Chicago MEDICINE

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FEATURE

A November to Remember

HOW MANY TIMES have you heard the upcoming elections will be critical in determining the future direction of our country? This year of course is no different.

In November, we will elect the next president, and also reshape Congress. While the majority of politicians have a legal background, the array of issues they will deliberate and legislate extend far beyond the legal realm.

This is where each of you has an opportunity, no, an obligation, to educate your elected officials about how legislation being debated by politicians has a profound impact on physicians and the health and well-being of the patients we treat. Most have heard the adage, "the squeaky wheel gets the oil." This is exactly how we should approach legislators on behalf of our profession and our patients. In my conversations with politicians, I have found that most are truly interested in the experiences of a physician, and how laws affect us and patient care.

Yet physicians are often reluctant to engage their legislators, and may offer the following reasons why:

- I don't know how to get involved.
- I don't know who my politicians are.
- I'm so busy running my practice, learning how to use my new EMR, and planning for ICD-10, that I have no time to do this.
- Political talks don't belong in the exam room.
- My patients don't come to me to hear my political views.

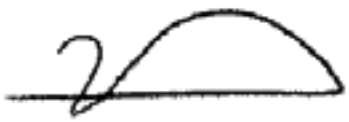
While many of us can relate to several of these reasons, now is the time to reach beyond these barriers and get engaged in the education of our patients and politicians. You will likely find the time spent rewarding. Patients will likely thank you for the information and for taking an interest.

Here is a primer on how to participate in the legislative process.

- Find your lawmaker by going to the ISMS website, *www.isms.org,* or the CMS website, *www.cmsdocs.org,* and click on the advocacy section.
- Write a letter or email to your representatives asking them to help you care for patients without so much outside interference.
- Ask to have a face-to-face meeting with your legislator.
- Let CMS staff know you are willing to host a legislative mini-internship, in which a local politician shadows you for a half- or full-day to understand the daily challenges you encounter practicing medicine.
- Print out and post copies of your letters and requests to politicians, and distribute them to patients as they sign in for their visit.
- Ask your patients to register to vote and study issues that will affect them.

We must all realize that to effect change, we must be "in the game," not just sitting on the sidelines as observers. Please join the game. And while you are at it, please help strengthen our team by encouraging your colleagues to join, so our voice is even stronger. Please continue to let your CMS leadership and staff know how they can help you. Also, let us know about your efforts and successes so we can share them with others.

And don't forget to vote on November 6.



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The Concrete Road to Getting Paid

Avoid the potholes **by Alina Baban, Chair, Practice Manager Section**

WITH THE instability of the economy and the decrease in payer reimbursements, getting paid has become a challenge for many practices. In order to create a solid road to getting paid, it should be made of concrete. Why concrete? It is permanent, low-maintenance, and potholes will be virtually non-existent. Concrete creates a smooth drive to payment. Is there a downfall to creating a concrete road? Yes! As practice managers, we cannot just dump concrete on the road and hope it will lead us to our destination. It is labor-intensive and requires a solid plan. Your initial sketch should be your financial policy, the concrete should be staff and patient education, and the end plan should be creating multiple lanes of payment methods. No one wants to be on a road with one lane. If you want to reach your destination in a timely manner, your road should have at least a few payment methods.

Have Written Policy, Not Verbal

As practice managers, we should have a clear written financial policy in place. Roads are not built on verbal plans. Your written policy should clearly outline when to collect, how to collect, and whether there are payment plans for larger balances. It is important to realize that the patients should be familiar with the policy prior to their appointment. It should not be brought to patients' attention for the first time when payment is due. When scheduling appointments, a simple statement that co-pays are due at the time of their visit is always a good way to start. When patients arrive for their appointment, your financial policy should be on their forms, posted in your office, and effectively administered by your staff. As patients continue to take responsibility for a larger portion of their medical bills, there should be a policy in place on how to collect payment for services provided. The policy can include collecting a deposit, having a credit card on file, or offering payment plans. Having a strong written financial policy that is enforced limits the number of patients who will fall in the bottomless pit of collections. Without creating a written plan, you are placing your staff and patients on a dirt road and expecting them to reach the destination of payment without an effective means of getting there.

After you have a policy in place, efforts should be made to better educate both staff and patients. Education is the concrete necessary for building roads that will withstand potholes. Staff should be educated on their responsibilities, strategies for collecting payments, patient communication, and the various components of insurance plans. Co-pays should always be collected at the time of a visit, and staff should be trained how to effectively communicate your policy to patients. Your staff should not ask the patient if they would like to make a payment, but emphasize how they would like to make a payment. Educating your staff will in turn educate your patients and help promote payment for services rendered. Patients should be educated on what their co-pays, deductibles, and out-of pocket costs are. It is surprising how unfamiliar the majority of patients are with their own insurance benefits. By educating patients on their benefits, and explaining what is expected prior to each service, your practice will minimize misunderstandings and increase the likelihood of payment.

Once a solid plan has been created and a road is in place, patients should be given multiple payment options. This will increase the likelihood that patients will fulfill their financial obligations. Give patients the ability to pay by cash, check, and credit card in the office or online. Flexible payment plans can also be a great tool to collect payment on larger balances. Give patients the option of setting up a recurring credit card payment or having their bank account directly debited until their balance is paid. If having payment plans is difficult for your practice or you feel it poses a risk, outsource. Some companies will give your patients a credit card for their medical expenses at no interest to them. You will pay merchant fees, but the card guarantees payment, eliminates risk, and does not require much work.

As practice managers, we do not want to be on a road filled with potholes that we are constantly trying to avoid. Start building your own concrete road to getting paid. Take the time to create an individualized financial policy, focus on effective education for staff and patients, and figure out the payment options your practice can offer. Once your financial policy is in place, and you give your practice the tools it needs, you will ensure a solid road to payment.

"If having patient payment plans is difficult for your practice or you feel it poses a risk, outsource."

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Meaningful Use

Here comes Stage 2 **by Theresa Walunas, PhD, and Abel Kho, MD, MS**

OVER THE PAST few months, many of you have expressed concern over the burden of the second stage of the electronic health record (EHR) incentive program on physicians, and whether EHR technology would deliver on some of the more complicated measures of Meaningful Use.

Now that the Centers for Medicare and Medicaid Services (CMS) released the final rule on Stage 2, we will devote the next two issues in *Chicago Medicine* to helping you fully understand what's being asked of you—and why, and when—so you make as smooth a transition as possible.

1ST YEAR	STAGE OF MEANINGFUL USE							
	2011	2012	2013	2014	2015	2016	2017	2018
2011	1	1	1	2	2	3	3	TBD
2012		1	1	2	2	3	3	TBD
2013			1	1	2	2	3	3

This month's issue provides an overview of the changes. Next month we will explain the nuances of the Medicare and Medicaid Meaningful Use incentive programs, and will give you concrete advice on preparing for the next steps you must take in your practice.

Stage 1 of the Meaningful Use incentive program gives physicians the chance to adopt a certified EHR system, if they haven't already, and get used to the building block functions for basic, effective documentation of a patient's clinical experience. But it's not enough to stop there, because you were already likely doing those things on paper. Stages 2 and 3 help you engage the technology in a way that allows you to take information and quickly make better decisions than you have been able to in the past. This is why most of the changes in Stage 2 focus not only on increasing initial proficiency of clinical EHR use but also on introducing opportunities for clinical decision support, care coordination, and patient engagement. Stage 3 will focus on demonstrating improvements in care, but let's not get ahead of ourselves.

Is Your Practice Falling Behind?

As the timeline illustrates, Stage 2 begins in 2014 for incentive program participants who first attested, or proved they are meaningfully using a certified EMR, in 2011 and 2012. Those starting in 2013 and later will spend two years in Stage 1, two years in Stage 2 and two years in Stage 3 (which has yet to be defined). If you haven't begun the process yet, you are strongly encouraged to consider that your practice is falling behind the national standard. Starting in 2015, there will be

CORE OBJECTIVE	STAGE 1 MEASURE	STAGE 2 MEASURE
Computerized physician order entry (CPOE)	30% of medications	60% of medications 30% of labs 30% radiology
Electronic prescriptions	40% of all prescriptions	50% of all prescriptions
Demographics	50% of patients	80% of patients
Vital signs	50% of patients	80% of patients
Smoking status	50% of patients	80% of patients
Interventions	Implement 1 clinical decision support rule	Implement 5 clinical decision support rules (4 linked to clinical quality measures)
Labs	40% of lab results incorporated as structured data	55% of lab results incorporated as structured data (was optional, now required)
Clinical summaries	50% of patients who request a summary receive it in 3 business days	Summaries provided to patients in 1 business day for 50% of visits
Electronic messaging		*New* A secure message was sent by more than 5% of patients

penalties to your Medicare payments if you do not achieve Meaningful Use.

Key Changes in Stage 2 Objectives

You will find that overall, there is no change in the number of objectives between Stage 1 and Stage 2, but there is a change in the number of required "core" objectives and the selectable "menu" of objectives physicians may use to demonstrate Meaningful Use. While Stage 1 requires 15 core objectives and five menu objectives, Stage 2 requires 17 core measures and three menu objectives that can be chosen from six options.

Many of the thresholds for structured data objectives, such as demographics and vital signs, have been increased 10 to 30 percentage points. An overview of the changes between Stage 1 and Stage 2 of core objective requirements are listed in the table. For a full explanation of core objectives, visit *www.cms.gov*.

In addition to the increased thresholds, the most significant changes involve patient engagement and exchange of clinical data. The important role that physicians play in encouraging patients to adopt and use health information technology is reflected in newly added core measures requiring more than 5% of patients to send a secure message to their physician and more than 5% of patients to access their health information online. These are the first measures that require patient action in order for a physician to meet the measure, most likely through the use of an EHR-tethered patient portal. To successfully meet the requirements, doctors must begin to educate their patients about the benefits of EHRs to their care, as well as describe the proper uses of patient portals that provide online access to health information and secure messaging functionality.

Highlighting the importance of the exchange of clinical data, the Stage 1 core measure requiring physicians to provide a summary of care document for more than 50% of patients who request it has changed. In Stage 2, physicians are required to provide online health information access to more than 50% of all unique patients. Additionally, they must demonstrate that a summary-of-care document can be sent electronically to a recipient with a different EHR vendor or to a CMS (government) test EHR system.

This transmission may require physicians to have access to both a certified EHR and certified electronic data exchange mechanism. With most of the Stage 1 menu measures being upgraded to the core of Meaningful Use, the newly added Stage 2 menu measures focus on improving the level of information in patient records and encouraging physicians to continue to participate in sharing data with public health entities. Program participants will now be able to select three of six menu measures that focus on incorporating additional data, such as imaging results, family health history and progress notes; participating in syndromic surveillance programs; or submitting data to cancer or disease specific registries.

Although reporting on clinical quality measures (CQMs) has been removed from the core requirements for Stage 2, all physicians will still be required to report on these measures to demonstrate Meaningful Use. Starting in 2014, nine out of 64 CQMs from a core set (which has not yet been finalized) will have to be reported electronically through the Physician Quality Reporting System, commonly known as PQRS, or a CMS-designated electronic transmission.

Physicians participating in the Medicaid incentive programs will submit their data through state-based tools. In addition to leveraging existing reporting mechanisms, CMS also plans to align many existing quality reporting programs to streamline the reporting process and reduce the reporting burden placed on physicians who may participate in more than one program.

Physicians have plenty of time to meet each of these measures—and many of them may be closer than they think. For more information about Stage 2, please refer to regulations and guidance under Medicare's EHR incentive programs.

Once you review the new Stage 2 rule, the Chicago Health Information Technology Regional Extension Center (CHITREC), will be happy to answer your questions. Please contact us at *info@chitrec.org* or go to *www.chitrec.com,* and we will explain what the changes might mean for you.

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 records.*

STAGE 2 MENU MEASURES

Data in EHR	Registries
Electronic progress notes for 30% of patients	Report cancer cases to state registry
Record patient family history	Report specific cases to a specialized registry
Imaging results should be accessible	Electronic submission of syndromic surveillance data

"Physicians participating in the Medicaid incentive programs will submit their datea through state-based tools."

Tide is Turning on Physician Compensation

Pay gap between specialists and primary care doctors slowly closing **by Bruce Japsen**

COMPENSATION of primary care physicians across the country—and in Chicago's Midwest—is rising faster than pay to specialists as health insurance plans and the government move toward reimbursement that rewards lower-cost outpatient medical care and those who provide it.

An analysis of physician pay by the Medical Group Management Association indicates a greater shift to lower-cost primary care as insurance companies, employers, and government health programs try to provide financial incentives to health professionals who work in medical groups, doctors' offices, and clinics. MGMA's survey mirrors other new reports out in recent weeks as the health care industry undergoes rapid reform and transformation during a period when government leaders and private insurers and employers are unwilling—and in some cases unable—to pick up the tab for the increasing cost of health care.

"No matter how the new White House or Congress decides to implement health reform or Medicare payment, health insurance companies are already moving toward payments that reward coordinated care for larger groups or "populations" of patients through so-called accountable care organizations (ACOs)."

Median compensation for primary care physicians in the Midwest grew nearly 6% last year to $212,394, capping a five-year increase of 16.7%, from 2007 to 2011, MGMA's 2012 Physician Compensation and Production Survey shows. Even though specialists make nearly two times as much as their primary care colleagues, specialized doctors saw median compensation levels in the Midwest rise just 10.3% over the same five-year period of 2007 to 2011, or $389,436, compared to $353,064 in 2007.

Nationally, the increase was similar, with primary care doctors seeing a 5.1% increase in median compensation to $212,840, which capped a five-year jump of 16.7% from 2007 to 2011. Specialists, meanwhile, saw their median compensation grow a bit more slowly at 15.6% from 2007 to 2011, to $384,467.

Pay Gap Slowly Closing

Analysts say the pay gap between specialists and primary care doctors is slowly closing as policymakers, members of Congress and the White House fret about overall health care costs. Primary care physicians such as internists, family doctors and pediatricians are expected to take on a greater role as health insurance benefits are expanded in the next 15 months under the Affordable Care Act.

"There has been an increased weight in the importance of primary care services and we can see that the forces contributing to that trend will only continue," says Todd Evenson, who is MGMA's director of data solutions.

No matter how the new White House or Congress decides to implement health reform or Medicare payment, health insurance companies are already moving toward payments that reward coordinated care for larger groups or "populations" of patients through so-called accountable care organizations (ACOs). These forms of payment also put more risk on the primary care doctors who have opportunities for rewards and higher compensation but also risks if their groups don't achieve the various quality measures set up by insurance companies or the government.

Under the Affordable Care Act, larger doctor groups and hospitals are forming ACOs to contract with the Medicare program, and more than 150 such organizations, including many led by physicians, have formed to contract with the federal program, the government announced this summer. Insurance companies are also moving away from fee-for-service medicine to "bundled" payments to hospitals and doctor groups and that places pressure on providers to keep patients in primary care settings.

Moving Toward Team Approach

"The industry is moving toward a team approach in delivering care," says Dr. Michael Nochomovitz, president of University Hospitals Physician Services in Cleveland and a past member of the MGMA board of directors. "There appears to be a growing focus on primary care providers in anticipation of new methodologies in payment, a focus on coordination of care, and the imperative to control utilization and costs in the system."

Physician staffing and recruitment firm Merritt Hawkins annual 2012 "review of physician recruiting incentives" reflects the coming change in compensation away from rewarding physicians based on the volume of medical care services they provide.

More than one-third, or 35% of physicians, were offered bonuses "based on the quality of medical care that they provide," according to Merritt Hawkins survey, which uses for its research the more than 2,700 physician recruiting assignments the Irving, Texas-based company tracks nationwide. By comparison, in 2007, just 7% of physicians were offered bonuses based on the quality of care they provide their patients, Merritt Hawkins said.

Still, analysts say the compensation change to quality bonuses for all doctors will not happen overnight.

"The tide is turning, but increasing the volume of services they provide remains the most practical way for physicians to increase their incomes," says James Merritt, founder of Merritt Hawkins.

Employment status is also affecting doctor pay to a greater degree. "There is increasing employment of physicians by integrated delivery systems and hospitals, which may also explain these shifts in compensation for primary care physicians," Dr. Nochomovitz says.

"Non-physician providers continue to play a pivotal role in the provision of health care services throughout the United States."

A shortage of primary care physicians is also playing into the trend of increasing compensation for these doctors because there simply aren't enough of them. And if these doctors are going to stay in the primary care disciplines, the pay is going to have to rise, analysts say.

Merritt Hawkins said primary care physicians "remain at the top of the wish list for most hospitals, medical groups and other health care organizations," the Dallas-based company said in its 2012 analysis of doctor recruiting incentives.

For the seventh consecutive year, Merritt's report says, family physicians and general internists were Merritt's "two most requested physician search assignments." In contrast, certain specialties are no longer in demand such as anesthesiologists, which dropped from Merritt Hawkins' list of top 20 most requested doctor searches for the first time in the survey's 19-year history. This is directly related to increasing use by hospitals in certain states of certified registered nurse anesthetists.

MGMA's data showed anesthesiologists' compensation grows rather slowly compared to other specialties, rising just 6.7% over the five-year period ending in 2011. Only obstetrics/gynecology, radiology, and psychiatry had slower growth in compensation over that five-year period.

Cost Pressures

Certain specialties are under cost pressures from insurance companies and government payers.

"At the end of the day, they are compressing the amount of dollars that are left over," says MGMA's Evenson. "Compensation is a function of collections."

Changes in health care and compensation trends

are also opening the door to traditionally lower paid mid-level health professionals to move up the pay scale as they take on a greater role in the system.

"Non-physician providers continue to play a pivotal role in the provision of health care services throughout the United States," Evenson says. "People are using their services in the most effective way. They allow the system to operate more fluidly and more effectively for the patient."

Physician assistants in primary care earned $94,115 in median compensation in 2011, capping a 16% increase over the period from 2007 to 2011. Meanwhile, nurse practitioners' compensation soared 18% to $91,123 during the same five-year period.

"We have seen some strong growth in compensation of these mid-level non-physician providers," Evenson says. "From a growth perspective, nurse practitioners have gone from the $70,000 range in 2007 to the mid-$90,000 range."

Nurse practitioners are being financially rewarded for filling voids in the primary care field. Nurse practitioners are in particular demand by hospitals and clinics working to complete their shortage of primary care doctors while grocery stores and retail pharmacies like CVS and Walgreens hire more practitioners to staff their growing number of in-store clinics.

The relationship between medical doctors and nurse practitioners that seemed adversarial in the past is growing more into a partnership to address primary care needs, analysts say.

Nurse Practitioner Demand?

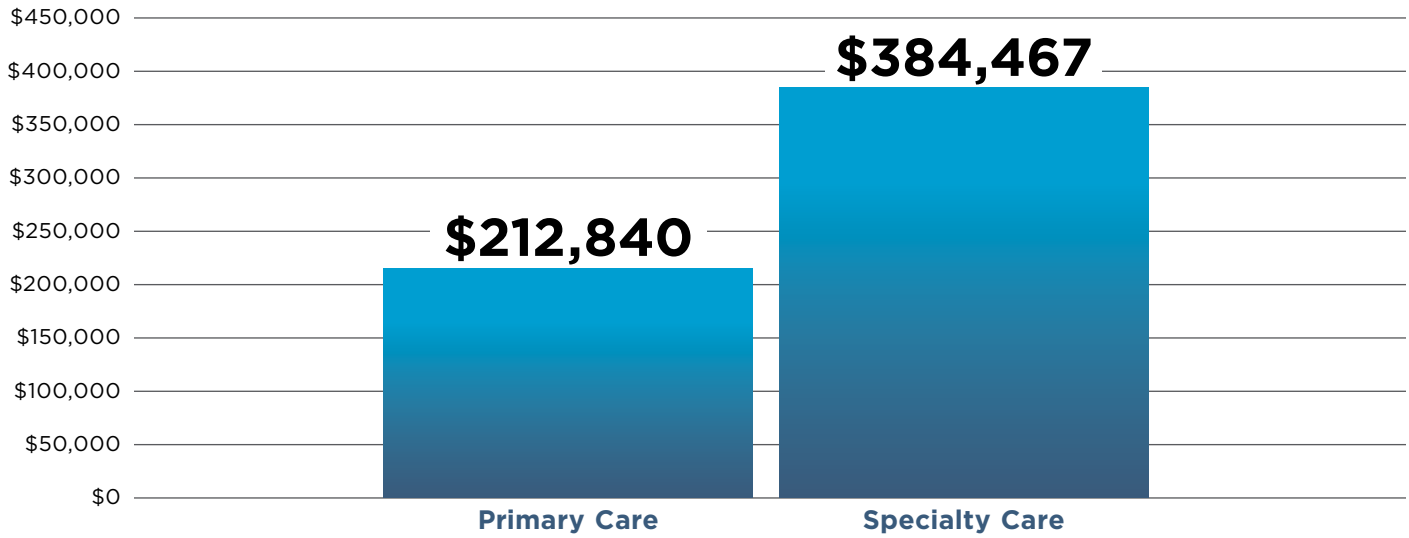
Once millions more people have coverage under the Affordable Care Act, analysts expect there will be even more demand for nurse practitioners and physicians assistants. When the Supreme Court this past summer upheld the individual mandate that will require millions of Americans to buy health care coverage on state-run insurance exchanges, it meant there will be an influx of patients with a pent up demand for health care services flocking to doctors' offices, hospitals and clinics.

Given the shortage of primary care doctors could be exacerbated under this scenario, the health system is going to need more primary care professionals of all varieties, particularly when certain areas of the country are already experiencing a shortage.

"People still have issues getting primary care in rural and urban settings and you are going to need more mid-level (health professionals)," Evenson says. "You're going to need more nurse practitioners, DOs and MDs because there has been a shortage of them all. If there are new folks entering the system as insured lives, there is an expectation that there will be increased demand for services."

Bruce Japsen is an independent Chicago health care journalist and a contributor to the New York Times and blogger for Forbes at www.forbes.com/brucejapesen/. He was health care business reporter at the Chicago Tribune for 13 years and is a regular television analyst for WTTW's Chicago Tonight, WBEZ's 848 program, CBS' WBBM radio 780-AM and 105.9 FM and WLS-News and Talk, 890-AM. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com.

Median Compensation Levels



Primary Stroke Centers More Likely to Give tPA

Increased use of intravenous thrombolysis for acute ischemic stroke

by Shyam Prabhakaran, MD

In this ongoing series about stroke care, Dr. Prabhakaran reports findings from a study he led in Illinois and that was published in Stroke, a journal of the American Heart Association, in December 2011.

STROKE CONTINUES to be the most disabling of any neurological disease, as well as one of the leading causes of death in the United States. The annual incidence of stroke in the U.S. is now 780,000, and and the most recent cost estimates of stroke care hae been calcualted at a staggering $74 billion. Here in Chicago, more than 9,000 people are estimated to have a stroke each year.

A recent study examined the association between duration of time at a Primary Stroke Center (PSC) and tPA utilization for acute ischemic stroke (AIS) in Illinois. The study included a retrospective analysis of the Illinois Hospital Association's (IHA) CompData and the identification of patients with a primary discharge diagnosis of acute ischemic stroke and those who received tPA. Information obtained from this dataset showed type of admission (from emergency department, transfer from another facility, or other), hospital characteristics (regional, teaching vs. non-teaching hospital, number of hospital beds >200, Primary Stroke Center designation, length of time with this designation) and type of insurance (private, Medicare, Medicaid, self-pay, or other).

Clinical information included percentage usage of tPA, length of stay, and discharge destination (home, acute rehabilitation, skilled nursing facility, another hospital, or death). For length of time at a PSC, data was obtained from the Joint Commission's website, and acute ischemic stroke patients were identified by nine discharge codes (433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, or 436.0). Other information utilizing PSC data characterized patient care as follows: care received in a PSC, care by a non-PSC, PSC>1 year before, <= 1 year before, <=1 year after, and >1 year after PSC certification. Analyses were performed to calculate the odds ratio for tPA utilization by PSC category.

A total of 119,539 acute ischemic stroke patients were documented in the IHA CompData set from 2003-2009. The mean age was 72 years and 55.2% were female. The majority of patients had Medicare insurance (72%) and more than 80% of the hospital admissions were from the emergency department. Of all regions in Illinois, Cook County had the highest number of AIS discharges at 45.7%, and only 16% of those with AIS were at teaching hospitals. Somewhat surprising, the majority of AIS discharges went directly home (43.8%), with the remainder going to acute rehabilitation facilities (17.9%), skilled nursing facilities (22.6%), another hospital (10.5%), or death (5.2%).

During 2003-2010, the number of PSCs steadily increased to 52 as of September 2010. Cook County had the most PSCs, totaling 24, with northern areas of the state having the second highest number of PSCs, at 14, followed by central (8), north central (5) and southern (1). During this period, care was provided by a PSC in 14.7% of patients.

Although more than 119,000 acute ischemic strokes were noted in the database, only 1.9% of those cases were treated with tPA. However, the proportion of tPA use was significantly higher among acute ischemic stroke patients treated at a PSC (5.7%) compared to 1.2% at a non-PSC. There was a strong relationship between increased odds of tPA use and length of time at a PSC. [Use of tPA: odds ratio 2.37 (95% CI 1.52-3.71) for >1 year after PSC certification].

No Waning Over Time

The findings demonstrate that tPA usage is strongly associated with PSC designation and the length of time of this designation. The results also suggest that quality improvement processes at PSCs do not wane over time but rather enhance tPA use. This trend was seen prior to passage of the Illinois Primary Stroke Center Act. Following its enactment and implementation of regional stroke systems of care, many expected tPA utilization at PSCs would further increase as patients arrived earlier and EMS gave pre-notification when triaging suspected stroke patients to PSCs. Preliminary data from Chicago suggest a 5% absolute increase in tPA use at PSCs associated with regional policies that route suspected stroke victims to stroke centers. Therefore, PSCs and policies to get patients to them are having a major impact on time-sensitive treatment for acute stroke.

"Here in Chicago, more than 9,000 people are estimated to have a stroke each year."

Dr. Shyam Prabhakaran is a stroke neurologist, and associate professor in the department of neurology at Northwestern Feinberg School of Medicine.

The History of Pyloric Stenosis in Chicago

Local physicians paved the way **by John Raffensperger, MD, and Timothy Lautz, MD**

Early History

In 1904, Dr. John B. Murphy, the "Stormy Petrel of Surgery," performed an anterior gastroenterostomy on an infant with hypertrophic pyloric stenosis in Chicago. The infant had vomited at three weeks of age and was four pounds beneath his birth-weight at seven weeks. His death, 12 hours after surgery, was most likely due to severe malnutrition and metabolic alkalosis. Dr. George F. Thompson, who reported the case, noted a 54% mortality rate for the surgical treatment of pyloric stenosis. The first operation for pyloric stenosis in the United States was performed by Dr. Willy Meyer of New York in 1898, using a Murphy Button. The device was too large and the patient died almost immediately after the operation. Dr. Thompson accurately described the bile free vomiting, gastric distention and the palpable tumor characteristic of pyloric stenosis. In his report, he mentioned a baby who had survived a gastroenterostomy performed by Weller Van Hook, who was the chief of surgery at Northwestern from 1899 to 1908.

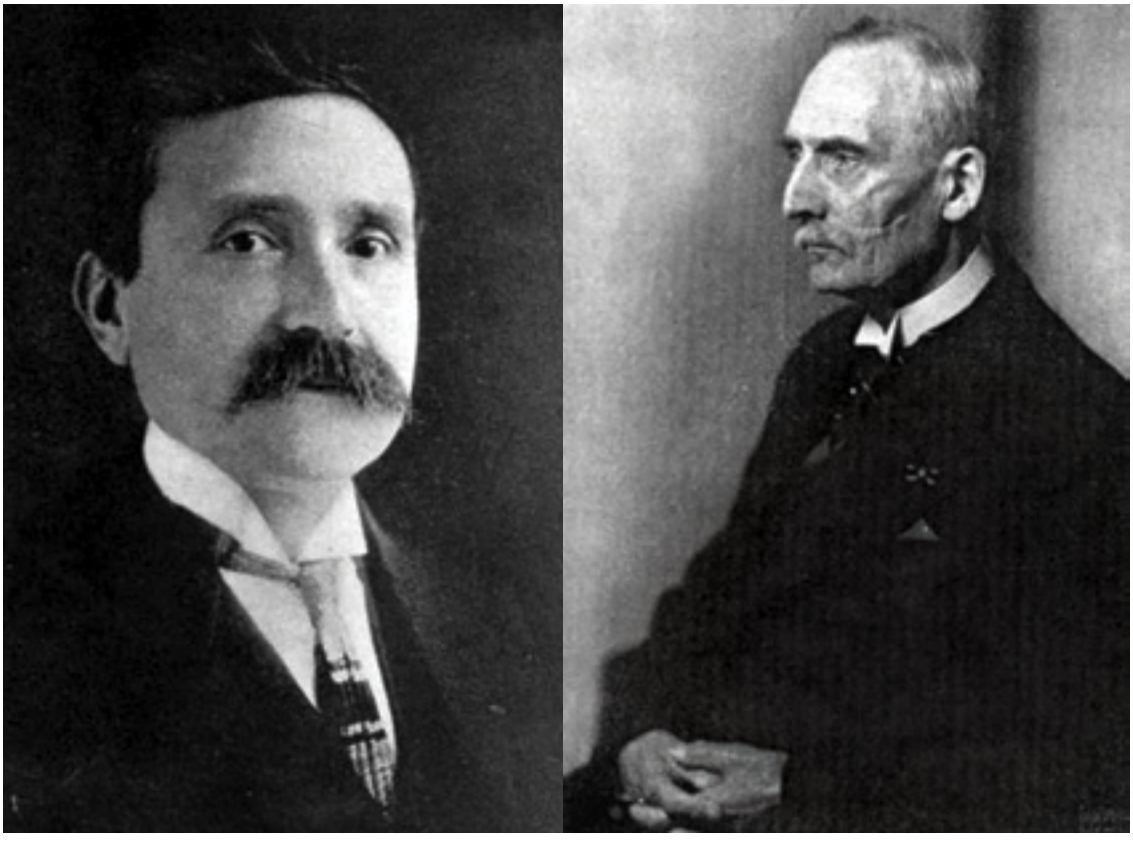
Dr. Arthur Dean Bevan did a gastroenterostomy on the first reported surgical survivor in Chicago on Dec. 10, 1905. Dr. H.W. Cheney, who reported the case, described the pylorus as firm, a somewhat hard, rounded rather elongated mass the size of a hickory nut. The infant thrived and by 11 months was taking whole milk, crackers, toast and egg.

By 1911, Dr. Bevan, who had operated upon four infants with three survivors, recommended gastric lavage prior to surgery and subcutaneous fluids. He said, "The children I have operated upon have developed in every way as healthy normal children. I pray you to give these poor little chaps the benefit of a good job of plumbing done early under the best aseptic and operative technique." Although Dr. Bevan reviewed the current literature, he missed the reports of Pierre Fredet's extramucosal pyloromyotomy in 1907 and 1910. Perhaps, this was because Germany was dominant in science and medicine at that time.

Dr. Bevan [1861-1943] was born in Chicago, graduated from Rush Medical College in 1883 and was chief of surgery at the Presbyterian Hospital until 1934. He was a founding member of the American College of Surgeons, president of the AMA in 1918 and president of the Chicago Surgical Society in 1908.

In 1968, William Longmire, in an address to the American Surgical Society, counted Bevan as one of the "wise men in American surgery."

Dr. Dean Lewis, another Rush surgeon, and Dr. Clifford Grulee, a pediatrician, reported on five infants who had survived surgery. Dr. Lewis said, "Gastroenterostomy is well stood by infants if performed rapidly and without much trauma and all infants have developed normally." In 1914, Dr. H.M. Richter, at Northwestern University reported on 22 operations for



Pierre Fredet (left) and Conrad Ramstedt (right), originators of the extramucosal pyloromyotomy that became the standard operation for pyloric stenosis in the 1920s.

pyloric stenosis with only three deaths. This was the largest series in the United States with the lowest mortality rate.

The Ramstedt Pyloromyotomy

Dr. Lewis graduated from Rush in 1899 and was a Cook County intern with Kanavel and Richter. He was a professor at Rush and was chairman of surgery at the University of Illinois until he was called to Johns Hopkins to follow Halstead as Professor of Surgery. By 1917, Dr. Lewis had performed the Ramstedt pyloromyotomy on four infants with no deaths. These, apparently, were the first reports of the Ramstedt operation in Chicago.

Ramstedt's operation became the standard treatment because of its simplicity and greatly reduced mortality rate compared to gastroenterostomy. In 1930 Dr. Bevan demonstrating a Ramstedt operation to a "wet clinic" and said, "We have developed a technique which makes the Ramstedt operation one of the most finished pieces in the entire field of abdominal surgery." During that clinic, Dr. Bevan did two cholecystectomies, drained an abdominal abscess, repaired bilateral undescended testicles, and did a radical mastectomy for cancer.

Dr. Edwin Miller, a graduate of Rush and a Cook County Hospital internship, joined the Rush faculty in 1915, then served in France during World War I. He and Dr. Sumner Koch were attending surgeons at the Cook County Children's Hospital from 1920 until 1947. During that time, he published many papers on children's surgery. He served in New Guinea during World War II, and was surgeon in chief at the Presbyterian Hospital from 1949 until 1954.

In 1933, during a symposium on "Important Operations in Children," Dr. Miller discussed errors in the diagnosis of pyloric stenosis, perforation of the duodenal mucosa, incomplete separation of muscle fibers, bleeding and evisceration. He suggested using a magnifying glass to ensure complete separation of the muscle and a transverse incision through the posterior sheath of the rectus muscle to prevent evisceration. In 1964, Dr. Miller, in a report to the Chicago Surgical Society, had the last word on patients who had a gastroenterostomy during infancy; all four of his patients had episodic gastrointestinal bleeding and two had definite marginal ulcers.

Dr. Alfred Strauss, with Dr. Isaac Abt, at the Michael Reese Hospital, studied a model of pyloric stenosis in dogs and modified the Ramstedt operation by shelling out the mucosa, and cutting thin flaps of muscle that he sutured back around the mucosa. In 1918, he had 65 surgical cases with three deaths. By 1926, Drs. Abt and Stauss reported upon 221 patients with seven deaths, a 3% mortality rate. They recommended Bismuth x-rays to make the diagnosis, infusions of subcutaneous saline and blood transfusions. The operation lasted only 12-15 minutes and feedings were commenced one hour following the operation. Of the seven infants who died, two were moribund upon admission to the hospital, one had peritonitis, two died with influenza during the epidemic of 1918, one had a pulmonary embolus, and one had multiple intestinal atresias.

Dr. Strauss, one of Chicago's most successful surgeons, graduated from Rush Medical College in 1908. He had a large surgical practice that included rich and famous people. Dr. Strauss was famous for demonstrating an increased survival rate in patients whose cancers were treated with electrocoagulation.

The argument over spasm versus hypertrophy of the pyloric muscle started with the earliest descriptions of the disease. Dr. John Gerstley of Michael Reese considered every case as "spasm" of the pylorus and recommended a medical regimen consisting of paregoric and bromides for sedation and thickened feedings given every two hours. He said, "Take the child away from the hands of nervous mothers and give the infant to calm unemotional nurses."

More Chicago physicians, however, drew attention to the symptoms of the disease and recommended the Fredet-Ramstedt operation as early as 1918. Some, like Dr. Max Thorek, who founded the American Hospital and the International College of Surgeons, made his own modifications. Isaac Abt, a Cook County Hospital intern and first director of the Sarah Morris-Michael Reese Children's hospital was instrumental in educating physicians about the need for surgery in infants with pyloric stenosis.

"More Chicago physicians drew attention to the symptoms of the disease and recommended the Fredet-Ramstedt operation as early as 1918."

Progressive Decline in Surgical Complications

Dr. Harry Oberhelman, while an attending surgeon at County and chairman of surgery at Loyola, reported upon 85 infants treated 1925 until 1946. In three, the diagnosis was wrong, two required re-operation and there were four duodenal perforations. There were nine deaths, a mortality rate of 10.7%. Five deaths were due to "shock," two resulted from evisceration and one operation was incomplete. Another baby died with "cerebromalacia." Dr. Oberhelman reported that during the last six years covered by his report, there had been only one death in 51 cases.

Dr. John Keeley, Dr. Oberhelman's associate, and later an attending surgeon at County and chairman of Loyola's surgical department was at least partly responsible for this improved survival. In 1949, Dr. Keeley discussed the need for careful preoperative treatment for dehydration and nutritional deficiencies.

He also recommended a high transverse incision, which essentially eliminated the postoperative evisceration seen so commonly in malnourished babies with a vertical incision.

During the five-year period, 1953 to 1958, the

mortality rate for pyloromyotomy at Cook County Hospital increased to 14%. There were no wound eviscerations but there were two duodenal perforations. Postoperative vomiting due to inadequate pyloromyotomy accounted for four post-operative deaths and the other three died with pulmonary complications secondary to aspiration. One infant whose stomach had not been emptied prior to surgery died immediately after surgery. These abysmal results were partly due to a shortage of nursing personnel, but largely because of surgical error. Most of the operations were performed by residents with little supervision and the pre and post-operative care was by inexperienced pediatric residents. During the next decade, with the advent of full-time attending physicians in pediatrics and pediatric surgery, the mortality rate was reduced to near zero.

"During the 1960s, with the advent of full-time attending physicians at Cook County Hospital in pediatrics and pediatric surgery, the mortality rate was reduced to near zero."

Dr. Willis J. Potts, another graduate of Rush Medical School who practiced general surgery and became an associate professor at Rush, became Chicago's first full-time pediatric surgeon. In 1938, he reported to the Mississippi Valley Medical Society on operations for pyloric stenosis performed at Children's Memorial Hospital. Ten of 78 patients died between 1923 and 1932, a mortality rate of 12.8%. Between 1932 and 1937 the mortality rate was reduced to 3.55%. Dr. Potts emphasized palpation of the abdomen for the pyloric tumor with the stomach empty, while the baby relaxed with a sugar nipple.

He also advised giving these infants 200 mL of dextrose in saline subcutaneously and recommended blood transfusions for especially sick babies. He avoided barium x-rays and emphasized emptying the stomach prior to an operation under ether anesthesia. In 1959, Dr. Potts reported upon 750 operations between 1938 and 1959, with one death. This was in a 3 1/2 lb. premature infant whom he had personally operated upon.

Earlier diagnoses and improved intravenous nutritional therapy markedly improved the preoperative condition of these infants during the 1960s. The high transverse incision eliminated evisceration as a postoperative complication; routine emptying of the stomach and improved anesthetic techniques eliminated pulmonary complications. The mortality rate for infants with hypertrophic pyloric stenosis reached zero. There remained, however, the rare, but important complications of duodenal perforation and incomplete separation of the muscle fibers. Dr. Pierre Fredet, the French surgeon who did the first extramucosal pyloromyotomy, had in 1927 demonstrated how the duodenal mucosa often folded back over the stomach and how to avoid duodenal perforation. The Quinby maneuver, which applies traction on the gastric mucosa, allows separation of muscle beneath the acute angle of duodenum without perforation of the mucosa.

The instrument used to separate the pyloric muscle was improved by grinding down the outside rounded edge of an ordinary hemostat, to flatten and narrow the blades. The thinner blades are easier to insert into the muscle and don't slip during the separation.

The Modern Era

Experienced clinicians are unduly proud of their ability to make the diagnosis by observation of the peristaltic waves and palpation of the pyloric tumor. There are times when the baby simply won't relax and palpation is difficult. Gastrointestinal x-rays are not always reliable and there is reluctance to do barium studies for fear of aspiration and the difficulties of removing barium prior to an operation.

By the mid-1970s, real-time ultrasonography offered a safe technique to literally "see" inside the abdomen. Dr. Arnold Shkolnik of Children's Memorial Hospital, a pioneer in pediatric ultrasonography, demonstrated the hypertrophied muscle as a thick hypoechogenic ring around a central "donut" hole. We clinicians hung our heads and humbly requested ultrasound to confirm our diagnoses.

At the beginning of the 21st century, with greater ease in making the diagnosis and the virtual elimination of death and surgical complications, attention turned to eliminating pain, cosmetic improvement of the incision, reducing costs, and shortening the hospital stay. Minimally invasive surgery in the form of laparoscopy replaced open methods for the treatment of pyloric stenosis. Since 2007, more than 150 laparoscopic pyloromyotomies have been performed at Children's Memorial Hospital with good results. Although still an active area of research, data from our institution as well as from an international randomized controlled trial demonstrate equivalent complication rates with open and laparoscopic surgery.

Acknowledgements

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For a list of references, please contact *esidney@cmsdocs.org* or call 312-329-7335.

Dr. Raffensperger is a former surgeon-in-chief at Children's Memorial Hospital in Chicago and professor of surgery at Northwestern University. He authored surgical textbooks, along with a history of Cook County Hospital; Dr. Lautz is a surgical reserach fellow at Children's Hospital of Chicago Research Center.

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Healthy New Food Carts

One step closer to eliminating food deserts **by Bechara Choucair, MD**

IN MEDICAL school, during residency, and in my clinical practice, I spent a lot of time with my patients talking about changing individual behavior as a key element to deal with obesity. In my role at the Chicago Department of Public Health (CDPH), I spend a lot more time focusing on the adoption of the right policies, systems and environmental changes to combat obesity in our City. We need both approaches to make a difference. As a City, we have made the elimination of food deserts and reducing the number of people living without access to fresh and healthy food a priority in Healthy Chicago, our city's public health agenda. Nearly 15% of Chicagoans, about 400,000 people—still lack convenient access to fresh produce and other healthy foods. Some neighborhoods have no grocery stores, while others are served by small corner stores that carry little or no produce, offering snack foods, sugary beverages, liquor and tobacco.

I often hear from clinicians that as they discuss healthy eating with their diabetic or overweight patients, access to healthy food comes up as a significant barrier to healthy living.

At CDPH, we are well aware of the impact that access to healthy foods can have on persons who live in communities with low food access. This is why rolling out the new healthy food carts is a public health achievement for Chicago.

This past June, the Chicago City Council approved a new ordinance that allows healthy food carts to operate across the City, providing new avenues for small business development while working to increase access to healthy fresh food throughout Chicago's neighborhoods. The new policy is strategically designed to place produce stands where our city needs them the most, in food deserts.

Javon Vivretter manages a healthy food cart on the corner of State Street and Chicago Avenue.

Currently, there are 15 healthy food carts in various Chicago neighborhoods. Over 50% of these carts are in areas designated as food deserts, ensuring that residents in these areas have increased access to healthy food. We are also seeing healthy food carts in busy areas such as main intersections with high foot traffic and public transportation sites, specifically within food deserts. In the first two years, we expect to see up to 50 carts throughout Chicago, resulting in the shrinkage of 2.5 square miles of food deserts in Chicago. Northwestern University is conducting an evaluation of these carts over the next two years to determine the economic and health benefits to Chicagoans.

This is another opportunity for our City to address a growing health concern, not only in Chicago but across many American cities experiencing high rates of obesity. In Chicago 67% of adults are either overweight or obese. As you know, adolescents are now being diagnosed with high blood pressure and Type 2 diabetes, which until recently was seen primarily in older adults. Researchers anticipate this could be the first generation with a lower life expectancy than its parents.

We know that people who eat produce three times a day or more are 42% less likely to die of stroke and 24% less likely to die of heart disease than those who eat them less than once a day. We know that 70% of Chicagoans, both adults and youth, are failing in this area and not eating the daily recommended servings of produce. For many, this is not an issue of preference, but rather one of access. This is why the healthy food carts are an important strategy in our toolbox for a healthier living. That toolbox also includes strategies for working with corner stores to make fresh fruit and vegetables available and working with mainstream grocers to open stores in communities with low food access.

I am very excited about the progress we are making in addressing food deserts. If you would like to learn more, please check our website at *www.cityofchicago.org/health* or follow us on Twitter (*@ChiPublicHealth*). As always, I am happy to respond to any emails at *Choucair@cityofchicago.org*.

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

Safe Patient Handling: A Must for Illinois Hospitals and Nursing Homes

Are physician practices next? **by Andrés J. Gallegos, JD**

LAST JULY, Illinois joined ten other states in enacting legislation aimed at controlling the risk of injury to patients, nurses, and other health care workers involved in transferring, lifting or moving of patients. P.L. 97-0122 amended the Hospital Licensing Act to require hospitals, by Jan. 1, 2012, to adopt and implement safe patient handling policies and establish strategies designed to control and minimize the risk of injury to mobility-disabled patients and members of the hospital's staff. This July, Governor Quinn approved a substantially similar amendment, P.L. 97-0866, to the Nursing Home Care Act. Effective Jan. 1, 2013, nursing homes in Illinois must also develop and implement safe resident handling policies to foster and maintain resident safety, dignity, self-determination, and choice in relationship to the manner in which residents are transferred, lifted, repositioned, and moved. Will the legislature extend similar requirements to physician practices next summer? Arguably it does not have to since physician practices already have a legal duty to ensure safe handling of the patient, but if disability rights advocates and labor organizations like the Illinois Nurses Association have their way, then yes.

The legislation requires hospitals and nursing homes to assess the risk of injury to patients, nurses, and other health care workers posed by the transferring and lifting of the populations they service. Restrictions on lifting must be achieved to the extent feasible with existing equipment and aids, while manual handling or movement of all or most of a patient's body is to be done only during emergent, life-threatening, or otherwise exceptional circumstances. Some of the other provisions include staff education and training on safe lifting procedures and the proper use of various lifting equipment, and the creation of safe lifting teams who must receive specialized and in-depth training, and demonstrate proficiency in the use of safe lifting techniques, safe lifting equipment, and accessories. The legislation also contains a procedure for a nurse to refuse to perform or be involved in handling or movement that the nurse believes in good faith will expose the patient, resident, nurse, or other health care worker to an unacceptable risk of injury without fear of retaliation.

The impetus behind safe patient and resident handling legislation is the need to ensure safety for persons with mobility limitations or mobility disabilities, and the health care workers caring for them. However, the risks the legislation addresses are prevalent in physician practices as well. For many people with mobility limitations or mobility disabilities, access to examination and diagnostic equipment, like examination tables, x-ray or mammogram machines, can be difficult or impossible if the equipment is not height-adjustable and if there is no lift equipment available. Health care workers in all practice settings are often not trained to provide lifting assistance, and often are unwilling to lift patients onto inaccessible examination and diagnostic equipment for fear of risk or injury to themselves or the patient. Some patients with mobility limitations or mobility disabilities do not wish to be lifted, out of fear that they will be dropped or injured. Given these considerations, health care providers frequently conduct examinations or diagnostic tests while those patients remain seated in their wheelchairs, which can generate inaccurate test results or conceal physical evidence required for appropriate diagnosis and treatment. As a result, persons with mobility limitations or mobility disabilities have learned to bring persons to assist them or just stop seeking preventative care altogether and present for medical care only when it is absolutely necessary.

While the safe patient handling laws do not yet apply to physician practices or other healthcare facilities other than hospitals and nursing homes, physician practices nevertheless have a legal duty to provide lift and transfer assistance to patients with mobility limitations or mobility disabilities when needed, and potentially face legal exposure for failing to do so. The safe patient handling legislation provides specificity to pre-existing legal requirements under Title III of the Americans with Disabilities Act (ADA)

"Some patients with mobility limitations or mobility disabilities do not wish to be lifted, out of fear that they will be dropped or injured."

and Section 504 of the Rehabilitation Act of 1973 (Rehabilitation Act), both of which apply to hospitals, nursing homes, physician practices and all other health care facilities and providers as public accommodations and recipients of federal financial assistance. The general prohibition in both those Acts prohibit discrimination on the basis of disabilities in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations. A physician practice that fails to provide lift or transfer assistance to persons with mobility limitations or mobility disabilities denies such persons the full and equal enjoyment of its practice. The failure to have safe lifting equipment, such as portable or ceiling lifts, to facilitate safe patient transfers, potentially exposes physician practices to workers compensation claims from its nursing and other patient care staff.

For the benefit of the mobility limited or mobility disabled patients they care for, and the benefit of their nursing and other patient care staff, and to minimize the potential legal exposure under the ADA and the Rehabilitation Act, physician practices should voluntarily adopt and implement the requirements of the safe patient handling laws.

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Managing Medical Staff Conflicts

Good organizational structure and leadership are crucial **by Elizabeth A. Snelson, JD**

The Chicago Medical Society and American Bar Association have established a formal relationship to address medical-legal issues affecting CMS members and their practices. This legal section is sponsored by the Health Law Section of the American Bar Association.

EVEN IF YOUR medical staff has been operating smoothly, it needs to have conflict management processes in place to satisfy recently adopted Joint Commission standards. This is especially true if your medical staff does not operate smoothly, in which case conflict management should be built in to the medical staff bylaws, to keep quality medicine the top priority.

Conflicts with Hospital Board

Medical staffs and their hospitals' governing bodies are supposed to collaborate, and have a mutual interest in providing care successfully to patients treated in the hospital. Occasionally, even rarely, the positions of the medical staff and hospital may diverge to the point of conflict. Conflict may arise from the board's refusal to adopt medical staff bylaws amendments, or differences in opinion over the addition of a new clinical service. In such circumstances, conflict can undermine public confidence in the hospital, in potential patients or donors, and cause serious rifts in the collaboration necessary to provide care.

Effective conflict management processes avoid such consequences. To meet the requirements set out in Joint Commission Standard LD.02.04.01, Element of Performance 4, the processes should include:

- Meeting with the involved parties as early as possible to identify the conflict.
- Gathering information about the conflict.
- Working with the parties to manage and, when possible, resolve the conflict.
- Protecting the safety and quality of care.

Conflicts within the Medical Staff

When the medical staff organization confers considerable authority to the medical executive committee, or when the medical executive committee's composition is not representative of the medical staff, or the committee otherwise fails to adequately represent members, conflicts can flare up between the two groups. Good organizational structure and effective leadership should prevent conflicts from happening, and are the best form of conflict management. A conflict management process is not just added insurance, but is necessary for compliance with Joint Commission Standard MS 01.01.01, Element of Performance 10, which states: "The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, policy, or an amendment thereto."

The conflict resolution process is not required to address conflicts over medical staff bylaws amendments. Medical staff bylaws are subject to adoption by the entire voting staff, while rules, regulations, and policies can be adopted by the medical executive committee, if the medical staff has delegated it that authority. Conflicts between the medical staff and the medical executive committee over bylaws amendments are resolved by a long-standing conflict management system: voting.

Creating Processes for Conflict Management

The Joint Commission calls for medical staff conflict management processes to be in place, but does not provide much direction on establishing those processes. Here are some tips for setting up conflict management processes for your medical staff:

- Put the conflict management process in the medical staff bylaws. Although not a requirement, placing them in the medical staff bylaws allows the medical staff organization and the board—two potentially conflicting parties—to vote on the processes, thus promoting buy-in, and giving the processes the weight of the bylaws.
- The board does not decide. There is no reason why the medical staff should accept processes that direct all conflicts through information gathering and a meeting or two, only to be finally determined by the hospital board—but hospitals typically design them to do exactly that. Sadly, the Joint Commission does not call for the conflict management process to be fair. In the case of a conflict between the medical executive committee and the medical staff, it would be a contradiction of medical staff self-governance to involve the hospital board. In the case of a conflict between the board and the medical staff, the board would have no incentive to participate effectively in any discussion, much less compromise, if it ultimately can make the final decision anyway. That the board has "ultimate authority" does not mean the board cannot commit to an even-handed conflict resolution process.

Exempt Peer Review

While corrective action involving membership or clinical privileges may well result in conflict, peer review is no circumstance for a conflict resolutions process. The hearing and appeals procedures included in medical staff bylaws are (or should be) carefully designed to protect the members involved, and allow the member and executive committee to appeal a hearing committee's decision, resolving peer review-related conflicts within the stipulations of Illinois statutes.

Medical staffs that have yet to adopt conflict resolution processes in their bylaws should be aware that the hospital may have adopted unilateral conflict management policies, without medical staff involvement. Do not wait for conflicts to arise before adopting conflict resolution processes.

The author is legal counsel for the Medical Staff, PLLC. She may be contacted at easesq@snelsonlaw.com.

What's Next for Illinois' Medicaid Program?

Will it really be a "boon" to Illinois?

THE CHICAGO Medical Society works through the Illinois State Medical Society to influence legislation at the state and federal levels. The policy-making and legislative process begins in the CMS Governing Council, where any physician member can sponsor a resolution. After being debated and adopted by the CMS Council, resolutions go directly to the State Society, with input from its influential Governmental Affairs Division. In addition to supporting pro-medicine policies and legislation, our organizations work to prevent harmful bills from becoming law. Our scope is ambitious and comprehensive. And members enjoy tangible results and savings as a result of our advocacy.

ISMS provided the following article for Chicago Medicine.

To hear Gov. Pat Quinn tell it, the expansion of Medicaid and the creation of health insurance exchanges will be a huge boon to Illinois.

The governor recently told Modern Healthcare that, "at the beginning of 2014, we have an opportunity to give about a million and a half more people in our state health care coverage, which would be a great legacy achievement, and I'm really committed to that" (video interview posted Sept. 5, 2012).

Of course, public officials aren't prone to following their statements with the kinds of qualifications, terms and conditions you hear at the end of pharmaceutical ads on TV, so let's dig into the details.

Medicaid Expansion

A significant portion of those 1.5 million people will gain coverage through a major expansion of Medicaid. The governor seems excited about an influx of federal cash to the Medicaid program: "The first couple years we get 100% federal funding, and then a couple years after that it goes down to 90%, but what a bargain… to insure a million and a half people for a rather modest state investment," he said. "It's gonna save us money, it'll pay huge dividends."

Given the current state of Illinois' Medicaid program, however, there is cause for concern. Illinois has proven unable to meet its current commitments, even with our state's abysmal Medicaid fee schedule, which ranks behind 40 other states. The program is also reeling from $1.6 billion in cuts enacted earlier this year. In light of this, it is no comfort that the Medicaid expansion will be funded mostly by federal dollars.

We hope Illinois policymakers will be sensitive to these facts as this Medicaid expansion moves forward.

Illinois physicians face a harsher reality. If Medicaid reimbursement continues to follow the current fee schedule, Illinois physicians will face reimbursements that do not even cover their costs, even as physicians in other states are reimbursed at more reasonable rates. No business can survive under those conditions.

Many other unknowns remain. What percentage of Illinois patients will rely on Medicaid? Will other cost-saving measures, like limitations on prescription drugs in the Medicaid program, compromise their care? Will higher fee schedules in surrounding states draw much-needed doctors away from Illinois? It's too soon to tell, but many fear that by the time these questions are answered, it may be too late.

Health Insurance Exchange

For those who hope to buy insurance on the upcoming health insurance exchange, there is more troubling news. The Illinois General Assembly has not taken action quickly enough for Illinois to get an exchange up and running by the deadline.

Fortunately, this doesn't mean there will be no exchange—remember that the Affordable Care Act guarantees exchanges even if states cannot, or will not, set them up themselves. As a result, Illinois officials have been in contact with the federal government, which will help our state establish its exchange.

Even assuming that such a partnership works smoothly and Illinois patients are able to shop for insurance in the exchange at the beginning of 2014, it is far from clear what "essential health benefits" those policies will cover. Nor is it clear that full-featured plans that meet Illinois patients' needs will be affordable once the federal government stops subsidizing them a year or two down the road.

As the answers to all these questions emerge, we will be here to keep you informed and help you stand strong even on shaky ground. Through the confusion and uncertainty, there is one fact that you can count on: the Illinois State Medical Society will advocate for fair reimbursements and a health care system that works for patients and physicians in Illinois.

To learn more about ISMS' legislative advocacy programs, member benefits and services, please go to www.isms.org *or call 312-782-1654. And be sure to visit the CMS website* www.cmsdocs.org *or call 312-670-2550.*

"If Medicaid reimbursement continues to follow the current fee schedule, Illinois physicians will face reimbursements that do not even cover their costs."

We Want Your Input!

The Chicago Medical Society represents all physicians **by Elizabeth Sidney**

TODAY'S physicians are exasperated with the myriad changes in their profession. But Dr. Howard Axe, president of the Chicago Medical Society (CMS), has a message for Cook County's physician community: "Your medical society is working to represent all doctors in all specialties in dealing effectively with the new health care environment." Speaking before a CMS district leaders' roundtable on Aug. 25, Dr. Axe said CMS is bringing new voices and perspectives to its Governing Council, a crucial step that will translate into a more inclusive, responsive organization.

"My number one goal is to engage members at the grassroots level," the Arlington Heights-based internist said. Since taking office in June, he has implemented key changes to unite Chicago's physician community. For example:

- CMS created seats on its Governing Council for hospital medical staff leaders and specialty medical society representatives.
- CMS is encouraging ALL members to bring a resolution to the Governing Council asking CMS to adopt policy or take action on an issue. Resolutions are the driving force behind many legislative proposals and advocacy initiatives. Resolutions need simply state a problem and the desired solution. Once adopted, resolutions move on to the legislative bodies of the Illinois State Medical Society and American Medical Association, for implementation in the General Assembly or U.S. Congress. "CMS leaders advocate personally with lawmakers, relaying the experiences and frustrations of individual members," Dr. Axe said. "But we need our members' feedback and participation."

CMS' eight districts form a network that is the foundation on which CMS is actively building new collaborative relationships. In the past year alone, the Society worked with the Department of Health and Human Services, Centers for Medicare and Medicaid Services, and American Bar Association to educate members on health care fraud, legal issues, and electronic medical records.

Dr. Axe is also mobilizing CMS' districts to promote programs and services at CMS and new opportunities for member engagement. "Members need to know that CMS is working to build coalitions that unify and strengthen physicians' voices." Dr. Axe said.

"We encourage all members to bring a resolution to the Governing Council for study and debate," Chicago Medical Society President Howard Axe (far right), told CMS District leaders during a recent Saturday morning roundtable discussion.

Advocacy Platform

CMS' Governing Council provides an advocacy platform for all 17,000 physicians in Cook County. With the support of medical schools, hospital medical staffs, and specialty medical societies, the Council aims to unify the region's fragmented medical organizations around shared interests. "A single strong body advocates more effectively than smaller ones going at it alone," Dr. Axe emphasized.

CMS' committees provide still more opportunities for member involvement. Committees address a range of interests and needs, studying issues suggested by members, assigned by the Governing Council and by the CMS leadership.

Districts reinforce CMS advocacy by identifying "key contacts," physicians who want to work with lawmakers on issues important to the Society. This new program mentors participants on the political process and how to communicate effectively with legislators. Working with their districts, key contacts will organize legislative breakfasts and political roundtables, and report back to their colleagues on specific bills and legislation.

The key contact program is complemented by the CMS mini-internship program, which arranges for a lawmaker to shadow a doctor for a day. The mini-internship is designed to highlight the challenges of practicing medicine and the effects of legislation on physicians and patients.

"Whether members serve on a committee, write a resolution or attend Council meetings, we want our members to know there is value in belonging to CMS, and that their membership can work for them," Dr. Axe said.

Log on to www.cmsdocs.org, *CMS' new website to view the breadth and depth of your society's services. The website is also a resource for education, recruitment, advocacy, and communication with CMS leaders and one another. And to find out how you can be more involved, or to ask questions, contact Dr. Axe at:* cmspresident@cmsdocs.org.

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Resident and Medical Student Mistreatment

A growing problem or a more visible problem? **By Megan Gayeski, MD, Co-chair, CMS Resident and Fellow Section**

The situation is common—medical students whispering about the feared attending who has reportedly thrown objects in the operating room when someone answers a question incorrectly. Or some residents who say they fudge their work hours out of fear their institution might get in trouble. At almost every institution in the country, there is talk behind closed doors about the darker side of our profession, with specific examples of poor behavior. While mistreatment occurs in all walks of life and even among us students and residents, the culture of medicine has its own particular brand.

What is considered mistreatment of medical professionals, as opposed to someone being short with another person after another stressful day? What can we do to bring this discussion to the forefront of our profession? And what can we do to change patterns of bad behavior?

In fall 2011, the LCME, ACGME, and AMA held a joint meeting on the subject of medical student and resident mistreatment. Interestingly, it was almost impossible for everyone in the room to agree on what exactly mistreatment was. While there were some obvious answers (physical and sexual abuse, for example), other examples were not as clear. It also became obvious that medical students, residents, and physicians have different definitions and different ways of dealing with mistreatment.

Because the stakes are so high in undergraduate and graduate medical training, we fear that reporting what happens may have potential repercussions. As medical students, we worry about getting a dreaded pass or even a failing grade in a rotation we need to graduate, much less landing a spot in our desired residency program. As residents, we are afraid of jeopardizing our relations with our institution and possibly our residency program. While most medical schools and residency programs are now publicizing different ways to report mistreatment, many of us believe that a culture of intimidation is preventing an honest conversation on this topic.

The Medical School Section will be holding a session on the treatment of residents during the upcoming AMA Interim Meeting, Dr. Gayeski reports.

Defining Mistreatment

As a direct result of the joint meeting, the Graduation Questionnaire, which is sent to every graduating medical student by the Association of American Medical Colleges, was revised. Instead of first asking if students had been victims of mistreatment and then asking them to define mistreatment, students were asked if they had ever experienced situations that would be defined by most of us as mistreatment. By asking about specific behaviors or incidents, nearly 50%, or half of this year's intern class, reported at least one mistreatment incident during their medical school career. In the past, less than 20% of students indicated that they had been mistreated.

With this recent data has come a flurry of exposés on the culture of medicine. When released at the beginning of August, practically every medical student and resident read Dr. Pauline Chen's "The Bullying Culture of Medical School," which detailed new initiatives at the University of California-Los Angeles to change the culture of medicine.

However, the conversation has been mostly focused on medical students, who make up the undergraduate medical population, and not on residents. Yet last April, KevinMD blogged that Chinese factory workers have better mistreatment policies than residents. Are statements like that really true? In an attempt to sort things out, the Medical School Section will be holding a session during the AMA Interim Meeting this November on the treatment of students and residents.

How to Help?

As individuals, what can we do to help change the situation? First, it helps to be educated. Schools and residencies are now required to publish instructions for reporting unacceptable behavior. There is concern, though, that many medical students or residents won't know where to find this information or what to do. One emerging technique allows students and residents to anonymously report incidents or behavior directed at themselves or others. Another allows them to report mistreatment when it occurs, but does not release the incident report until the person has completed a particular rotation or their entire schooling. Still another technique allows individuals to report to someone hired by the university or institution but still entirely removed from medicine and with the power to conduct an investigation.

Second, for change to occur we have to speak up. When we feel we have been mistreated, we need to do more than report our experiences on the Graduation Questionnaire or in memoirs.

Finally, we must encourage other students and residents not to mistreat others. Possibly the most surprising piece of information gleaned from the Graduation Questionnaire is the fact that many students feel they are being mistreated by their own classmates. If we can't even play well together among our peers, how on earth can we expect those around us to behave differently?

The Golden Rule tells us to treat others as we wish to be treated. It should guide the interactions of all members of the health care team.

CMS Council Highlights

Going to bat for independent physicians **by Elizabeth Sidney**

THE CHICAGO Medical Society's newly expanded Governing Council kicked off the 2012-2013 year on Sept. 18 with an overview of the current political landscape and the potential impact of the November elections. The policymaking body also voted overwhelmingly to advocate on behalf of its independent physician members, by supporting the concept of equal pay for identical services and for changes in the Medicare program. Meeting highlights included an appeal from an FBI special agent for doctors' help in combating health care fraud.

The Governing Council is an advocacy platform for all Cook County physicians, CMS President Dr. Howard Axe said, as he welcomed new councilor-representatives from nine area hospitals. Recent changes to the governing structure give seats to hospital medical staff leaders and specialty medical societies. To complement this expansion, CMS is encouraging all members to submit resolutions, an activity that was once reserved only for councilors.

The modifications allow grassroots physicians to shape the direction of CMS in a way never before possible, Dr. Axe emphasized. In response to this opportunity, rank and file members recently submitted eight new resolutions, a clear sign they want to be involved in the organization. The Resolutions Reference Committee will meet on Nov. 5 to consider the resolutions and make recommendations for the Nov. 27 Council meeting. CMS is working closely with its districts to educate members on utilizing resolutions to accomplish their goals, Dr. Axe said. *See story on page 20.*

The Governing Council meets quarterly to set CMS' policy agenda and legislative objectives for the coming year. Members are urged to use this forum to bring issues and concerns directly to their peers and the CMS leadership.

Support for Independent Practice

As compensation models change, doctors are rapidly leaving independent practice to join larger health systems. Yet payment policies tilt the playing field away from private practice in favor of hospital-based services. A resolution asking CMS to protect reimbursement for independent physicians resonated strongly with the Council. And with little fanfare, the governing body voted overwhelmingly to support the concept of equal pay for physician services regardless of practice setting and to correct the pay imbalance within the Medicare program.

The resolution directs CMS to identify stakeholders and legislators to introduce legislation that would enact a policy change within Medicare, and to request policy adoption and similar action by both the Illinois State Medical Society (ISMS) and American Medical Association (AMA).

Approval of this resolution underscores CMS' commitment to members who practice independently, and account for the majority of CMS physicians. The measure also protects patients by promoting transparency in payment policies. As noted in testimony, the higher cost of doing business in a hospital is unfair to consumers, who may be assessed a surcharge facility fee, ultimately increasing the cost of health care for employers and society in general.

The many concerns raised in this resolution were highlighted in *The Wall Street Journal* (Aug. 27, 2012) in an article reporting the cost of heart scans increased fourfold in a Reno, Nevada, cardiology group after it was bought out by a local hospital system. A growing number of rate increases are tied to physician-practice acquisitions, likely resulting in higher Medicare spending, according to the article.

In coming months, CMS workforce surveys will pinpoint the needs and interests of both independent and employed physicians.

Council guest speaker Jeffrey Jamrosz, an FBI special agent, who supervises the Chicago field office for health care fraud, urged doctors to routinely check their billing records for anything unusual. "It's important to be aware of providers or companies that bill in the referring doctor's name," he said. Mr. Jamrosz is flanked by (from left) Drs. Robert W. Panton, CMS president-elect, Howard Axe, president, and Kathy Tynus, chairman of the Council.

Combating Health Care Fraud

Another major trend in the shifting practice environment is the prosecution of health care fraud. To allay the worries of CMS members who fear that simple billing mistakes could lead to an investigation, your Society hosted guest speaker Jeffrey Jamrosz, an FBI special agent who supervises the Chicago field office for health care fraud.

His talk was the first of several informative programs CMS hosted in September to keep doctors apprised of changes under the *Affordable Care Act*.

Indeed Jamrosz offered councilors many tips on protecting themselves and appealed to them to report suspected cases of misdoing, no matter how trivial seeming. Small things can be the tip of the iceberg, and Chicago is considered a hot spot for activity.

Fraudsters rob the Medicare program of $273 million a day. In some areas of the country, drug dealers have switched to health care fraud because it's easier and involves less prison time, Jamrosz said. But Medicare fraud strike forces are changing that with stiffer sentences.

When physicians sign up for a provider number to bill Medicare, it's like taking the Hippocratic Oath, Jamrosz explained. That number is a very powerful thing, conferring a special duty.

"You are taking responsibility for the key that allows other people to bill for services" he said.

Almost anyone can commit fraud because a doctor's number is readily available on Google.

Jamrosz urges physicians to routinely check their billing records for anything unusual. It's important to be aware of providers or companies that bill in the referring doctor's name, like durable medical equipment companies and home health agencies, he stressed.

"Is your name being used repeatedly by the same agency as justification for a $2,000 brace, and how many years has this been going on?" Jamrosz asked. He says the FBI sees many cases where patients are paid to sign forms for physical therapy when no services are actually provided.

During the waiting period after a doctor applies for a Medicare number, services should never be billed under another physician's name. The federal program also rates providers according to risk, which means that physicians without permanent offices may be denied Medicare numbers.

"A simple call to Medicare to find out who is using your number at least creates a record showing interest. If we come knocking on your door, you can say you called up, or wrote a letter," he said.

"Ultimately, you are responsible for your practice and need to create processes to safeguard it," Jamrosz emphasized.

How do state and federal authorities decide when to investigate?

"We are interested in off the chart cases, where something egregious is going on," Jamrosz assured doctors.

Investigators look at irregular practices and data anomalies, not inadvertent mistakes. In fact, most audits show some under and over coding, Jamrosz said, and this is considered normal.

He recommends that physicians use reputable billing services and avoid contracts that give the biller a percentage of reimbursements.

Catching up with credit card companies, Medicare is now relying on sophisticated data mining tools, and algorithms. "The program's fraud command center cycles through claims to see where potential fraud is and try and stop it or identify it in real time as opposed to openly catching the 3% to 5% of claims that are actually physically audited by a person," Jamrosz explained. And it seems to be working fairly successfully.

Each dollar spent on enforcement saves

one-and-a-half times that amount. Looked at another way, enforcement provides a return of $4 billion or 4%. "While not the greatest return in the world, we spend one-fifth of that amount on enforcement," Jamrosz said.

The federal government wins 95% of cases it brings, but detecting fraud remains very difficult, Jamrosz noted. "That's where we need help from doctors who suspect a "bad actor" to give us the little nudge we need."

He said that big fraud investigations often begin with someone seeking revenge. Informants are a rich source of material for investigations as are whistleblowers and defendants who want to cut a deal.

Physicians are ideally situated to observe and report suspicious practices. Under what's known as the qui tam provision, whistleblowers may receive up to 20% of the return if the government decides to intervene in a case and the whistleblower's information proves accurate.

In 2011, whistleblower complaints led to roughly $2.8 billion in recoveries, an increase of $500 million over 2010.

This past July, GlaxoSmithKline LLC agreed to the largest health care fraud settlement in U.S. history—$3 billion—and the largest payment ever by a drug company. Whistleblowers in this case were amply rewarded, Jamrosz said.

"You're out in the community; you see what's going on. Just give us your tip on where to go and where to start and we'll try and take it from there."

Countdown to SGR Cuts

As the year comes to a close, physicians who accept Medicare are bracing once again under the threat of SGR-imposed cuts. In what has become an annual rite, Congress enacts a temporary fix to stop the projected cuts that grow bigger each year because of the flawed funding formula.

As expressed by Dr. William N. Werner in his Council address: "The previous patch-but-don't-fix-it approach to dealing with the flawed funding formula means we are now facing a 27% cut in reimbursements on Jan. 1, 2013."

The Illinois State Medical Society (ISMS) president said that physicians may feel immune to the threat because Congress has always saved the day with a last-minute patch.

But the cuts are very real, Dr. Werner stressed. The state of Illinois stands to lose over $1.04 billion each year for the care of elderly and disabled patients without Congressional action.

To add insult to injury, last year's Budget Control Act imposes a 2% across-the-board cut for physicians, hospitals and insurers in 2013. "Medicare patients will pay the price when $11 billion is stripped from the program if Congress fails to act," Dr. Werner cautioned.

Vigorously opposing these cuts, ISMS and CMS are working to educate physicians and patients about the Medicare Patient Empowerment Act. This legislation, currently sponsored by only one Illinois Congressman (Rep. Aaron Schock) would allow Medicare patients to privately contract with their physicians. ISMS recently joined more than 100 other states and specialties in a letter calling for Congress to intervene in both impending cuts.

For more information, to participate in an online petition, and to contact your federal lawmakers, please go to *www.isms.org* or *www.cmsdocs.org*.

Politics of Health Care

Against a backdrop of election uncertainty, ISMS' James Tierney updated councilors on the current political landscape in Illinois.

The vice president of state legislative affairs affirmed "there is no more divisive political issue than health care. The debate and disagreement over state and federal health care policy has been raging for decades."

And the battle will go on no matter who wins control in Washington, DC.

"Even if the *Affordable Care Act* were to be repealed, which is highly unlikely, reforming our health care system will continue to be a major issue with our federal and state governments," Mr. Tierney predicted.

There's Still Common Ground

While Democrats wish to follow through with the implementation of the Act, Republicans are seeking ways to privatize federal programs, including a major overhaul of Medicare that would essentially give senior citizens a voucher to purchase private insurance.

Despite significant disagreements—there is common ground between the two parties on health care, Mr. Tierney said.

"Both the extreme left wing and the extreme right wing believe the cost of our health care system is out of control. At the federal and state levels, policymakers have been looking for ways to control and cut costs. Too often this means cuts or no increases in physician reimbursement."

But the November elections are not the only topics on ISMS' radar.

"Many other issues will confront us in the upcoming legislative session," Mr. Tierney noted. They include proposals to double physician licensure fees; allow psychologists to prescribe drugs; permit physical therapists to treat without a physician referral; allow APNs to practice independently; and permit the insurance industry to limit physician networks.

Take Collective Action

Mr. Tierney advises physicians to take collective action. Contributions to the ISMS Political Action Committee (IMPAC) are pooled together and focused on collective efforts for maximum results.

CMS and ISMS remain the profession's best opportunity to speak with one voice and be heard. Public officials are much more inclined to listen to politically active organizations than to ones that are not active. And the larger the group the closer they listen.

"If physicians want to continue to have a major presence in the halls of government, they must increase their participation in organized medicine and contribute to our efforts to engage in the political process," Mr. Tierney urged.

Doubt over Medicaid Expansion

Expanding Medicaid is one of the primary means of increasing access to care under the *Affordable Care Act*. Though this expansion was mandated by the federal law, the U.S. Supreme Court decision now gives discretion to the states on its implementation. But the Illinois legislature remains divided. Medicaid is already a troubled program plagued by low and slow reimbursement and poor access. The federal government will pay for the expansion during the first few years using the Illinois fee schedule. "We need answers to questions about the economic impact on physician practices when 30% of the population is enrolled in Medicaid, " Mr. Tierney said. "Will physicians subsidize the care because of reimbursement that does not cover the cost of providing that care?"

These issues and more will be the subject of future meetings of the CMS Governing Council. The next meeting is scheduled for Tuesday, Nov. 27.

Focus on Fraud

Symposium spotlights new enforcement environment **by Elizabeth Sidney**

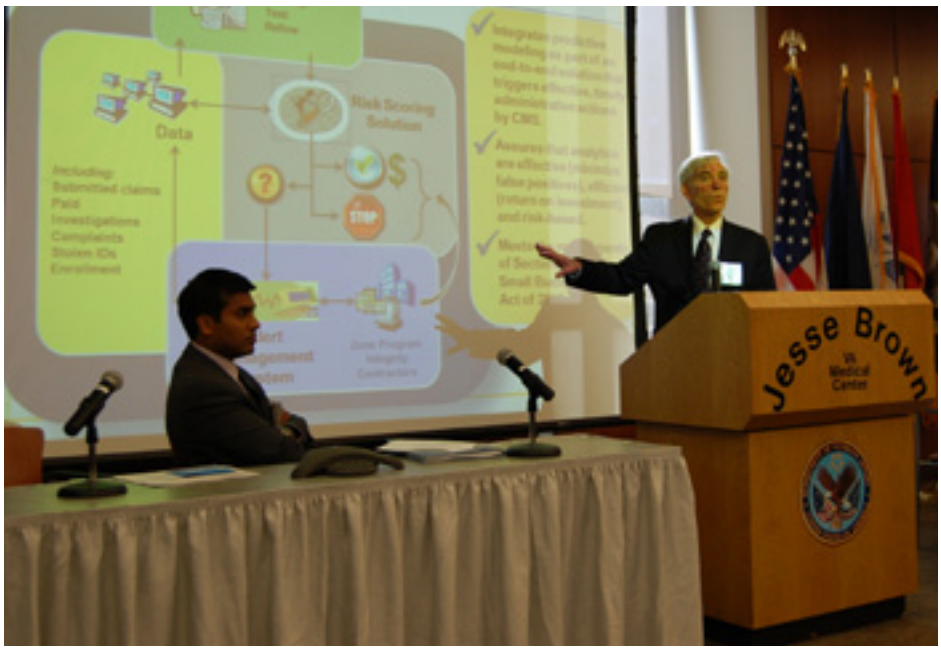
AFTER YEARS of "pay and chase" the federal government is aggressively cracking down on fraud and waste in the Medicare program, leaving no sector of the health care market unturned. To help physicians and staff navigate the new environment, the Chicago Medical Society recently teamed with the federal Centers for Medicare and Medicaid Services to host a joint symposium on health care fraud and prevention.

The Sept. 20 program featured a panel of heavyweights from the U.S. Department of Health and Human Services, Department of Justice, Office of the Inspector General, and Federal Bureau of Investigation. Their collective message to doctors: "You are the first line against bad care. We need your help."

An array of speakers explained to 200 participants how combating health care fraud had become a cabinet-level priority within the Obama administration. Enforcement aims to dissuade others from committing fraud at a time of shrinking budgets and expansion of the Medicaid program under the *Affordable Care Act*. Last year alone, the DOJ and HHS recovered more than $5.6 billion in civil and criminal cases. Recognizing this untapped revenue source, Congress recently allocated another $1 billion on enforcement.

Prevention has moved into the 21st century, with a new focus on claims technology and enrollee screening, according to Peter Budetti, MD, JD, deputy administrator and director of the federal CMS, and Shantanu Agrawal, MD, who serves in the specially created position of medical director of CMS. Enrollment is the doorway to getting in. And for the first time, computer programs are assessing risk using predictive analytics and modeling, based on data from claims, complaints, stolen IDs, and other sources. Federal agencies are talking to one another, sharing information, another first for the various departments that have historically operated separately, said both leaders.

On the enforcement side, the DOJ is investigating more improper payments and removing more bad actors from the Medicare program, Felicia Alesia, deputy chief and health care fraud coordinator of the Chicago office, told participants.



Experts from the Centers for Medicare & Medicaid Services discuss claims technology and enrollee screening: Peter Budetti, MD, JD, (at podium) deputy administrator and director, and Shantanu Agrawal, MD, medical director. Monique Anawis, MD, JD, facilitated the panel.

She said many violations fall under the *False Claims Act*, and involve upcoding, billing for medically unnecessary services and for services never rendered. Home health agencies are an acute concern for prosecutors, particularly in the Chicago area, but the list of bad actors includes surgeons, podiatrists, transportation companies, suppliers, manufacturers, psychiatrists, and nursing homes. In recent years, Alesia's office has seen an uptick in false claims for psychotherapy and services for deceased patients. Under the Act, providers do not need to make a statement directly to the federal government but to an agency or insurance company that submitted the claim to Medicare.

Other enforcement targets involve violations of the anti-kickback and self-referral statutes, such as marketing schemes that provide financial rewards for bringing in new patients. Cash in an envelope in exchange for referrals is strictly forbidden.

Doctors should protect their profession by reporting suspected cases of Medicare fraud, Alesia stressed. Anyone who robs the federal program is likely to submit false claims to other third-party payers.

The False Claims Act allows for the collection of treble damages, and an additional 5,000-11,000 for every false claim submitted. Providers can be pursued for both civil and criminal liability in the same action, Alesia said.

With the establishment of the special Health Care Fraud Prevention and Enforcement Action Team (HEAT) in 2009, the number of cases accelerated dramatically. At least nine states have Medicare fraud strike forces, including one in Chicago.

Rounding out the symposium were representatives from the Illinois Department of Professional Regulation, the state's Medicaid Fraud Control Unit, Office of the Attorney General, Illinois Bar Association, and several Medicare contractors.

Enforcement is coordinated by the OIG, DOJ, and the FBI. Investigations begin with the OIG, although Medicaid investigative activities are delegated to fraud control units established by individual states with federal funding. Once investigators determine that a law has been broken, the case is reported to the U.S. Attorney General and the FBI for further investigation.

Created by Physicians for Physicians

Physicians' Benefits Trust Life Insurance Program

IN 1987, the Chicago Medical Society (CMS) and the Illinois State Medical Society (ISMS) merged their member life and health insurance programs together into a single, professionally administered trust-Physicians' Benefits Trust (PBT). The primary goal of the merger was to offer health coverage and other benefit plans that met and exceeded the expectations of physicians in Illinois. That goal was later expanded to include members of the Illinois State Dental Society (ISDS).

Now known as the Physicians' Benefits Trust Life Insurance Company (PBTLIC), the company is a wholly owned subsidiary of ISMIE Mutual Insurance Company. Doctors can count on PBTLIC to provide their health, Medicare supplement and dental insurance plans. In addition, PBT utilizes other independent, financially sound insurers like the Hartford, to make available additional plans such as Term Life, Long-Term Disability, and Business Overhead Expense insurance.

PBT offers CMS, ISMS, and ISDS members a broad selection of health insurance plans that provide uncompromising quality, flexibility and value. Through the PBT Insurance Program, members can apply for coverage that insures them and their families and also the employees of their practice.

The PBT Advantage

When you choose a PBT health insurance plan, you benefit from several distinct advantages:

- PBTLIC's board of directors is represented by physicians from Cook County.
- PBTLIC is a wholly owned subsidiary of ISMIE Mutual Insurance Company.
- Insureds enjoy "Freedom of Choice" to select any doctor or hospital.
- Coverage is completely portable and travels with you, not your employment.
- Coverage is guaranteed renewable.
- The PBT Health Plans provide some of the most comprehensive eligibility for dependent children who are full-time students.

PBT's Comprehensive Portfolio of Health Insurance Plans

PBT offers multiple plan options when it comes to insuring members, their families, and their employees. Here are a few highlights of the plans available:

- Preferred PPO Plan, Preferred Choice Indemnity Plan, and HSA-Qualified Plan.
- All three plans provide members with multiple deductible options. Plus, these plans provide comprehensive benefits for services like Newborn Routine Nursery Care and Preventive Care.
- These plans are available to individual members, their families and to group practices.

PPO Value Plans and Value HSA-Qualified Plan (Available only to individuals)

Both of these Value Plans are PBT's newest plans and are available to individual members and their families.

With the PBT PPO Value Plan, members can select from two calendar year deductibles; the PBT Value HSA-Qualified Plan provides members with several deductible options. Both plans include a Maternity option, while the PBT PPO Value Plan also includes a Prescription Drug Option. With either of the Value Plans, members can tailor their coverage and premium based on their individual and family needs.

With the PBT Value HSA-Qualified Plan, benefits begin when the individual deductible is satisfied for that individual rather than the family deductible.

PBT Major Medical High Deductible Plan (Available only to individuals)

This plan offers individual members the choice of two deductibles. All in-network eligible expenses are paid at 100% after the insured satisfies the calendar year deductible. As with the other PBT medical plans, this plan also provides comprehensive benefits for Preventive Care services and Newborn Routine Nursery Care.

PBT Medicare Supplement Insurance Plans

Medicare was never intended to cover all health care expenses. There are Part A and Part B deductibles and co-payments that could amount to thousands of dollars of out-of-pocket expenses if an individual doesn't have a Medicare Supplement Insurance Plan.

PBT offers members (and their spouses) age 65 and over, two plan options to help pay for some of the costs not covered or only partially covered by Medicare. Both plans are competitively priced and provide members and spouses with the freedom to choose their own doctor and hospital, and to receive medical services without the need for a referral.

For more information, please visit www.pbtinsurance.com or call 1-800-621-0748, and ask for Option 2. A representative will be happy to an swer questions.

The PBT Health Insurance Program

THE PBT HEALTH Insurance Program gives you the best combination of freedom, choice, and price for you, your family, or your group practice.

Freedom – See the doctor, specialist and hospital you want without referrals.
Choice – Select the plan and coverage options that meet your needs and budget.
Price – Exclusive access to economical coverage for Illinois doctors.

Calendar of Events

OCTOBER

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

24 CMS Board of Trustees
Meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 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.

NOVEMBER

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

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

9:30-11:30 a.m.; Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; Advocate Lutheran General Hospital, Park Ridge; Participants may earn up to 2.0 credits; $89 for CMS members or staff; $129 for non-members or staff. *To RSVP, please contact Elvia 312-670-2550, ext. 338; or* emedrano@cmsdocs.org.

4 CMS Nominating Committee Meets annually to nominate candidates for CMS leadership positions. 9:00 a.m.; Chicago Medical Society, 33 W. Grand Ave., Chicago. *For information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.*

5 Resolutions Reference Committee At this meeting, members will hold hearings on eight new resolutions and make recommendations for the Governing Council. 7:00 p.m.; Go-to-Meeting telephone conference. *For information, please contact Liz 312-670-2550, ext. 335; or* esidney@cmsdocs.org.

7 Practice Management Lecture Protecting Your Practice Against HIPAA Enforcement in a HITECH World. For all physicians and practice managers. With the passage of the HITECH Act, a growing concern involves HIPAA compliance. The Act imposed new compliance obligations, and stiffer penalties for non-compliance, on covered entities and their business associates. It also opened the door for a new wave of government enforcement actions, giving state governments the authority to file suit in federal district court on behalf of state residents for HIPAA violations. Several developments in 2011 point to this renewed focus on HIPAA enforcement. 6:00 p.m.-6:30 p.m. Registration & Light Dinner; 6:30 p.m.-7:30 p.m. Presentation; Speaker: Tracey A. Salinski, Partner, Arnstein & Lehr, LLP, Chicago Medical Society, 33 W. Grand Ave., Third Floor, Chicago; Participants may earn up to 1.0 CME credit. No cost to CMS members or staff; $25 for non-members or staff. *To RSVP, please contact Elvia 312-670-2550, ext. 338; or* emedrano@cmsdocs.org.

10 Advanced Cardiovascular Life Support (ACLS) Recertification Course This day-long course is for all physicians, residents, and allied medical professionals. Mastery of ACLS assures that an individual has the education and training to use this life-saving process properly and safely. To qualify for ACLS training, you must be a medical professional—a registered nurse or physician. ACLS education is mandatory for employment in hospitals, clinics, doctors' offices, and other medical facilities. 8:30 a.m.-4:00 p.m.; Speakers: Vemuri S. Murthy, MD, Program Coordinator and Teaching Faculty, Resurrection Healthcare Training Center, and Dennis McCauley, EMT-P, Course Director, Training Center Coordinator, Resurrection Healthcare Training Center; Chicago Medical Society Building 33. W Grand Ave., Third Floor, Chicago; Participants may earn up to 7.0 CME credits. Fees are $175 for CMS members or staff; $225 for non-members or staff; $125 for residents. *To RSVP, please contact Elvia*

312-670-2550, ext. 338; or emedrano@cmsdocs.org.

10-13 AMA House of Delegates Interim Meeting The legislative and policy-making body of the American Medical Association transacts all business not otherwise specifically provided for in its Constitution and Bylaws, electing general officers except as otherwise provided in the Bylaws. CMS actively participates in the American Medical Association's policy-making meetings, advocating for both members and their patients. Resolutions adopted at the CMS governing Council frequently travel to the Illinois State Medical Society, where they are implemented, before ultimately reaching the AMA. CMS delegates to the AMA may submit a resolution directly to the AMA House for consideration and support. Physicians are encouraged to exercise this membership privilege, ensuring their voice is heard at the highest levels of organized medicine and beyond. Hawaii Convention Center, Honolulu, Hilton Hawaiian Village. *For information, please go to* www.ama-assn.org.

15 Illinois Society of Plastic Surgeons Annual Business Meeting This meeting will be held to elect the new 2013 board of governors and also recognize selected area plastic surgeons. 6:30 p.m.; Metropolitan Club, Willis Tower, 233 S. Wacker Dr., Chicago. *For information, please contact Amanda 312-670-2550, ext. 325; or* aworley@cmsdocs.org.

17 Indian American Medical Association (IAMA) Details TBA

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

Welcome New Members!

The Chicago Medical Society welcomes its newest members elected in September 2012. We are now 36 voices stronger

STUDENT DISTRICT

Jonathan D. Alterie
Pankaj Chhabra
Vanessa Cutler
Sherryl DeLeon
Ashley DiLorenzo
Dan Fischer
Michael D. Henry
Karen E. Jackson
Robert Kasper
Ambreen Khalid
Matthew Koscica
Zachary Kozel
Renee Kreidl
Timothy A. Lane
Michael G. Mank
James A. Mays
Michael J. McKenna
Samuel Muench
Roland Njei
Christina Nypaver
James Park
Alejandra I. Sacasa
Garrett R. Schwarzman
Elaine Tanhehco
Jamie P. Treadway
Patrick R. Tyrrell
Eric Yoo
George Ziegler

RESIDENT DISTRICT

Bridget S. Banach, MD
Yashaar Chaichian, MD
Anthony Del Priore, MD
Megan A. Gayeski, MD
Tracy E. Sambo, MD
Tina R. Shah, MD
Edward C. Yang, MD

DISTRICT 1

Kimberly V. Dettloff, MD

EARN YOUR ACLS CERTIFICATION

THIS DAY-LONG COURSE is for all physicians, residents, and allied medical professionals. Mastery of ACLS assures that an individual has the education and training to use this life-saving process properly and safely. To qualify for ACLS training, you must be a medical professional—a registered nurse or physician. ACLS education is mandatory for employment in hospitals, clinics, doctors' offices, and other medical facilities. The Chicago Medical Society is host.

DATE: Nov. 10

TIME: 8:30 a.m.-4:00 p.m.

SPEAKERS: Vemuri S. Murthy, MD, and Dennis McCauley, EMT-P, Resurrection Healthcare Training Center, Chicago

LOCATION: Chicago Medical Society, 33. W. Grand Ave., Third Floor, Chicago.

CME: Up to 7.0 credits.

COST: $175 for CMS members or staff: $225 for nonmembers or staff; $135 for residents.

TO RSVP: Please contact Elvia 312-670-2550, ext. 338; or emedrano@cmsdocs.org.

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*.

We are a medical center looking for a physician who can accept Medicare patients. Established in 1986. Please call 773-533-2535 ASAP; or email *shahpravinm@gmail.com*.

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

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

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.

Hinsdale—Medical office space available. Several options—new suites and build-to-suit offices. Superior demographics. DuPage County offers lower taxes and insurance expenses. Schramko Real Estate Corporation 630-986-9400 or contact *cjschramko@schramko.com*.

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.

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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

Geriatrician gets "Great Satisfaction"

Being there at time of need **by Scott Warner**

"Too often the elderly don't have anyone to help them make informed decisions and achieve quality of life at the end," says geriatrician Dr. Rajeev Kumar.

ACTRESS BETTE Davis famously opined that, "old age is not for sissies." And many a physician has faced a challenge when dealing with the elderly.

"It's very frustrating for physicians when they treat elderly patients and do not see immediate results," says Rajeev Kumar, MD, medical director of geriatrics and palliative care, Adventist Health Systems, Midwest region. "Sometimes physicians give up on them. But there's a need for a completely different approach when treating the elderly. That's where geriatricians can be called in—as a resource," says Dr. Kumar, who sees patients in their 80s, 90s, and even 100s.

"Even the smallest difference that a physician can make in their lives can be very helpful," says Dr. Kumar, who also serves as president of the Illinois Medical Directors Association, an association of health care professionals practicing in the long-term care setting.

The most vulnerable of his patient population ends up in palliative or hospice care, "where the focus is on providing comfort and symptom relief and making patients feel better, rather than chasing a cure which may not be possible," he says. "Too often the elderly don't have anyone to help them make informed decisions and achieve quality of life at the end."

Patients are "most grateful"

And how does Dr. Kumar react to such an endless wave of end-of-life patients? He couldn't be more gratified. "It is so wonderful to be able to be there at such a time of need. Our patients are the most grateful." And he says he's not alone in his job assessment. "Geriatricians have the highest job satisfaction—and the lowest suicide rates among physicians!"

Another source of satisfaction for Dr. Kumar has been his involvement in the Chicago Medical Society. A member for only four years, Dr. Kumar joined at the invitation of then-President-elect

Dr. David Loiterman, and has risen to become a Council whip, and vice chair of the Resolutions Reference Committee. He's also a delegate to ISMS.

Organized Medicine is Key

"Most physicians are clueless and turn a blind eye and a deaf ear to the health care issues facing us today," he says. "But being part of organized medicine gives us a chance to learn about changes and discuss them with our colleagues. And we are able to bring about change starting with our resolutions and our collaboration with CMS, ISMS and AMA, ultimately influencing legislation."

Dr. Kumar says he encourages his colleagues to get involved by attending CMS District meetings, and sit in on Council meetings as well.

"Be willing to spare a little time, and you can rise quickly to the top and make yourselves heard."

Dr. Kumar's Lifetime Highlights

"IT TAKES ONE to know one' as the saying goes, and no one could know or understand Dr. Kumar better than his wife, Karin Kumar, MD, who, like her husband, is also a geriatrician. The Kumars' are the parents of 8-year-old twins, a boy and a girl, Rohan and Rhea. In addition to the positions mentioned in the story above, Dr. Kumar is also medical director at several other facilities, including Adventist St. Thomas Hospice and Palliative Care in Hinsdale. He serves as geriatrician and teaching attending at Loyola/Hines VA geriatrics fellowship program, and at Hinsdale Hospital family practice residency program.

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