committing fraud in any health care benefit program or intentional personal deception of any government agency.

The defense, which was well-funded, unlike so many of these cases, fought the exclusion through the administrative appeals process and into the federal courts. They challenged both the

Secretary's authority to exclude them and the 20-year term of exclusion (which was significantly above the presumed three-year period). By the time they ended up in the Court of Appeals, defendants had succeeded in convincing the Secretary and the courts to shorten the exclusion period to 12 years. This comparatively modest achievement was the result of numerous hard-fought battles that certainly were as costly as they were contested. By the time the matter reached the Court of Appeals, the issues had distilled: first, defendants argued that because they had not been convicted of a "fraud" crime, the Secretary did not have legal authority to exclude; second, they argued that the 12-year period was unreasonable and an abuse of discretion.

As noted at the outset, the court's decision contained bad news on the disagreement over whether the crime charged or the underlying allegations control the scope of the Secretary's authority. On that point, the court sided with HHS: it effectively held that the Secretary's exclusion authority was not dependent upon the specific type of crime alleged, but instead included a consideration of the underlying facts. Because there were alleged acts of deception, namely deceptive misbranding (although fraud was not an element of the crime itself) and off-label usage generated claims for reimbursement to federal health benefit plans, the court concluded that the Secretary was within her authority to exclude the defendants because the conduct "related" to fraud, namely it had a connection to or reference to fraud.

The court also held that the basis for the individual's personal criminal liability—namely, whether it was predicated upon a responsible corporate officer theory (i.e., based on conduct that they were not involved in and may not even have been aware of) or their own personal knowing acts, didn't matter. Indeed, in that case the individuals, including the physician-medical director, had a basis to believe that because they did not admit personal culpability in the underlying conduct—i.e., that they knew of and/or participated in the off-label promotion—they could not be excluded.

"Unsupported" Decision

The good news for physicians facing potential exclusion is that the Court of Appeals made clear that the Secretary's decision regarding the length of the exclusion period in that case was unsupported. The facts concerning the length of exclusion period are as follows: after criminal judgment was entered against the executives, HHS-OIG fairly swiftly issued its exclusion decision, initially barring each for a period of 20 years. On administrative appeal to an administrative law judge, HHS-OIG reduced the exclusion period to 15 years due to mitigating factors. The executives persisted with their appeals despite the shortened period. The exclusion itself was upheld


on appeal to the Departmental Appeals Board (DAB), although that court shortened the period to 12 years. This exclusion was subsequently upheld by the federal district court. The Court of Appeals reversed the 12-year term as arbitrary and capricious insofar as the Secretary had failed to provide a reasonable explanation for departing from agency precedent.

The court in Friedman was persuaded that, to demonstrate why the default exclusion period of three years was not applicable, the Secretary had to provide additional significant evidence, particularly in light of the fact that no prior conviction on analogous facts had ever yielded a permissive exclusion of over 20 years. Defense counsel have interpreted Friedman to require the Secretary to meet a more demanding requirement both in terms of evidentiary basis (i.e., the facts that resulted in the determination) and legal precedent (i.e., that the term is in line with or appropriately distinguishable from prior exclusion enforcement precedent. This holding may seem cold comfort to those physicians facing potential exclusion; however, it provides counsel with ammunition to argue that any term of exclusion should be shorter than HHS may be inclined to impose.

It remains too early to tell what the agency's complete response will be in the Friedman case itself and what period of exclusion will be imposed and sustained on any appeal. Most expect the agency will attempt to cure the deficiency identified by the Court of Appeals and provide additional support for their departure and the length of the exclusion. The agency may even shorten the period out of an abundance of caution.

Conclusion

Where do these three recent developments leave physicians? Well for one, those who occupy administrative positions in health care sector companies—hospitals, pharmacies, manufacturers—should read the decision carefully because it provides a cautionary tale on how individuals in such positions can be excluded for conduct in which they were not personally involved. Second, every physician who is facing or may be facing conviction for a crime—even a state misdemeanor—should make sure that their criminal counsel is aware of and apprises them of the potential ramifications of exclusion. Finally, for those few physicians who have been or are likely to be excluded, the decision offers some hope that the Secretary will now have to work harder to justify longer exclusion terms, and consequently, may be prone to impose shorter terms.

The author is partner in the law firm of DLA Piper (US) LLC, San Francisco, CA. Questions or comments may be sent to carolyn.mcniven@dlapiper.com or www.dlapiper.com. 

“Every physician who is facing or may be facing conviction for a crime—even a state misdemeanor—should make sure their criminal counsel is aware of and apprises them of the potential ramifications of exclusion.”

Stroke in Asians and Pacific Islanders

Risk factors similar but prevalence rates differ among Asians and non-Asians
by Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

BACK IN THE LATE 1990s the U.S. Department of Health and Human Services launched the Initiative to Eliminate Racial and Ethnic Disparities in Health, and identified stroke as one of six target conditions. Over the last 15 years, the continued focus on stroke prevention and treatment resulted in the ongoing emphasis on racial/ethnic disparities associated with stroke. Until recently, many stroke studies focused on African Americans and Hispanics, with relatively few describing stroke in Asian and Pacific Islanders (APIs).

However, this is changing, as APIs now constitute approximately 5.5% of the total U.S. population and represent the fastest growing racial/ethnic group in the country. Estimates from the U.S. Census Bureau suggest that the API population will increase as much as fivefold in the coming years, comprising up to 10% of the U.S. population by 2050.

“Estimates from the U.S. Census Bureau suggest that the Asian and Pacific Islander population will increase as much as fivefold in the coming years, comprising up to 10% of the U.S. population by 2050.”

Risk Factors for Stroke

Although the risk factors for stroke appear to be similar in Asians and non-Asian population groups, the prevalence rates are different. Most of the data on risk factors and stroke prevalence have been gleaned from international studies in Asian populations. In these studies, hypertension, smoking, and diabetes have all been associated with increased risk of stroke.

Of these risk factors, hypertension accounts for the greatest burden of disease. In a well-known international study of over 30,000 patients in China, the risk of stroke increased by 25% for each 10 mm Hg elevation in systolic blood pressure. Hypertension was also reported as the most commonly associated risk factor for stroke in mixed Asian populations in Malaysia and India. Larger studies in the U.S. are needed in order to ascertain whether these risk factors are similar for Asians living outside of Asia. Smoking and tobacco use, both high in API populations, have risk profiles similar to those

seen in white populations for vascular disease and stroke.


Alcohol use, on the other hand, appears to be associated with an increased risk for hypertension and intracerebral hemorrhage in Asians compared to non-Asians. Finally, diabetes, a prominent condition affecting many Asians, has been shown in some studies to pose the same relative risk for stroke in both Asians and non-Asians. Interestingly though, a few studies have suggested an increased risk of carotid bifurcation disease with diabetes in Japanese patients compared to whites.

Stroke Subtypes

Most data on subtypes of ischemic stroke among Asian populations comes from relatively small studies and case series. Even so, several observations suggest that the distribution of ischemic stroke subtypes may be different in Asian populations. Data from stroke studies have indicated that stenosis or occlusion of the middle cerebral artery of the intracranial portion of the carotid artery is more commonly found in Asians than in whites. Conversely, stenosis or occlusion of the extra cranial portion of the carotid artery appears less common in Asians. Data from the U.S. have shown that APIs are more likely to have subarachnoid hemorrhage and intracerebral hemorrhage compared to whites. Further available data have shown that mortality from hemorrhagic stroke is higher in APIs than in whites and that death occurred at a younger age for some subtypes.

Final Thoughts

Although the relative number of stroke studies in APIs is small, data from larger stroke surveillance systems and databases are becoming available, thus allowing for better identification of stroke, treatment, and long-term follow-up. Ascertaining the racial/ethnic distributions of stroke incidence, stroke type, and mortality in the API population is important for the development of more efficient and effective secondary stroke prevention programs.

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. 

Communication *saves lives.* **Just ask Dr. Singh.**



When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela's EKG, and sent an image of the recording to the on-call cardiologist via CocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quickthinking and the secure mobile app, DocbookMD.

DocbookMD is helping physicians like Dr. Singh communicate more efficiently when it really counts. Learn more at docbookmd.com.



Shaping Healthy Behaviors with PlayStreets

Program brings sports, fun, and fitness to local communities **by Bechara Choucair, MD, Commissioner, Chicago Department of Public Health**

WITH FIVE major professional sports teams at the core of its history and culture, it is no surprise that Chicago is a sports town. It is a city where athleticism, health, and fitness are celebrated.

At the Chicago Department of Public Health (CDPH), we want to empower our kids to develop healthy behaviors by being active through sports and fitness. Also, we want to ensure that parents have the best resources available to help instill an active lifestyle into their family.

And that is why we started PlayStreets Program brings sports, fun, and fitness to local communities.

An innovative new program to help combat childhood obesity, PlayStreets secures city streets to offer open and safe spaces for families to get active.

PlayStreets spaces feature basketball courts, obstacle courses, jumping castles, life-size chess, jump rope, hula hooping, dancing, Zumba, and more. It is a fun, effective, and creative way to directly target our city's children, mostly in neighborhoods with limited access to play lots.

In the United States today, one in five kids doesn't have access to a playground. That's millions of children who can't pick up a ball, run outside, or have fun in a safe environment.

Available data reveal that the obesity rate for Chicago kids between ages two and seven is more than twice that of young children in the United States as a whole. Among older children, disparities also exist between Chicago and the rest of the country, with 71% of high school students and 29% of adults not getting adequate physical activity.

PlayStreets closes off city streets within a community to provide a safe, supervised space with organized outdoor activities for sports, fitness and dancing.



One Tool in Toolbox

In our five-year strategic health agenda, Healthy Chicago, one of our targeted goals is to reduce adult and childhood obesity by 10%. We have identified a comprehensive strategy to help us reach our goals. PlayStreets is one tool in our toolbox that offers a variety of interchangeable activities that meet the needs of Chicago's diverse population and culturally different family structures.

And by creating an environment that incorporates multiple aspects of health, including diet and exercise, PlayStreets promotes healthy living. It is a great stride in the right direction.


In addition to the many physical activities offered by PlayStreets, children and parents snack on fruits, vegetables, whole grains, lean proteins and low-fat dairy products that contain the nutrients we need to maintain healthy lifestyles. Personal trainers and nutritionists are also on site and available to give advice to families on developing healthy eating plans.

PlayStreets is endorsed by First Lady Michelle Obama as part of her "Let's Move!" physical activity and fitness campaign. It is a joint effort with agencies that support and advocate making healthy choices available and accessible to all Chicago residents.

Non-profit community organizations are responsible for implementing PlayStreets in Chicago neighborhoods and for coordinating day-to-day logistics and operations. Those organizations include: Active Transportation Alliance, Gads Hill Center, Local Initiatives Support Corporation Chicago (LISC Chicago), World Sport Chicago in partnership with community-based organizations in a number of Chicago neighborhoods, including, Pilsen, Little Village, Brighton Park, Woodlawn, Chicago Lawn, and South Chicago.

PlayStreets is a public-private partnership with Blue Cross Blue Shield of Illinois (BCBSIL). BCBSIL is the exclusive funder for the PlayStreets program through a \$317,000 grant that also includes continued financial support for the joint CareVan community immunization program with CDPH.

Over 70 PlayStreets events are scheduled in six Chicago neighborhoods from now until the end of November.

To learn more about the program, please go to www.cityofchicago.org/health, or Twitter @ChiPublicHealth. Dr. Choucair will respond to emails at Choucair@cityofchicago.org, and on Twitter @choucair. 

The Simplicity of Difficult

Training in Malawi adds unique dimension **by Devin D. Mehta, MD**

THE CCAP NKHOMA Synod Hospital sits upon a hill, approximately 60 km south of the Republic of Malawi's capital city, Lilongwe, in Sub-Saharan Africa. The brick and mortar hospital is surrounded by lush rolling hills and maize plantations. Unless you stand on the outskirts of the hospital grounds, you forget the sky blue horizon is accented by small mountains. It is hard to believe that a location so beautiful places the burden of life in hands that are tied by limited resources. But, alas, that is the story of everyone I met in Nkhoma during a February 2012 medical mission there.

My first impression of Malawi—based on paved roads, a central market, and few panhandlers—was that of a developing country with an upward trajectory. But first impressions are often rushed, and Malawi hides its poverty well. The average Malawian is poor by world standards but residents have carved out an existence where less is more and more is too much. Malawians make do with what they have. This simple principle withstood the test of time while I was there, and is worth remembering because we often lack this guiding concept in our own lives: making the best of what we have.

Staff of Life

The Malawian diet is a clear example of simplicity. Maize, a staple of the diet, is the primary agricultural product. It is often charred and sold on makeshift roadside grills, or ground into flour and boiled to make nsima, a thick starch consumed at mealtime with relishes, boiled pumpkin leaves mixed with tomato and onion, and if lucky, protein from chicken or egg. Nsima fills the belly, and is relatively inexpensive and readily available.

At the hospital, all inpatients must have a guardian present to attend to the patient's needs, which include preparing the patient's meals. There is an outdoor area where smoke rises from large pots and families combine their flour to make nsima. When one cannot afford food, Malawians share and make do with what they have. The always smiling and generous hospital interpreter, Pearson, told me that nsima is never to be made just for oneself.

The simplicity of the difficult life led in Malawi is not by choice, but a forced adaptation to the environment. Electricity is a luxury; the service can be interrupted for days without notice. Cooking was sometimes confined to a single propane tank shared by a house full of volunteers, but this was a first-world problem compared to the hospital's loss of power. While I was training at Nkhoma Hospital, the back-up generator was in and out of repair, so when the power went out and the generator failed, patients could not receive oxygen. Pediatric cerebral malaria



is a challenge for Western-trained physicians to manage, but it's an even greater battle when children don't have oxygen to limit cerebral ischemia. No power meant no x-rays, and the only imaging modality available was ultrasound, for which there was no skilled operator. When power was present, another obstacle presented itself—the processor for the x-ray machine needed repair. Patients had to travel 1.5 hours by vehicle to another hospital for their x-rays, a trip often made unfeasible because of the cost.

My training in Malawi added a unique dimension to my medical education. Having to rely on my clinical judgment in a resource-limited setting was a life-changing experience. I also witnessed the strength of the human body in the presence of disease.

But the most important thing I learned at Nkhoma Hospital is that in spite of many challenges and their myriad causes, Malawians in general do the best they can with the resources they have. There is no time to complain when people are dying. You wake up, smile, celebrate life, value human relationships, and make the best of what you have. Our line of work is not easy. Dealing with other people's problems can be draining, and being a physician is arguably no longer as financially rewarding as it once was—but the choice to serve others was our choice to make. If we choose to grow with our patients, we are given the opportunity to heal and to be healed.

Dr. Mehta is a resident physician in the department of internal medicine at Rush University Medical Center in Chicago. He is a co-founder of MedReferrals, a non-profit organization that increases access to health care for the underserved and uninsured through a free, online website www.medreferrals.org.

Dr. Devin Mehta and local schoolboy Dalitso climbed to the top of Nkhoma Mountain together. Despite language barriers, everyone who visits Nkhoma is struck by its beauty.

Help Preserve Patient Choice in Medicare

No easy solution to problem by William N. Werner, MD, President, Illinois State Medical Society

ARE YOU concerned for the future of Medicare? Perhaps a better question would be: “How could anyone not be?”

Nearly every physician in America is well aware of the crisis Medicare is currently facing. Drastic cuts are mandated by its own funding formula, the so-called “Sustainable Growth Rate” (SGR), and have so far been narrowly averted only by repeated last-minute congressional intervention. A wave of Baby Boomers will be entering the program in the coming years, and trillion-dollar federal deficits have placed formerly unthinkable options on the negotiating table.

As the pressure builds, physicians and patients find themselves squarely in the crosshairs. If the cuts to Medicare reimbursement that are currently planned are allowed to go through, physician reimbursements would drop by nearly a third, leaving large numbers of physicians with no choice but to restrict the number of Medicare patients they see, or opt out of the program entirely.

There is no easy solution to this problem, but the surest way to disaster is to do nothing.

That’s why over 40 members of the

U.S. House have joined together in support of H.R. 1700, the Medicare Patient Empowerment Act (MPEA).

The MPEA would allow physicians and patients to freely contract without penalty, while still taking advantage of the same Medicare benefits our patients rely on.

Under current law, patients who wish to see a physician who does not accept Medicare must either pay the full amount out of their own pocket or find another physician. ISMS believes that our nation’s seniors should not have to choose between seeing their physician and receiving Medicare benefits.

With the support of ISMS and many other state and national medical societies, the AMA has launched the My Medicare My Choice campaign, designed to educate physicians and patients about the benefits of this legislation. The campaign’s website, www.MyMedicare-MyChoice.org, features frequently asked questions about Medicare private contracting, an online petition in support of the MPEA, and downloadable materials to help spread the word about this important legislation.

To send an email directly to your U.S. Senator and Representative, visit the Grassroots Action Center on www.isms.org.

org. Tell them it’s vital that they preserve seniors’ Medicare benefits and ability to choose their own physician. And while you’re at it, tell them to stop the SGR-imposed cuts that threaten Medicare once and for all.

*Editor’s Note: Another steep payment cut of 27% will kick in on Jan. 1, 2013, unless Congress intervenes. But eliminating the SGR is only half the battle. On Oct. 15, the AMA and more than 100 state and specialty medical societies, including ISMS, wrote to Congress, offering principles and core elements as a basis for a new system (see box). The Chicago Medical Society also advocates for Medicare payment reform through its resolutions process. Within organized medicine, all resolutions begin at the county level, and in recent years CMS members used this powerful tool to support the right of physicians to contract with their Medicare patients and to urge the AMA to draft legislation that would create a new payment option within the Medicare program. The resolutions process is open to all members. Once they are adopted by the CMS Governing Council, resolutions are debated by the State Society, and relayed to the AMA for implementation in the U.S. Congress. **C***

AMA Driving Principles and Core Elements

SUCCESSFUL delivery reform is an essential foundation for transitioning to a high performing Medicare program that provides patient choice and meets the health care needs of a diverse patient population.

The Medicare program must invest in and support physician infrastructure that provides the platform for delivery and payment reform.

Medicare payment updates should reflect the cost of providing services as well as efforts and progress on quality improvement and cost management.

The transition plan must include core

elements that:

- Reflect the diversity of physician practices and provide opportunities for physicians to choose payment models that work for their patients, practice, specialty and region.
- Encourage incremental changes with positive incentives and rewards during a defined timetable, instead of using penalties to order abrupt changes in care delivery.
- Provide a way to measure progress

and show policymakers that physicians are taking accountability for quality and costs.

In addition, the plan needs to be structured in a way that will:

- Reward physicians for savings achieved across the health care spectrum.
- Enhance prospects for physicians adopting new models to achieve positive updates.

Welcome New Members!

The Chicago Medical Society welcomes its newest members elected in September 2012. We are now 135 voices stronger.

STUDENT DISTRICT

Haroon M. Ali
 Hossein Amirjamshidi
 Elhaam N. Anvar
 Cameron H. Araghi
 Catherine K. Arellano
 Arslaan Arshed
 Bryce T. Austell
 Laurel A. Barras
 Barry L. Baylosis
 Karl N. Becker
 Andrzej Belzowski
 Michael K. Benefiel
 Danielle E. Binler
 Brent R. J. Bjorklund
 Kohldon C. Boydston
 Shaun D. Boyes
 John Cha
 Thymur A. Chaudhry
 Danielle S. Crawford
 Natalie R. Dale
 Christine M. DiPompeo
 Zaneta Dymon
 Anna E. Dziamski
 Amna Elahi
 Taryn K. Fernandes
 Marisa E. Gilbert
 Karl F. Godlewski
 Manjot Grewal
 Meg L. Groom
 Philip C. Gutsell
 Nicholas W. Hawley
 Candice A. Henry
 Brody J. Jones
 Janice Y. Joo
 Megan C. Kaszuba
 Annika K. Khine
 Iris Y. Kim
 Sorabh Kothari
 Jason B. Kramer
 Sarah C. Kwon
 Brandy Le
 Llison J. Louis
 Nabil Z. Madhun
 Alexandru T. Marginean
 Ana C. Mauro
 Wesley N. McLaughlin
 Brandon M. Meyer
 Kristin A. Minkowski
 Amir S. Mohamed

Vishal V. Naik
 William Park
 Anish V. Patel
 Jeremy Patel
 Nikhil J. Patel
 Richard J. Patterson
 Ian L. Pearson
 Mamtha S. Raj
 Prachi Rana
 Miriam L. Robinovitz
 Zachrey M. Rosengarten
 Roger R. Roxas
 Joel C. Saeedi
 Shoab M. Safiullah
 Anna K Sankovsky
 Sakshi Sahni
 Joseph A. Santamaria
 Lindsey Sattler
 Zain Sayeed
 Joshua M. Schatzman
 Brittany L. Seidensticker
 Bennett E. Smith
 Christopher L. Smyre
 Joshua Symes
 Giuseppe V. Toia
 Gary Tran
 Jessica Tuan
 Sarah E. Uzzardo
 Elizabeth J. Van De Graaf
 Jesse J. Waldera
 Julie E. Witkowski
 Amanda J. Wojciechowski
 Linda I. Yala
 Farhad Yazdi
 Jaquelyn R. Yeh

RESIDENT DISTRICT

Mary E. Acree, MD
 Christopher J. Allen, MD
 Warren Alperstein, MD
 Riham M. Alwan, MD
 Melissa M. Arredondo, MD
 Michelle Blanco, MD
 Steven S. Carey, MD
 Christine E. Carlos, MD
 Anabarbara Chelse, MD
 Siddhartha A. Dante, MD
 Shalome Dsouza, MD
 Jaclyn F. Eisenberg, DO
 Leah P. Finkel, MD

Richard M. Friesen, MD
 Ernesto E. Gonzalez, Jr., MD
 Anne C. Goodenow, MD
 Brandon T. Greene, MD
 Steven J. Healan, MD
 Jaimee S. Holbrook, MD
 Laura C. Holmes, MD
 Matthew J. Howard, MD
 Jingtao Huang, MD
 Umair M. Jabbar, MD
 Andrew C. Johnson, MD
 Nicole R. Johnson, MD
 Niloufer Khan, MD
 Jarrett R. Linder, MD
 Andrew S. Nickels, MD
 Emily M. Obringer, MD
 Paula B. Osterhout, MD
 Lindsay Petty, MD
 Aisha P. Reuler, MD
 Katie Ryder, MD
 Karen E. Schultz, MD
 Amanda M. Sebring, MD
 Shreya Sengupta, MD
 Jennifer Y. Seo, MD
 Kshama P. Shah, MD
 Susan M. Slattery, MD
 Heidi C. So, MD
 Andrew D. Spearman, MD
 Megan E. Spokes, MD
 Sima S. Thakkar, MD
 Margaret Z. Tsien, MD
 Rukmini Velamati, MD
 Laura A. Vella, MD
 Angela J. Weingarten, MD
 Lauren D. Wellisch, MD
 George W. Weyer, MD

FIRST-YEAR MEMBER

DISTRICT 4

Madhu K. Singh, MD

REGULAR MEMBER

DISTRICT 6

Derek L. West, MD

Medicaid Expansion Ruling to Top List of Effects

Other ramifications and repercussions of Supreme Court decision by Elizabeth Sidney

THE FINAL CHAPTER on the *Affordable Care Act's* implementation has yet to be written. But in removing itself from the political fray, the U.S. Supreme Court majority opinion lit a fuse that ensures the controversial law will likely remain at the center of attention for years to come, said health expert Mark E. Rust, in a talk before members of the Chicago Medical Society (CMS).

The CMS-hosted program on Oct. 10 was part of an informative series to help physicians sort through the political and practical realities of the Court's decision last June. And the Barnes & Thornburg attorney affirmed that the decision is already effecting the way hospitals, providers, and employers think about the law.

While much reporting has centered on the commerce clause and taxing power of the federal government, some aspects of the decision don't lend themselves to headlines, and were not readily apparent immediately after the ruling. Rust's lecture focused on those key points.

For instance, in ruling that the Act unconstitutionally coerced the states into expanding their Medicaid populations, the Court interpreted an existing pre-Act Medicaid law to permit states to opt out of the expansion without losing their entire Medicaid funding.

First Time for Court

As the only provision on which a clear consensus of justices agreed, including two liberal members, the ruling marks the first time the Court has limited the spending power of the federal government. It also potentially guts a key component of the Act.

"The ruling set off reverberations in the states that are already chipping away at the wobbly underpinnings of the Act's claim to provide coverage for virtually every American," Rust explained.

"The fact that each state can now consider its options for such an important piece of legislation means that full political discussion must wait until the final stages of implementation, to one degree or another, in all 50 states," Rust said.

Opting Out?

At least 15 states have indicated interest in opting out altogether, and when coupled with new limits on government spending, the manner and method of an expansion remains uncertain.

Moreover, with the individual mandate in place and federal subsidies and tax credits for those near the poverty level, Rust suggested the under-insured population might prefer to purchase insurance on the free market, rather than rely on Medicaid.

"But the biggest question to grow out of Medicaid expansion and the new option is whether states can participate in the first two years—the "free period"—and then de-participate without penalty," Rust said.

Medicaid expansion would not only immediately and dramatically alter the Medicaid program, but also the political review of the full Act. Even if Republicans achieve a trifecta of House,

Senate, and Executive Branch control, certain provisions of the Act cannot be undone, Rust said.

For instance, changes to Medicare reimbursement rates have been in effect since 2010. There is also bipartisan agreement on discrete issues, such as refining the anti-kickback and anti-self-referral rules.

"The lobbying pressure to keep a portion of the Act will be too great, and the subject matter is so far afield from the individual mandate that it will not be subject to reversal," Rust predicted. The ban on physician ownership of hospitals is one example, he said.

Many provisions are popular, such as the guaranteed issue of insurance, lifting of lifetime caps and yearly limits, and inclusion of young adult children on the benefit plan of their parents.


"Quite apart from Medicaid, states are now parsing other areas of the Act to see what other legislative loopholes they might drive through. For example, some are considering declining to authorize the operation of an exchange, forcing the federal government to operate one for them," he said.

"We are at a critical juncture in the implementation timeline where states may either rebel from federal-state partnerships envisioned in the Act or test the scope of their bargaining power with an administration that would like to see the Act succeed in practice the way it was designed in theory."

Cornucopia of Programs

Rust's presentation offered one hour of CME credit, and was part of the Chicago Medical Society's ongoing practice management lecture series.

The Chicago Medical Society is offering a cornucopia of programs to help members understand the practical implications of the Affordable Care Act, as well as absorb the massive law's requirements into their practices.

Joint programs with the federal Department of Health and Human Services, American Bar Association, and Chicago Healthcare Information Technology Regional Extension Center, are among the recent partnerships CMS has formed to guide physicians on health fraud issues, EHR implementation, and alternative payment models. 

REPUTATION INSURANCE

A New Way of Looking at Malpractice Protection.



Who would you
be without your
reputation?

When you protect your reputation,
you protect your livelihood.
Switch to **Reputation Insurance**
from PSIC: It's a whole new way to
look at malpractice protection.

For more information, call
1-800-788-8540 or visit
www.psicinsurance.com.

Malpractice insurance is underwritten by Professional Solutions Insurance Company.
14001 University Avenue | Clive, Iowa 50325-8258 ©2012 PSIC NFL 9459



Behaviors that Undermine a Culture of Safety

A Physician Workshop on Professionalism

This event is for Physicians, including
Hospitalists and Residents, other Healthcare
Professionals, Practice Managers and
Medical Students.

Tuesday, Nov 27, 2012

Maggianno's Banquets
111 W. Grand Ave.
Chicago, IL 60654

CME: Up to 1.0 credit

Fee: Complimentary for CMS
Members and Staff

Registration: 5:30-6:00 p.m.
Presentation: 6:00-7:00 p.m.
*Note: Held immediately prior
to the Council Meeting.*

Registration Info
emedrano@cmsdocs.org
or call 312-670-2550 x338

www.cmsdocs.org



Calendar of Events

NOVEMBER

17 Hellenic Medical Society of Chicago Fundraising Cocktail Reception for Pan-Arcadian Hospital in Tripolis, Greece. 7:00-10:00 p.m.: International Museum of Surgical Science, 1524 N. Lake Shore Dr., Chicago. *For more information, please contact Dr. Georgopoulos, HMS Secretary 630-632-7608 or email Christina.georgopoulos075@gmail.com.*

21 CMS Executive Committee Meeting Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; Chicago Medical Society,

33 W. Grand Ave., Chicago. *For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.*

26 CMS Public Health Committee Meeting This Chicago Medical Society Committee reviews and responds to requests for advice, opinion, or program approval from health departments, municipal health committees, and other public health bodies in Cook County. The Committee also initiates contact with groups when directed by the CMS President, Executive Committee, or Governing Council, on matters of concern to organized medicine. At this last bimonthly meeting of the year, the Committee will discuss current and future initiatives. 6:30-8:00

p.m.; Chicago Medical Society, 33 W. Grand Ave., Chicago. *For information, please contact Christine 312-670-2550, ext. 326; or cfouts@cmsdocs.org.*

27 Behaviors that Undermine a Culture of Safety: A Physician Workshop on Professionalism Immediately prior to the Council Meeting, this CME activity offers learning strategies for identifying and dealing with unprofessional behavior in the health care setting. 6:00-7:00 p.m.; Target audience: physicians, residents, and medical students. Speakers: Vineet Arora, MD, and Aashish Didwania, MD; Maggiano's Banquets, 111 W. Grand Ave., Chicago. Participants may earn up to 1.0 CME credit. No charge for CMS members or staff; \$25 for non-members or staff. *To RSVP, please contact Elvia Medrano at 312-670-2550, ext. 335; or email emedrano@cmsdocs.org.*

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

29 Time for a Check-up: Improving the Business Health of Your Practice This CME activity offers learning strategies for better managing your medical practice. 7:30 a.m.-4:30 p.m.; Target audience: physicians and practice managers/administrators.

Speakers: Elizabeth Simpkins, MS, Robert John Kane, JD, Wendy Lipton-Dibner, MA, and Toni Johnson, MBA. Café la Cave, 2777 Mannheim Rd., Des Plaines; Participants may earn up to 6.0 CME credits. CCPA PP or ISMS member group rate \$50/per person; CCPA PP or ISMS member and staff \$65/per person; non-member or staff \$115/per person. *To RSVP, please contact Katrina Llagan at 312-227-7442 or visit www.ccpapp.org/check-up-registration.*

DECEMBER

8 Illinois Residency Program Directors Meeting Hosted by the Illinois State Medical Society, this event is for Illinois residency program directors and physicians in medical education. Attendees will be updated on the latest residency training news from medical educators. The meeting will also provide networking opportunities with other Illinois-based program directors and medical educators. 7:30 a.m.-12:00 noon; Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago. *To register and learn more, please go to <http://rpd.eventbrite.com>. Questions, please contact Evan at 312-580-6497 or evanrotter@isms.org.*

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

PROMPT MEDICAL BILLING

- ▶ Expert billing & follow-up service
- ▶ Electronic claim submission
- ▶ Professional staff
- ▶ Reduce expenses/maximize profits
- ▶ No setup fees
- ▶ Affordable rates – 1st month FREE!

Toll Free: 877.672.8357

Tel: 847.229.1557

www.promptmedicalbilling.com

classifieds

Personnel Wanted

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@mpi-health.com or fax 708-336-7420.

Physician Care Services is seeking full-time and part-time psychiatrists for individual and group therapy counseling in our Oak Forest Rehabilitation Center. Please email CV to or fax 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

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.

Space for rent in Glenbrook Hospital Professional Building, in Glenview. Please email questions to Lipkis54@gmail.com or call 847-212-0961.

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.

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

Athena Health.....	3
CMS Insurance Agency	Back Cover
Docbookmd	23
The Doctors Company	4
Go Next Travel	19
ISMIE	Inside Front Cover
Physicians' Benefits Trust.....	Inside Back Cover
ProAssurance	9
Professional Solutions	29
Prompt Medical Billing	30

Reaching the Multitudes

Medical epidemiologist makes his mark on public health care **by Scott Warner**

POPULATION-BASED medicine is what he practices, and Kenneth Soyemi, MD, MPH, couldn't feel more fulfilled. "We help millions of people with the decisions we make," he says. And he's not exaggerating.

As medical epidemiologist at the Illinois Department of Public Health in Chicago, Dr. Soyemi works in the Office of Health Protection/Division of Infectious Diseases. He provides medical leadership in vaccine preventable disease (measles, pertussis, and influenza), refugee health programs, syndromic surveillance, and the HIV/AIDS program.

Dr. Soyemi explains that whenever there's an outbreak, or medical investigation, he works with local health jurisdictions in disease control and prevention activities.

He gives an example: "If a health care provider suspects a case of measles, the provider is required by state law to report it to his local health department. He and IDPH staff will work the local health department to investigate the case by looking for possible sources of infection and protecting those with close contact to the case."

Dr. Soyemi gives another example: influenza (A) H1N1 virus pandemic (swine flu) occurred in 2009-2010. "It came on all of a sudden, but the Illinois Department of Public Health as part of preparedness planning was able to distribute antivirals to the hospitals and local health departments—we did a big public awareness campaign, and held immunization programs."

Currently Dr. Soyemi is working with local health departments and affected clinics on the national fungal meningitis outbreak by doing patient outreach, and notifying people who were exposed to implicated products.

Dr. Soyemi says that although health care providers who are on the frontlines are key partners, it's important that they remember something he considers crucial. "They need to call their local health department when they see or suspect a reportable disease, an unusual illness, or cluster of




unusual diseases."

How did Dr. Soyemi end up working in public health? He says he always loved math and its application to population medicine. He became a medical epidemiologist/administrator. In his position he has applied for grants for the state health department, which has, in turn, helped run public health programs in Illinois.

He says that his involvement as a member of the Chicago Medical Society and the Illinois State Medical Society helps him in his work. He has served on both the Public Health and Health Care Economics Committees of CMS.

"My state and local societies have helped provide advocacy and have assisted in passing major health bills. They greatly help implement change," he says.

And what is the best advice that Dr. Soyemi can give to his colleagues?

"I would ask them to be familiar with reportable diseases and report them to their local health department as soon as they see or suspect a reportable disease or an unusual cluster of illness." 

IDPH medical epidemiologist Kenneth Soyemi, MD, MPH, asks all physicians and health care providers to ensure their patients age 6 months and above get their influenza vaccine. And all health and medical professionals and their families should get the vaccine too.

Dr. Soyemi's Career Highlights

HIS CAREER has taken him from medical school in Nigeria to postgraduate studies in London, residencies in pediatrics, general preventive medicine and public health in Illinois and Florida, a master's degree in public health in the U.S., to work at John H. Stroger, Jr. Hospital of Cook County, and ultimately, to his current position as assistant medical director of the Illinois Department of Public Health in Chicago. Trained originally in pediatrics, Dr. Soyemi now works in the Office of Health Protection/Division of Infectious Diseases, covering the entire population of Illinois.



Price

Exclusive access to economical rates for Illinois physicians and dentists.



Individual and Group Health Insurance Plans

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

ISMS/CMS Members

1-800-621-0748 • www.pbtinsurance.com

ISDS Members

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


Sponsored by:



PBTLIC is a wholly owned subsidiary of:



Experts & Advocates in **Liability Protection**



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

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

CMS Insurance

A SUBSIDIARY OF **CHICAGO MEDICAL SOCIETY**

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