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The Urban Health Initiative

A Model for All Physicians

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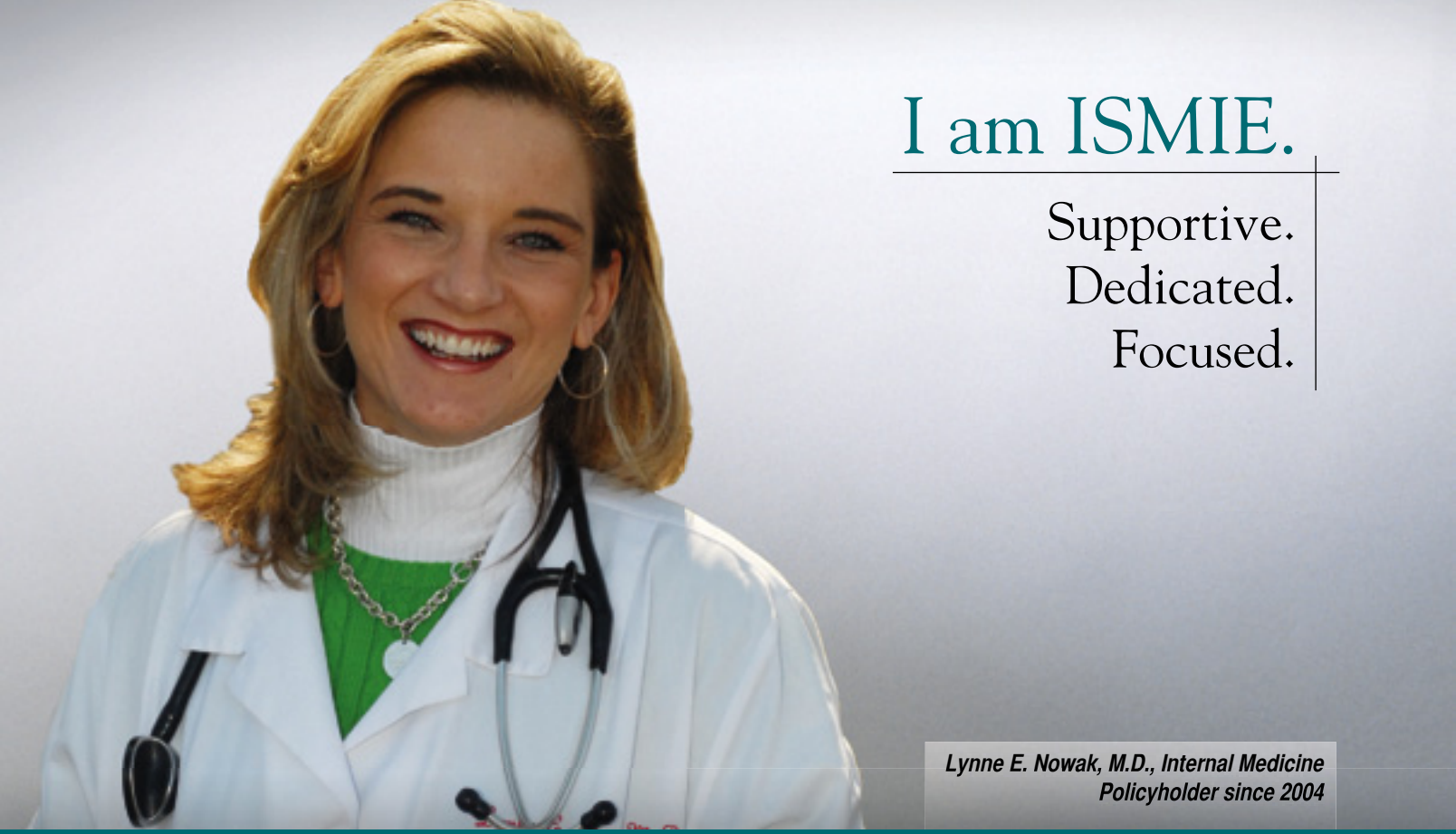

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A Different Kind of Engagement

AS WE ENJOY summer activities here in Chicago, from neighborhood street fairs, to music festivals in Grant Park, to the Air and Water Show, I remember why I chose to live in the Chicago area after completing my residency. Yet summer is also a time when our elected officials return to their districts and their constituents, and an opportunity for us to influence the political process.

When you share your experiences of running a practice and caring for patients, you help to humanize the practice of medicine. You show politicians that medicine can be both tremendously rewarding and overly burdensome. Your specific examples can inform lawmakers when health care issues are debated in the Chicago City Council, in Springfield, and in Washington, DC.

An example of our advocacy involves the Chicago City Council's vote to ban minors from using indoor tanning beds at city salons. Previously, anyone under age 18 could use these facilities with parental consent. The American Medical Association, American Academy of Pediatrics, American Academy of Dermatology, and World Health Organization have all called for a ban against this age group. Your CMS governing body passed a resolution addressing this issue, and the Chicago City Council took action.

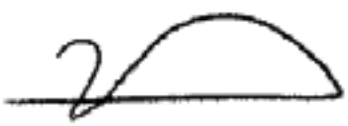
Over 400 pieces of legislation were introduced each session in Springfield recently. While scope of practice challenges continue to come up regularly, two other issues demand your attention.

First, the Medical Practice Act will expire in December if not renewed. Previously, the Act was renewed for 10-year intervals, but in recent years has been extended for only one or two years. Legislators also will discuss an increase to our licensing fee, from $300 for three years to $600 for two or three years. They claim the increase is needed to pay for the oversight of physicians, yet government officials diverted $8 million of the fund into the general fund. We must oppose this tax on physicians.

The second issue involves the Affordable Care Act and creation of an insurance exchange here in Illinois. While many popular issues have been addressed in the law, much work remains to modify the law so the goal of increased access is truly achieved. We must keep informing our legislators how much running a medical practice costs, and how Medicaid slow pay and no pay make it difficult to meet overhead and maintain cash flow. Doctors who don't participate in Medicaid actually decrease health care access. Private practice physicians must know how FQHCs get additional payment to see Medicaid patients. And this pay is often below the cost of providing the service, with rates not tied to the cost of providing care.

You will hear soon about a "Key Contacts" program being created by CMS and ISMS. The program will collect data on members and their connections to elected officials, either personal or professional. This data will help us focus our advocacy on legislators directly involved in deliberations based on their legislative assignments. Please provide any data to CMS staff member Chrissie at 312-670-2550, ext. 326; fax to 312-670-3646; or email *cfouts@cmsdocs.org.*

As physicians, we can influence the legislative process more than we recognize. And re-shape our health care delivery system from the inside out.



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President, Chicago Medical Society

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The Arrival of Clinical Informatics

Meaningful use is one outcome of this new medical subspecialty **by Abel Kho, MD, MS**

MEANINGFUL USE entered the vocabulary for most of us as a required set of measures to receive electronic health record incentive dollars. However, at its core, Meaningful Use is centered on the principle that effective use of electronic health records can improve the quality of care we deliver to our patients. Much of the evidence behind this principle grew from clinical informatics, an interdisciplinary field that brings together best practices from clinical care, information technology, and business processes, and applies them to improving the safety, quality, and efficiency of health care. Until recently clinical informatics professionals labored in relative obscurity. No longer, and especially in Chicago.

Mayor Rahm Emanuel recently declared Oct. 30–Nov. 7 Informatics Week in Chicago. In his proclamation, the Mayor stated, "Chicago is a center for informatics research and education, home to thousands of health care providers who use informatics-based tools and numerous corporations that provide informatics solutions and hire informatics professionals."

Information Resources

IF YOU'RE INTERESTED in finding out more about informatics or how to participate in Chicago Informatics Week, check out these sites:

Chicago Informatics Week
www.chicagoinformaticsweek.org

American Medical Informatics Association
www.amia.org

American Board of Medical Specialties
www.abms.org

CHITREC research initiatives
www.chitrec.org/research

Northwestern University Master's of Science in Medical Informatics:
www.scs.northwestern.edu/grad/medical-informatics-online

University of Illinois at Chicago Master's Degree in Health Informatics:
www.healthinformatics.uic.edu/masters-health-informatics

University of Illinois at Chicago 10 x 10 Course on Patient Safety and Health Information Technology:
www.amia.org/education/academic-and-training-programs/10x10-university-illinois-chicago

Not by accident, Informatics Week coincides with Chicago's hosting of the American Medical Informatics Association's (AMIA) Annual Symposium on Nov. 3–7. This premier scientific conference highlights advances in the effective use of information to improve the health of patients and populations. Chicago-based clinical informatics experts will be well represented at the conference as leaders, presenters, hosts, sponsors, and attendees.

Nationally, clinical informatics has gained important recognition. In September 2011, the American Board of Medical Specialties approved clinical informatics as a board-certified medical subspecialty. This iexciting development signals public acceptance of clinical informatics as a profession, and acknowledges the significant contributions of informatics professionals to the advancement of medicine. Clinical informatics will be offered by the American Board of Preventive Medicine and the American Board of Pathology with testing to begin in late 2012. Fellowship training programs, in addition to 14 existing ones offered through the National Library of Medicine, are currently in the works. Locally, the University of Illinois at Chicago, in partnership with AMIA, offers a three-month program focused on the application of health IT to improve patient safety. Both the University of Illinois and Northwestern University offer online masters' degrees in health informatics.

With wide adoption of electronic health records, technology-related health startup companies are emerging. This past year Chicago hosted the inaugural class of Healthbox, an accelerator program for health care startups. A number of these startups now occupy space in 1871, the technology hub on the twelfth floor of the Merchandise Mart, named after the year of the Great Chicago Fire. Similar startup accelerators have emerged in Silicon Valley, and New York City. As in any industry, most will fail, but some won't, and many of these innovations will find their way back to the future office practice.

So as you are checking off the boxes for Meaningful Use, keep in mind you're using tools developed by the recognized and growing medical specialty of clinical informatics, with acknowledged benefits for health care delivery. The application of technology undergoes the same scientific scrutiny and evidence-based evaluation as other treatments we prescribe for our patients.

Dr. Kho is an internist, informatics researcher, and co-executive director of the Chicago Health IT Regional Extension Center (www.chitrec.org) *assisting providers in Chicago to achieve Meaningful Use of electronic health records.*

The Alert Physician

Five tips for keeping on top of your practice **by Deborah Hill, MBA**

YOU CAN positively affect your bottom line and improve staff and patient relationships in your practice with the following tips. Although it's a cliché, it's still true that the devil is in the details. It's also true that not all surprises are good ones.

Don't shun administrative details. Unless their job description includes the words "mind reader" or "telepathic interpreter," don't expect your staff to be mind readers. This is especially important when it comes to documentation of patient encounters. Participate in the development of effective tools to communicate the important information in your office such as charges, test orders, and referrals. If you are spending your time handwriting commonly performed procedures or frequently encountered diagnoses, it's time to rework the forms to be more efficient.

Don't shun documentation details. Documentation of patient encounters should be a clear portrayal of the patient history, current medical status, factors and conditions contributing to that status, treatment plan and future considerations—in other words, why you did what you did and where you plan to go if Plan A falls through. Your thought process should be clear to not only other medical professionals but also to the layperson. Limit the surprises in your calendar. Sudden and frequent changes to the workday create unnecessary work for your staff and negatively impacts patient satisfaction. Review the daily schedule setup with your manager to ensure sufficient time is allowed for visits and procedures. If a complete physical typically takes 25 minutes, don't set it up as a 15-minute appointment. This will only create unnecessary interruptions to an efficient schedule. Rescheduling patients because of unplanned events—personal or professional—should be very limited. Make a strong commitment to give at least 30 days' notice of such events.

Limit surprises to your bank account. Be sure to keep informed of claim denials, charge adjustments, co-pay collection rate, average days in accounts receivables, and charges/patients turned over to collection agencies. If you have questions about trends or changes, insist that someone go through the numbers with you. If you are only concerned about the amount of your paycheck every month, you don't have your finger on the pulse of your office and you won't sense trouble should it arrive. Make sure that your managed care contracts are current and that someone is checking to ensure payments received are in compliance with the terms of the contract. Watch for inconsistent patterns in your revenue stream that might indicate improprieties in your collections processes. Ask for the details of any adjustments that don't seem quite right.

Invest in an outside perspective. Hire someone to perform an annual or semi-annual audit to identify opportunities that could generate revenue and help the practice be in compliance with current guidelines and regulations. Appropriate coding for the services provided is paramount. Changes to the procedural and diagnosis codes occur every year, and if you and your staff aren't on top of them, you are risking denials and delays by billing deleted or changed codes or missing out on the revenue for new codes. If your staff is using a 2006 CPT book, chances are good you are not billing with current information.

"Prepare your staff and physicians for the impact ICD-10 will have on coding and billing."

- Offer a basic coding/billing class to your entire staff so that each person recognizes their role in the revenue cycle. Every person in the office plays a part in making the office successful. Understanding how each person's performance impacts other areas of the office can be quite enlightening.
- Request utilization information to see how your charging and coding patterns compare to those of your peers nationwide. This bell curve information is exactly what Medicare, Medicaid, and the managed care plans use to identify outliers and target billing audits. This information is available by specialty.
- Prepare your staff and physicians for the impact that ICD-10 will have on coding and billing. Verify that your practice management and electronic medical record vendors are prepared for the monumental task of upgrading your systems to comply with these changes so that there is minimal impact on your daily processes and cash flow.

Conclusion

The commitment you've made to your patients is only sustained by taking an objective look at processes in your office and by taking an active role in redesigning those processes for efficiency and profitability. I encourage you to use these tips to help find and improve the key processes needed to run your office smoothly.

For more information on how to effectively and efficiently run your practice, readers may contact Deborah Hill at dhill@cokergroup.com.

Five Fundamentals of Good Care

Advice to practice managers and office staff

by Alina Baban, Chair, CMS Practice Manager Section

AS PRACTICE managers, we constantly strive to keep our offices running smoothly. In the midst of our organized chaos, we must never lose sight of our end goal: patient satisfaction. In order for us to keep our practices and physicians successful, we must place ourselves in the shoes of the patient and keep in mind the care and compassion we would want for ourselves. We can reach our goal by using tools such as AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank), a program that encompasses five fundamentals of communication to improve patient satisfaction.

AIDET began with a thorough review of literature and best practices, including those from the Studer Group, Press Ganey, Baptist Leadership Group, and high-performing hospitals, according to *Health Management Magazine* (Oct. 25, 2011). Consistent use of this evidence-based approach to good communication has been shown to significantly decrease patient anxiety, improve the patient's perception of care and service, and ultimately reduce the number of complaints while increasing the number of satisfied and compliant patients. Introducing AIDET to physicians and staff creates a strong framework for any practice.

The AIDET program consists of five main behaviors:

A: Acknowledge: Greet patients and their families with a smile and call them by their name whenever possible. It is important to maintain a positive attitude and create a lasting impression. Also remember that acknowledging patients does not simply begin when they walk through the door, but with the initial phone call to schedule an appointment.

I: Introduce: Always give your name, explain your role, and what you plan to do. Make sure your name badge is visible. Let patients know that you, or your coworkers, will be taking good care of them. Manage up your coworkers, physicians, or other departments when transitioning patients' care. You can successfully manage up by introducing the next person providing care, while giving a positive explanation of their experience and qualifications.

D: Duration: To ease the wait, give patients an accurate estimate of how long it will take to see the physician. Keep patients informed of the length of procedures and how long it will take to get the results. Remember that patients have daily responsibilities and routines outside of the office as well. Keeping them informed helps them plan and rearrange their day accordingly.

E: Explanation: Keep patients informed on what you plan to do, what they should expect, how procedures work, and who to contact if they need assistance. It is important to keep in mind that your patients may not be familiar with medical terminology and may require explanations using common words.

T: Thank You: Always encourage an attitude of gratitude among staff and physicians. Show your patients appreciation for the trust they place in your practice. Conclude every visit by asking your patients if there is anything else you could do for them or if they have any other questions that you can answer.

As leaders of our practices, our responsibility is to ensure that our staff and physicians have the tools they need to improve the overall experience and quality of care they provide to patients. Always keep in mind the care and compassion we would want for ourselves and use the AIDET program to achieve our ultimate goal of a satisfied patient.

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

Meet Your Practice Manager Colleagues

MEMBERSHIP in the Chicago Medical Society's Practice Manager Section is an excellent way to expand your professional networking horizons. Practice managers employed in the offices of CMS physician-members enjoy discounted dues of only $99 per year. The nonmember rate is $395.

To download a membership application, please go to *www.cmsdocs.org* or call 312-670-2550.

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The University of Chicago's Urban Health Initiative aims in part to ensure appropriate usage of the emergency room. Through the initiative, staff at the new hospital pavilion, shown above, will refer patients to a network of primary care providers closer to their homes.

The Urban Health Initiative

A model all physicians can learn, benefit from **by Bruce Japsen**

A **UNIQUE** program on Chicago's South Side that started with First Lady Michelle Obama educating the community on when it was best to use the hospital emergency room has blossomed into a national model on how to link patients to an array of community-based health care services.

Known as the Urban Health Initiative, it has gained notice in part because of the well-known people who were involved when it got off the ground. Michelle Obama, now the First Lady of the United States, headed the initiative eight years ago when she was a vice president of community affairs at the University of Chicago Medical Center. It is now run by Dr. Eric Whitaker, the former head of the Illinois Department of Public Health.

Now in its eighth year, the program is coming into its own. Its network of about three dozen clinics and health centers are building a relationship with low-income patients, including many who tend to have multiple chronic conditions and don't seek regular care, leading to more serious and costly illnesses.

But the initiative is showing results that can be adopted in the typical doctor practice or clinic as a way to get patients into a medical home. Providing regular access to medical care, a medical home improves access to care and potentially saves money. In the future, all medical care providers will need to be mindful of models that achieve better outcomes and lead to lower costs, the head of the Urban Health Initiative says.

Value—Yes or No?

"We better make the case for what provides value and what doesn't," Dr. Whitaker, who is executive vice president of strategic affiliations and associate dean of community-based research at the University of Chicago, told about 200 health officials and community leaders at a meeting in Chicago's South Side Bridgeport neighborhood to discuss the initiative earlier this year. "People want help managing chronic conditions, but they need guidance navigating available resources."

The initiative started as a way to better educate patients on the appropriate use of the emergency room, particularly the uninsured and those on Medicaid. The idea here is that patients who show up in the emergency room with problems that could be handled elsewhere cost the system thousands of unnecessary dollars that could be allocated to primary care.

But the Urban Health Initiative is about more than just providing patients a prescription that needs to be filled or handing patients an educational brochure on their illness or condition.

Rather, the initiative is more aggressive in how it guides patients and provides them with information. Among its efforts, the initiative's South Side Healthcare Collaborative involves U of C patient advocates who make appointments for people who come to the emergency room, scheduling them near their homes if

PHOTO BY BRUCE POWELL, COURTESY OF UNIVERSITY OF CHICAGO MEDICINE

possible, at nearly three dozen clinics and health centers throughout the South Side.

"The U of C advocates don't just say: 'Oh, here is a number, now go get care,'" said Dr. Kohar Jones, a director of community health and service learning at the University of Chicago and a family doctor at Chicago Family Health Center, located at 91st St. and South Exchange Ave. on Chicago's far South Side. "They provide additional information and additional support."

Since early 2005, patient advocates at the University of Chicago have made appointments for more than 21,000 patients at participating clinics and providers in the initiative's South Side Healthcare Collaborative. Every year, a larger and larger percentage of those patients keep their appointments, proof that the referral system is working, observers say.

"The goal of the emergency room is to treat emergencies," Dr. Jones said. "The emergency room is not for routine problems."

Last year, 40% of patients, or 1,075 out of 2,687 patients, had appointments scheduled for them at the University of Chicago emergency room and kept their appointments at a clinic or health center that is part of the collaborative. The rate of appointments kept has improved steadily from 2005 when just about 33% of the appointments made by U of C advocates were kept by patients.

If the patients referred then follow through and maintain a relationship with the primary-care provider and clinic, the health centers say it improves quality and saves money.

Lessons for All Doctors

"Anytime somebody comes in the door, the goal is to develop a relationship with them," Chicago Family Health Center's Dr. Jones said. "We have physicians, psychologists, social workers and others working together so the patients can stay well."

Though not all Chicago practices will see patients with the same access issues as those on Chicago's South Side, Dr. Jones says there are lessons for all doctors in the Urban Health Initiative. They say all patients and their doctors should work together to establish a medical home, which requires doctors to have information related to each patient.

Physicians and patients should be working to ensure their patients are getting the right care, at the right place and at the right time.

"Physicians should be encouraging patients to understand when to seek care from the appropriate provider, empowering the patient to understand where different ailments are treated," Dr. Jones said.

Government and private insurers are increasingly using information technology to get patients into a medical home and incentivize doctors who participate in the homes. Most of the efforts so far are pilot programs being introduced by insurance companies or government health plans but analysts expect such efforts will become the norm soon.

One such initiative won the Urban Health Initiative a $5.9 million federal grant through funds available under the Affordable Care Act by setting up a "real-time automated system" that will link 200,000 patients on Chicago's South Side with the latest information about medical-care services and related resources.

The University of Chicago was among just 26 projects selected because the U of C's ideas will improve quality and provide more efficient and cost-effective service. "We can't wait to support innovative projects that will save money and make our health care system stronger," U.S. Health and Human Services Secretary Kathleen Sebelius said in a statement at the time the Urban Health Initiative and other grant winners were announced.

The grant money will be used by the Urban Health Initiative and partners like the Chicago Health Information Technology Regional Extension Center to create "CommunityRx," a system those involved say will better connect people in the community with the medical care services that they need. The CHITREC, which is in development, is part of a national effort to provide technical assistance to health professionals and link them to other providers in Chicago and beyond.

University of Chicago officials see CommunityRx as a system that will gain momentum once it becomes operational within the next year.

"It's an idea that we are developing on the South Side but I believe it has salience for doctors and their patients regardless of their income level," said Dr. Stacy Tessler Lindau, associate professor of obstetrics and gynecology at the University of Chicago, and a lead researcher for CommunityRx.

To help patients better navigate the health system and start on a path to better health, CommunityRx has collected "really granular data on the resources in the community," Dr. Lindau said.

It works through a system that will have an electronic database of resources that is continually updated for doctors when they transfer a patient's health records from one provider to another. Using the patient's information, the system will process and print out a so-called "Health.eRx" that includes resources that are relevant to the patient's condition, disease and health status.

Stress Reducer?

The system provides patients with much more information than simply giving them a prescription and hoping they get it filled at their neighborhood pharmacy.

"In the case of diabetes, a patient might get a diagnosis but they first have to find a pharmacy, be able to afford the medication and be able to get to the pharmacy to pick it up," Lindau said. "Then we say: you have to exercise. You have to lose weight."

Through CommunityRx, more information and knowledge about resources is coming into the "doctor-patient" encounter. The system could also reduce stress on the patient and physician, who will have ready access to the auto-generated list of providers, health centers, grocery stores and other resources that the doctor doesn't have for each patient in a particular community.

"The system will spit back a prescription, tell the doctor and patient where the closest pharmacy is as well as a grocery store and the YMCA and even a farmer's market," Dr. Lindau said. "Doctors and patients will have a better handle on what is available to them. Google and Yelp are far less complete."

By providing this information, those involved say it should help patients better engage in health care services.

"The outcome will be better and more efficient health care delivery and stronger, more vital communities," Dr. Lindau said. "That's ultimately the way we'll cut costs from the system. It will make a difference in health and health care utilization."

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

The Legacy of Virginia Apgar, MD

A special score for pioneering physician **by Fernando Ugarte, MD**

"Nobody, but nobody, is going to stop breathing on me."

—Dr. Virginia Apgar

(explaining why she kept basic resuscitation equipment with her at all times)

IT'S THE FIRST official test a newborn receives. Given at 60 seconds post-birth and again at five minutes, the test measures a baby's transition to life outside the womb, providing fast, reliable data for doctors. So well has the Apgar assessment withstood the test of time, it remains a delivery room mainstay 60 years after its introduction.

Dr. Virginia Apgar first presented what became her namesake test in 1952 before a scientific meeting, and published her landmark paper in 1953. Her scoring system revolutionized obstetric care, drastically reducing infant mortality worldwide, and bringing acclaim to Dr. Apgar, a pediatric anesthesiologist who effectively founded the field of neonatology.

Evaluating five key signs—heart rate, respiratory effort, muscle tone, reflexes, and skin color—the system assigns a number to each. The points are then totaled to arrive at the baby's score.

For clinicians who previously relied on their subjective impressions, and paid more attention to the mother, the Apgar method provided a standardized, reliable system, which could even predict 28-day survival and neurological development.

In later years, Dr. Apgar and colleagues refined the score, demonstrating that babies with low levels of blood oxygen and highly acidic blood had low Apgar scores, and that giving cyclopropane anesthesia to the mother was likely to result in an infant's low score.

Dr. Apgar's groundbreaking paper appeared in the International Anesthesia Research Society's *Current Researches in Anesthesia and Analgesia*. Ten years later, an acronym for APGAR was reported in *JAMA*. Co-authored by Dr. L. Joseph Butterfield, the acronym was used as a learning aid: Appearance (skin color); Pulse (heart rate); Grimace (reflex irritability); Activity (muscle tone); and Respiration.

While she never became a household name, Dr. Apgar profoundly influenced the lives of millions of people, not to mention the field of anesthesiology.

The perinatal section of the American Academy of Pediatrics created the Apgar Award to honor outstanding contributions to the field.

True Trailblazer

The Westfield, NJ, native is known chiefly for the Apgar test, not for her trailblazing role as a woman physician and tireless advocate for research into birth defects.

Born in 1909, Dr. Apgar was the daughter of an amateur scientist and musician who worked as an insurance executive. Her eldest brother died early from tuberculosis, and another brother suffered with a chronic childhood illness. From her father she inherited boundless curiosity and love for adventure, making her own musical instruments and taking flying lessons. She hoped to someday fly under the George Washington Bridge.

Dr. Apgar put herself through Mount Holyoke College, winning scholarships and waiting on tables. She played in the school's orchestra as a violinist and cellist, before earning her degree in zoology, graduating fourth in her class. Four years later, in 1933, Dr. Apgar graduated with her medical degree from Columbia University's College of Physicians and Surgeons. For the next two years she studied to become a surgeon until her mentor urged her to shift course.

The head of Presbyterian Hospital's surgery department, Dr. Alan Whipple, cautioned Dr. Apgar that economic prospects for female surgeons were poor, and especially so during the Depression. He encouraged her to pursue anesthesiology, a new area of study that had the potential to advance surgical practice. Anesthesia was handled mostly by nurses in those days, and not a recognized specialty.

Dr. Apgar took this advice, going on to train in Dr. Ralph Waters' anesthesiology department, the first in the United States,

at the University of Wisconsin-Madison, and under Dr. Ernest Rovenstine at Bellevue Hospital in New York.

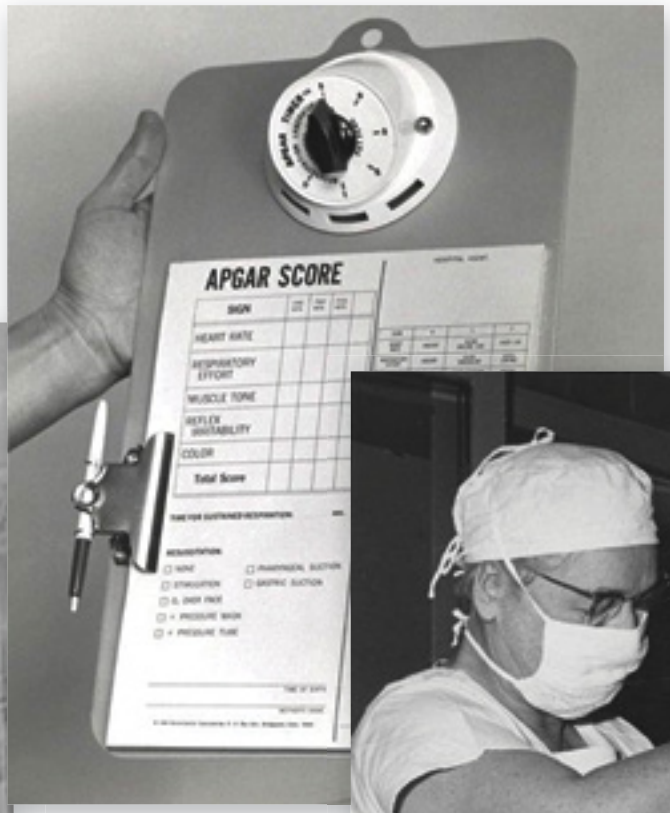
In 1938, she returned to Presbyterian Hospital to direct its fledgling division of anesthesia within the department of surgery. While she was the only staff member at first, over the next 11 years Dr. Apgar transformed the anesthesia service at Presbyterian into one staffed with physicians rather than nurses, and established the anesthesiology education program there. The field of anesthesiology gained recognition as a medical specialty in the mid-1940s, and Presbyterian's anesthesiology division became a separate department in 1949.

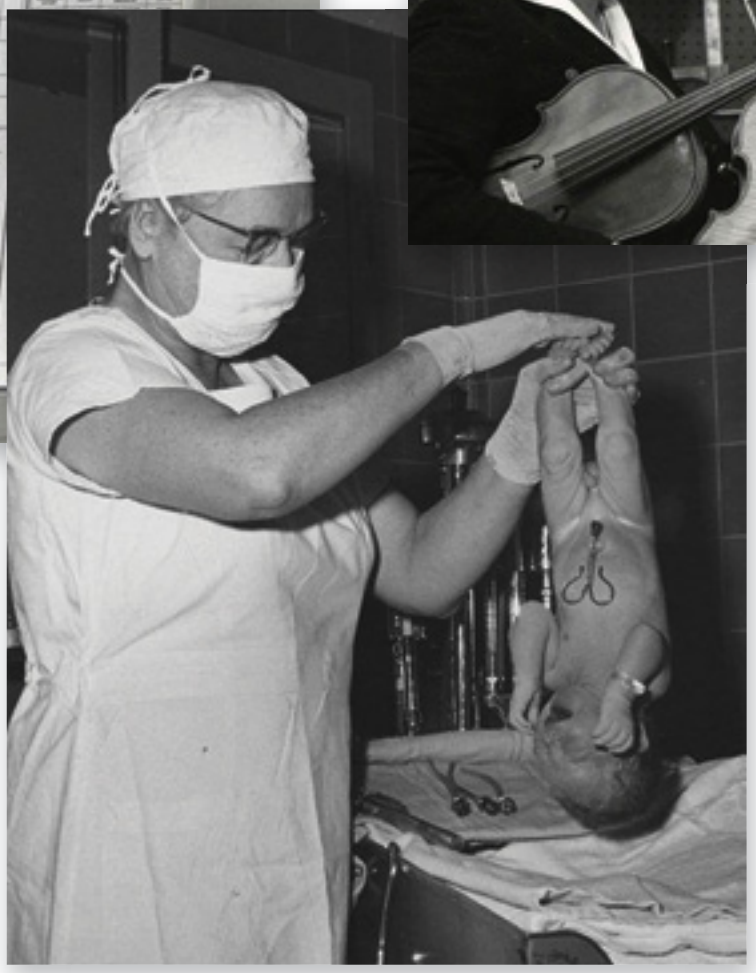
Though not selected to chair the department, Dr. Apgar was made full professor, the first women to be named as such in Columbia's College of Physicians.

At this point, freed from her administrative duties, Dr. Apgar began to research her landmark proposal, which became known as the Apgar Score.

Caring to Her Last Day

The woman who one U. S. Surgeon General said did more to improve the





Opposite page: Dr. Apgar examines a newborn in 1966 (courtesy of National Library of Medicine, National Institutes of Health). Clockwise this page: The Apgar scoring form; Dr. Apgar poses with a violin she made herself; Dr. Apgar holds a newborn baby upside-down to test its reflex irritability (photos courtesy of Mount Holyoke College and Series 6 of the College's L. Stanley James Papers (MS 0782). Below: U.S. postage stamp honoring Dr. Apgar.

health of mothers, babies, and unborn infants than anyone in the 20th century, assisted in at least 17,000 deliveries during the 1930s and 40s.

During this period, Dr. Apgar became interested in the effects of anesthesia given to a mother in labor on her newborn. She observed that babies required more attention from clinicians who lacked an accurate, standardized method for evaluating their health. In seeking to address these needs, Dr. Apgar came out with her proposal in 1952. Although resisted at first, her ideas were later widely adopted.

In the course of refining her scoring system, Dr. Apgar increasingly noted birth defects, and began to correlate them with each other and with the scores. While on sabbatical leave, she studied genetics as part of a master's degree in public health she earned at Johns Hopkins University in 1959. This new focus opened a door in Dr. Apgar's life. At that time, the National March of Dimes was expanding its efforts beyond polio to other childhood disabilities, and offered Dr. Apgar a position as head of its new division of congenital malformations. Accepting this post, she advocated passionately throughout the world for research into birth defects and funding. She stepped down in 1968.

Dr. Apgar's academic journey concluded with her appointment as clinical professor of pediatrics at Cornell University from 1965-1971, and as lecturer in medical genetics at Johns Hopkins in 1973.

Active until her final day on earth, Dr. Apgar died in her sleep in 1974 at the early age of 65, from liver cirrhosis, the result of unrecognized childhood hepatitis.

Dr. Apgar published at least 60 scientific articles and numerous shorter essays for newspapers and magazines during her career, including her book, *Is My Baby All Right?* She earned many awards, including honorary doctorates from the Woman's Medical College of Pennsylvania (1964); the Elizabeth Blackwell Award from the American Medical Women's Association (1966); the Distinguished Service Award from the American Society of Anesthesiologists (1966); the Alumni Gold Medal for Distinguished Achievement from Columbia University College of Physicians and Surgeons (1973); and the Ralph M. Waters Award from the American Society of Anesthesiologists (1973).

According to a website devoted to Dr. Apgar's life and work (www.apgar.net), created by a grand nephew, Dr. Apgar would have been pleased to know she was honored in 1994 with a 20-cent postage stamp in her name. Among her hobbies, stamp collecting was one of them. The stamp appeared in a series on Great Americans, an honor she shared with Dr. Paul White, founder of cardiology as a specialty, and Dr. Harvey Cushing, the father of neurological surgery.

Dr. Ugarte, a former resident of Chicago, practices general surgery in Marysville, Kansas. Sources: U.S. National Library of Medicine, National Institutes of Health; Columbia University Department of Health Sciences; Oct. 9, 2002.

ISPS Hosts Resident Competition

Doctors-in-training showcase their research

THE ILLINOIS Society of Plastic Surgeons is pleased to announce the winners of its Senior Resident Abstract Competition held on July 8. Residents from Cook County's training programs presented their research findings, competing for top honors and cash prizes during the ISPS general membership meeting, which took place at the Metropolitan Club, Willis Tower, Chicago. The Chicago Medical Society encourages academic program directors and educators to submit outstanding student/resident research papers for publication in *Chicago Medicine*.

1st Place

Expanding the Envelope: The PoRSh-Liver Vascular Composite Allotransplant

by Justine C. Lee, MD, PhD, University of Chicago Medical Center

Background: Primary abdominal wall reconstruction after liver transplantation presents a challenge in patients with size mismatch, multivisceral transplants and prior recipient abdominal surgery. We report our experience on a novel technique for abdominal wall reconstruction with a new vascular composite allotransplant.

Methods: Five posterior rectus sheath (PoRSh)-liver composite vascular allotransplants were procured by a multidisciplinary team and transplanted into four patients over the course of two years. Transplantation of the liver was performed in the standard manner and the PoRSh was inset as an inlay flap.

Results: Abdominal wall integrity was re-established with vascularized fascia in all five cases. In two cases, the fascia was closed immediately at the time of initial transplantation. In three cases, the abdomen was left open for a planned second look and closed definitively when the liver appeared satisfactory. In one patient, hepatic artery thrombosis was detected 11 days after transplantation requiring a second PoRSh-liver transplant. Skin closure was performed for all five PoRSh-liver transplants in either an immediate or delayed fashion. Re-operation was performed in one patient requiring elevation of the PoRSh flap for a suprahepatic vena cava stenosis.

Conclusions: Closure of the abdominal cavity is critical to the success of liver transplantation for organ survival as well as overall patient morbidity and mortality. We describe our institutional experience on a novel method of concurrent abdominal wall reconstruction and liver transplantation using the PoRSh-liver vascular composite allotransplant in situations of size mismatch, multivisceral transplants, and compromised abdominal wall of the recipient. Furthermore, we propose the universal application of the PoRSh recovery as a standard component in all hepatic recovery procedures for both pediatric and adult patients.

2nd Place

Pressure Characteristics of Hospital and Non-Hospital Mattresses

by Erika A. Henkelman, MD; Joyce Stoelting, RN; Dawn M. Lucasey, PT, ATP, DPT, Southern Illinois University School of Medicine and Affiliated Hospitals

Introduction: The causes of decubitus ulcer development are multifactorial. However, common to all pressure sores is unalleviated pressure for an extended time period. Specialty hospital mattresses have been developed to alleviate pressure, but they are often costly, heavy, noisy, uncomfortable, and subject to user error. On discharge, most patients are unable to obtain such a mattress for long-term use, contributing to the exorbitant recurrence rates for pressure sores. The purpose of this study was to determine the pressure off-loading properties of hospital and non-hospital mattresses.

Methods: The XSENSOR X3 surface pressure imaging mat was used to create pressure maps for a person in supine, flexed knees, semi-supine, lateral, and seated positions on each available hospital mattress and local commercially available mattress. Adjustable features such as inflation, flow, and temperature, as well as surface factors such as draw sheets, absorptive pads, pillows, and wedges were also evaluated. The videos were analyzed using the X3 MEDICAL software to interpret the efficacy of each mattress as a pressure off-loading surface.

Results: The seated position, followed by either the semi-sitting or lateral positions, had the highest levels of pressure points for almost every mattress. Bottoming out was a problem in underinflated hospital beds, and the recommended settings were often not appropriate. The surface factors did not significantly change the pressure off-loading properties of each mattress. Cost of the mattress, and whether it was in a hospital or non-hospital did not correlate with pressure relief capacity.

Conclusion: Pressure relief mattresses may have a higher capacity than standard hospital mattresses to give pressure relief, but are very reliant on indefinite and patient-specific settings. An appropriately chosen non-surgical mattress can be just as effective as a hospital mattress at pressure relief, although repositioning is still required for all mattresses except the fluid air beds. Rather than renting medical mattresses from insurance companies, a less-costly and more effective approach may

"An appropriately chosen non-surgical mattress can be just as effective as a hospital mattress at pressure relief, although repositioning is still required for all mattresses except fluid air beds."

be pressure mapping of non-surgical mattresses and purchasing a surface suitable for that patient.

3rd Place

Human Bites Resulting in Hand Infections: Is Eikenella a Bug of the Past?

by Victor J. Hassid, MD, Simple Banipal, MD, Benjamin Liliav, MD, Mansour V. Makhlouf, MD, Orhan Kaymakcalan, MD, University of Illinois at Chicago College of Medicine and Mount Sinai Hospital

Background: Human bites and other wounds contaminated with oral flora are common and result in frequent visits to emergency rooms. Successful management depends on timely diagnosis, appropriate cultures, early administration of broad-spectrum empiric antibiotics and tailoring treatment based on culture results, thorough emergent surgical debridement and irrigation, and close follow-up. Traditionally, hand infections resulting from clenched-fist injury have been associated with *Eikenella corrodens*. The purpose of the current study is to identify the incidence of cultured microorganisms as a result of human bites, which would contribute to the initiation of a more accurate antimicrobial empirical therapy.

Methods: A retrospective chart review was performed of patients who were evaluated by the hand surgery service as a result of human bite to the hand during the period between April 2007 and October 2011. Patients without culture results were not included in the study population. In order for these patients to be identified, the ICD-9 codes E928.3 and E928.7 were used, which represent "human bite" and "accidental, environmental causes," respectively.

Results: A total of 46 patients were identified who met the inclusion criteria. Of those, 40 hand infections were the result of clenched-fist injury, four of human bite, and two of nail biting. The most frequently isolated micro-organisms were gram-positive aerobes (58%), of which 32.4% belonged to Streptococcus species. More than half (57.1%) of *Staphylococcus aureus* isolated was resistant to methicillin (MRSA). *Eikenella corrodens* was isolated in 6.7% of specimens.

Conclusions: Timely surgical debridement and accurate broad-spectrum antibiotic therapy initiation are of significant importance in the treatment of hand infections resulting from human bites. Gram-positive aerobes are the most frequently isolated micro-organisms from such wounds, followed by gram-negative anaerobes. *Eikenella corrodens* remains an important micro-organism related to human bites. The empiric antibiotic regimen chosen should be effective against both these groups of pathogens, including MRSA, and tailored appropriately based on final culture results.

Transformational Medicine

Community health workers are on the frontline of public health **by James M. Galloway, MD**

AS PHYSICIANS, our appreciation of health literacy (the ability to understand health information and to use that information appropriately) and its relationship to compliance, medication adherence, hospital transition and follow-up, are rapidly evolving. The home and community play an important role in developing this understanding, a fact underscored by various aspects of the *Patient Protection and Affordable Care Act*. Indeed, one significant and innovative effort involves utilizing community health workers (CHW), also known as lay health educators, lay health advisors, neighborhood workers, indigenous health workers, health aides or promotoras.

Defined as a frontline public health worker, the CHW is a "trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."

- The Affordable Care Act increases the use of CHWs as members of accountable care organizations.
- The Centers for Disease Control and Prevention utilize grants "to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers."
- The U.S. Department of Health and Human Services' action plan to reduce racial and ethnic health disparities suggests the increased "use of promotores to promote participation in health education, behavioral health education, prevention, and health insurance programs."

Community-based research has repeatedly shown that women and men who serve as CHWs strengthen already existing ties with community networks. This aspect remains one of the most important features of CHW programs. CHWs are uniquely connected to the community because they generally live in the communities where they work and understand the social context of community members' lives.

As noted by the Institute of Medicine, CHWs can serve as liaisons between patients and providers; educate providers about community needs and culture; educate patients; contribute to care continuity and coordination; assist in keeping appointments; increase medication adherence; and encourage use of preventive and primary care services. In addition, some evidence suggests that lay health workers can help improve quality and general wellness as well as reduce costs by facilitating community access and negotiation of services. For these reasons, the Institute of Medicine gave its support for the use of CHWs.

"CHWs are also known as lay health educators, lay health advisors, neighborhood workers, or indigenous health workers."

Along with improving health outcomes, CHWs have also been shown to reduce health care costs by diverting care from emergency departments to primary and preventive care services.

For example, in a study of underserved men in Denver, CO, Whitley and colleagues found that care shifted from expensive inpatient and urgent care to less costly primary care services because of CHW intervention. This shift resulted in a return on investment of $2.28 per $1.00 spent on the CHW intervention, for a total savings of $95,941 per year.

CHWs have also been effectively utilized to support specific medical interventions. In a study of patients with diabetes, patients who received CHW services had reduced emergency room visits and hospitalizations. These CHW interventions resulted in an estimated gross savings to the hospital per CHW of $80,000 to $90,000 per year. Another study demonstrated that CHWs significantly improve outcomes in blood pressure care and control. They have also been found to increase health care access, knowledge, and behavioral change among minority women.

Our colleagues at the Sinai Urban Health Institute in Chicago published the results of the evaluation, "The Use of Lay Health Educators (LHEs) to Improve Asthma Management among African American Children." This study utilized trained LHEs (CHWs) from inner-city, predominantly African American communities to teach children and their families in similar communities how to more effectively manage asthma. Individualized family education was provided in the family's home whenever possible. The LHE also served as a liaison between the family and the medical system and helped bridge the gap between parents and primary care physicians. The intervention was found to reduce emergency department visits by 73%, asthma-related hospitalizations by 71%, and provided a $5.58 return on investment for every $1.00 invested intervention.

From my perspective, especially as a physician who has used CHWs extensively in underserved communities, these trained workers offer substantial benefits and opportunities to advance our efforts to improve the health of our families, friends, neighbors and communities.

Dr. Galloway is assistant U.S. surgeon general and regional health administrator for Region V, U.S. Public Health Service. The opinions expressed in this paper are those of the author and do not necessarily reflect the views of the office of the U.S. Department of Health and Human Services or the federal government. *Acknowledgement: Special thanks to Kathryn Brandt, MPH, and Amanda French, MPH, for their support in the development of this document.* *For a list of references, please contact* esidney@cmsdocs.org *or call 312-329-7335.*

Mental Health Reforms

We're moving in the right direction **by Bechara Choucair, MD**

THIS PAST YEAR, the Chicago Department of Public Health (CDPH) embarked on changes that reform the way we support and provide mental health services, with one goal in mind: to provide access to more people.

Our reforms were based on two main pillars:

- To focus the city's services on the uninsured.
- To partner with community providers to improve the system throughout the city.

Let me start by sharing with you what we did to improve our own CDPH services.

Currently, we provide services to around 2,900 clients with serious mental illness. We worked to transition 429 insured clients to community mental health providers and we continue to provide services to the remaining majority of our clients. Also, we consolidated our clinics from 12 to six. As a result, each of our clinics is better staffed and is already providing more efficient services. Since the transition, we have accepted 263 new clients in our system and are monitoring the transition very carefully. More than 97% of our clients who moved to a community provider have an appointment already scheduled and we are following up with every one of them to make sure they made it to their appointment and are happy with their care.

We are also monitoring hospitalizations very closely. I am happy to report that we have not seen any increase in hospitalizations since the transition was completed in April 2012. As a matter of fact, we had eight fewer hospitalizations in May and June of this year than we had in May and June of last year.

By partnering with community providers to improve the overall system in Chicago, we are helping more people to gain access to services throughout the City. We already invested $500,000 for community mental health providers to provide more psychiatry services. As a result, 1,000 more people will be able to see a psychiatrist. We also invested an additional $1 million to improve the integration of mental health, substance abuse and HIV services. This investment will allow our residents to have better services in the community. In addition to these investments, we are also making some of our city-owned facilities available to community mental health providers to help them expand their services.

Effectively engaging community partners is critical for us to help leverage mental health resources says Chicago Public Health Commissioner, Dr. Bechara Choucair.

Effectively engaging community partners is critical for us to help leverage resources. Last year, I invited a group of community leaders to join me in discussing strategies to address the needs of persons with serious mental illness who are homelessness and/or more frequently involved with the criminal justice system. This workgroup included representation from the Chicago Police Department, Cook County Sheriff, community providers, advocacy groups and other city agencies. Through this group, we are identifying strategies to improve this population's access to services and quality of life.

I am committed to finding more ways to support Chicagoans in need, located right in their communities. I am very pleased with the positive impact of our mental health reforms and we are definitely moving in the right direction.

"We consolidated our clinics from 12 to six. As a result, each of our clinics is better staffed and is already providing more efficient services....We are also closely monitoring hospitalizations."

If you have questions or you would like to share your thoughts or ideas with me, please don't hesitate to email me at *Choucair@cityofchciago.org* or you can follow me on Twitter (@choucair).

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

What is ERISA?

Profound effects on insurance reimbursement **by Mark D. DeBofsky, 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.

Introduction

ERISA is an acronym for the *Employee Retirement Income Security Act of 1974*, a federal law that impacts all U.S. employee benefit programs, except for governmental plans and benefit plans sponsored by religious organizations, as well as plans in which only business owners but no employees participate. Although the law was initially intended to regulate retirement benefits, shortly before its passage, ERISA's scope expanded to encompass employer-sponsored "welfare" benefits, consisting of both insured as well as self-funded health, life and disability benefits.

ERISA's regulation of health benefits has had a marked impact on physicians and patients as well. ERISA's applicability makes it more difficult for physicians to pursue collection actions against insurers; in situations involving union-sponsored plans, the direct assignment of benefit payments to physicians are often not recognized. ERISA also eliminates remedies traditionally available under state law, such as the right of the policyholder to sue for damages or penalties in addition to the benefits claimed. Jury trials are precluded; and courts will rarely consider new evidence outside of the insurer's claim file. The treating physician's opinions are given no special deference in ERISA claims and can be overridden by non-examining consultants, although the Affordable Care Act now permits independent reviews upon request. Moreover, ERISA-governed plans frequently incorporate provisions granting insurers the discretion to both interpret policies and decide whether claimants are entitled to benefits. When such clauses apply, a party challenging a claim denial must go beyond simply proving the insurer wrongfully denied benefits or misinterpreted a policy provision. Instead, the insured is required to show the benefit determination or policy interpretation was arbitrary or unreasonable. Overcoming such a formidable burden of proof can be nearly impossible. Fortunately, Illinois, along with several other states, now bars insurers from incorporating such "discretionary" clauses into their policies. That prohibition does not apply to self-funded plans, though.

"The treating physician's opinions are given no special deference in ERISA claims and can be overriden by non-examining consultants."

ERISA Pre-emption

Where ERISA applies, all state laws that impact employee benefit plans are pre-empted, rendering those laws inapplicable, with the exception of laws regulating the content of insurance policies. ERISA pre-emption is triggered by the establishment of an employee benefit plan by the employer, and may be accomplished by the mere purchase of a group insurance policy. Thus, if a medical practice purchases a group health or disability insurance policy that covers even a single employee in addition to the practice's owners or shareholders, an employee benefit plan is established; and any claim made under that policy is governed by ERISA. Likewise, patients with group insurance coverage or coverage through their union are almost certainly incurring ERISA-governed claims.

ERISA and Your Practice

ERISA profoundly affects insurance reimbursement. If a claim is denied in whole or in part after being submitted, ERISA mandates a "full and fair review" of the claim disposition upon request. Although the review is typically conducted by the same entity that denied the benefit, various requirements promote a fair process. First, patients can be represented either by an attorney or their medical provider who is entitled to access a complete copy of the claim record at no charge. For matters involving medical judgment, the plan must utilize a consultant possessing appropriate medical training and experience and must furnish copies of any articles or treatises relied upon to support the claim decision. Also, if the plan claims a charge is excessive, the insurer's schedule of reasonable charges must be provided on request. Courts consider pre-suit claim appeals so important that a failure to exhaust pre-litigation appeals will result in a refusal by the courts to entertain any ensuing litigation.

ERISA and You

ERISA also impacts physicians' own benefits, including group disability insurance or even individual insurance purchased on a discounted "list-bill" basis. Physicians incur a high number of disability claims due to the physical and mental/cognitive demands of their profession. It is critical for doctors to obtain occupation-specific coverage since the inability to practice within a specialty would trigger an entitlement to benefits, even if the physician is able to continue working as a doctor, but only in a less demanding area of practice.

Due to the complexities of ERISA, it is important to immediately secure the services of an experienced attorney if a claim is denied. Waiting to retain a lawyer until after appeals are exhausted could preclude a successful litigation outcome.

Conclusion

ERISA has significantly impacted health and disability insurance claims. However, with some basic understanding and foreknowledge of ERISA's limitations, issues can be addressed pre-emptively and draconian consequences avoided.

The author practices in the Chicago law firm of Daley, DeBofsky & Bryant. He can be reached at mdebofsky@ddbchicago.com *or* www.ddbchicago.com.

Minor Consent and Confidentiality

What docs need to know **by Danielle Erin Drayer, Esq.**

GENERALLY, everyone in Illinois age 18 and older may give consent to all medical and surgical procedures for themselves, without the consent of others. However, consent from a parent or guardian is required for patients under age 18 unless an exception applies. The following article discusses a number of exceptions that give treating physicians the authority to render emergency services without consent of a parent or guardian.

Mature Minor Exception

Illinois has for more than 20 years recognized the mature minor doctrine, a common-law rule that allows minors to consent to or refuse medical treatment on a case-by-case basis if they are able to demonstrate an appreciation of the risks and consequences of obtaining or foregoing treatment. When minors are deemed mature and give consent solely for their own care, the HIPAA privacy rule requires the patient's written consent for disclosure of the relevant records.

Status Based Exceptions

Illinois recognizes several status-based exceptions that enable minors to give consent for medical and surgical care. By statute, minors ages 16 to 18 who are emancipated pursuant to a court order may consent to all care. Married or pregnant minors may also give consent. Finally, minors who are parents may consent for medical and surgical care for themselves and their children.

If minors have the authority to give consent based on their status and do so consent, the HIPAA privacy rule treats their entire medical records as confidential and requires written consent from patients before any disclosure.

Service Based Exceptions

Minors not otherwise permitted to give consent based on their status may, nonetheless, give consent in certain limited situations for specific medical care. The effect of service-based exceptions is to involve minors in medical decision-making, particularly when the services sought are essential to their overall well-being. When a minor may lawfully obtain health care services and does so without the consent of a parent or guardian, HIPPA prohibits the treating physician from disclosing relevant medical records without the patient's written consent.

Reproductive Health

All minors may consent to abortion services in Illinois. Disclosure of abortion records is subject to the limitations of HIPAA. Notwithstanding the statutory grant of decision-making authority or the privacy rights under HIPAA, the governor in 1995 signed into law the Parental Notice of Abortion Act, which, if not enjoined, would require physicians to notify a parent or legal guardian 48 hours in advance of performing an abortion unless the minor had obtained a judicial waiver. The parental notification law is currently being reviewed so the policy is not in effect.

Minors may also give consent for the diagnosis and treatment of sexually transmitted diseases, including HIV/AIDS. Additionally, minors may consent to contraceptive services but only if referred by a physician, clergyman, or planned parenthood agency. Although disclosure of a minor's reproductive health services records is generally prohibited by HIPAA if the minor solely consented to care, physicians are permitted, but not required, to notify a parent when such services have been accessed.

If a minor requests any reproductive health service (excluding abortion) and privacy is a concern, the physician can refer the minor to a federal Title X Family Planning Clinic. Title X clinics are strictly required to make family planning services and contraceptives available to all patients regardless of age and without parental consent or notification.

Rape and Sexual Assault

Minors of any age may consent to medical care and counseling for the diagnosis or treatment of any disease or injury arising from rape, sexual assault or sexual abuse, including emergency contraception. Minors who are survivors of sexual assault may also consent to the collection of forensic evidence but only minors age 13 or older may consent to release a rape kit to the police.

Drug and Alcohol Abuse

Minors age 12 and up may give consent to drug and alcohol abuse counseling services when the care is for the minor's own condition or that of a family member who abuses drugs or alcohol, provided the minor may consent to a maximum of five 45-minute outpatient counseling sessions.

HIPAA generally requires a minor's written consent before disclosing drug or alcohol abuse counseling records for which the minor has solely consented, but a physician may notify a parent or guardian of a minor's condition when the physician believes doing so is necessary to protect the minor or another individual.

Psychotherapy

Any minor age 12 years or older may consent to and receive psychotherapy on an outpatient basis, subject to the five session/45-minute rule, but only minors age 16 or older may consent to voluntary admission for inpatient services at a mental health facility. HIPAA prohibits the disclosure of a minor's psychotherapy records without the written consent of the patient, yet a parent or legal guardian may be notified of an outpatient's condition if the facility director believes disclosure is necessary.

Conclusion

Enabling minors to consent for their own medical care promotes autonomy and timely treatment. When minors request confidential services under state or federal law, physicians should encourage them to involve a parent or guardian but respect the minor's privacy wishes. If parental notification is permissible, physicians should use discretion and only notify a parent or guardian if doing so is in the minor's best interests.

The information contained in this article is not intended to be used as legal advice. Please consult with legal counsel for patient-specific application of minor consent and confidentiality laws.

The author practices in the New York law firm of Whiteman, Osterman & Hanna, LLP. She may be reached at ddrayer@woh.com *or* www.woh.com. *For a list of references, contact* esidney@cmsdocs.org *or call 312-329-7335.*

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CHICAGO MEDICAL SOCIETY

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

Chicago's Primary Stroke Centers

Spotlight on Sinai Health System

This garden sits atop Schwab Rehabilitation Hospital and provides stroke patients with a sensory healing experience. It's one-of-a kind in Chicago.

MOUNT SINAI Hospital, the site of a Chicago Medical Society mini-internship, is one of Cook County's 22 regional Primary Stroke Centers. This Joint Commission-certified stroke center treats more than 200 patients each year under the leadership of Mir Yadullahi, MD, neurologist and stroke program medical director.

Hospital staff demonstrated the full range of services on June 4 when Ald. Jason Ervin (28th Ward) toured Mount Sinai's Primary Stroke Center and Schwab Rehabilitation Hospital.

The CMS educational program arranged for the alderman's visit, and is working to introduce more legislators to this vital public health resource.

As showcased in the tour, stroke care at Sinai Health System encompasses a variety of interventions from preventive to post-acute care. Indeed, the AHA recently honored Sinai with its "Get with the Guidelines" Stroke Silver Achievement Award.

With clinics on the west, southwest, and south sides of Chicago, residents have access to:

- Health screenings and educational programs through Sinai Community Institute.
- Acute stroke care at Mount Sinai Hospital.
- Inpatient stroke rehabilitation services at Schwab Rehabilitation Hospital. Schwab's rehab program has disease-specific certification from the Joint Commission, and CARF-accreditation for rehab specialty services as well as outpatient stroke physician follow-up clinics, therapy services, and peer mentoring programs to extend into the patient's community.
- Transitions of care connect the acute and rehabilitation facilities to Sinai Medical Group and other community clinics that provide primary, preventative and post-acute care.
- Mount Sinai partners with neighboring institutions to offer services, such as clot retrieval or endovascular neuro-interventional aneurysm repair.
- Stroke support groups for patients and family members.
- Urban epidemiology and translational research intended to reduce the impact of chronic disease through the Sinai Urban Health Institute.

Early Rehabilitation Improves Outcomes

As part of Mount Sinai's multi-disciplinary approach to stroke care, patients are assessed for rehabilitation prior to discharge. Those in need of a specialized inpatient facility are often transferred to Schwab Rehabilitation Hospital, a freestanding building that meets the specific needs of each stroke patient.

Schwab assesses each individual and works with the patient and family to set personal goals. The hospital offers physical, occupational, and speech therapy, private treatment, gym space, aquatic center, rooftop garden, psychological services, music therapy, horticultural and recreational therapy.

Minorities at Greater Risk for Hemorrhagic Stroke?

AS A SAFETY net hospital, Mount Sinai cares for patients with unique challenges.

To better understand the patient base, Roberta Glick, MD, Sinai Medical Group neurosurgeon, conducted a retrospective study of stoke patients seen at Mount Sinai Hospital. The study found that among African-American and Hispanic patients, 31% of strokes were hemorrhagic. National rates are closer to 20%. The rate increased significantly for uninsured patients, at 50%, compared to 25% for privately insured and for Medicare patients.

Investigators concluded that uninsured minority patients may be at risk for more severe hemorrhagic strokes due to their higher risk for hypertension, diabetes, and lack of early intervention due to financial and educational reasons.

Join the Mobile Revolution

Here's how CMS members can "enlist"

READ HOW your colleagues across Chicago are taking advantage of the latest technology by using the DocBookMD app to securely send HIPAA-compliant messages directly from their iPad, iPhone, and Android devices.

Case Study

A patient arrives in the emergency department (ED) after injuring his toe while mowing his lawn. The ED physician determines that the wound can be treated with antibiotics and local care. He calls the on-call orthopedic surgeon.

The ED physician describes the wound and what is shown in the x-rays to the orthopedic surgeon. The orthopedic surgeon is unsure of the diagnosis, having just treated a patient who lost his toe due to necrosis after being lost in follow up. The orthopedic surgeon must decide whether to accept the ED diagnosis or go to the ED and see the patient in person.

Due to his recent experience, the orthopedic surgeon requests that x-rays and photos of the wound be sent to his smartphone through DocBookMD. Within minutes, the orthopedic surgeon reviews the images and agrees with the ED physician's assessment of the wound. The patient does not need to see a specialist.

The patient is released from the ED much quicker and received more appropriate care. The orthopedic surgeon could be sure the wound was not severe and did not require him to see the patient in the ED. He avoided an unnecessary trip to the ED and was able to participate in his family event.

DocBookMD

Physicians in Chicago now have access to a tool that can help them communicate more efficiently and save time and money in the process. That tool is DocBookMD, a physicians-only smartphone app that allows physicians to:

- Send HIPAA-compliant text messages and photos. Message content can include diagnosis, test results, or medical history. Physicians can also add a high-resolution image of an EKG, an x-ray, lab report, or anything that can be photographed with a smartphone.
- Assign an urgency setting to outgoing text messages. Physicians can assign each message a five-minute, 15-minute, or normal response time. If the physician does not answer the message within five minutes or if the message does not get to the physician, the sender will receive a message back stating that the message did not make it.
- Enable enhanced notifications. The physician can enter a cell phone number to receive text messages or an email address to receive notifications that DocBookMD messages are waiting. The email feature will send a weekly reminder to view DocBookMD messages.
- Search a local medical society directory. Physicians can look up other physicians in their state by first or last name or by specialty. Physicians can then contact other physicians by messaging, office phone, cell phone, or email.
- Search a local pharmacy directory. Physicians can search for a local pharmacy alphabetically or find a pharmacy by zip code. Users can also create a "favorites" list of physicians or pharmacies.

DocBookMD is offered through county and state medical societies to their members and is currently available throughout 25 states. Sponsors such as professional liability companies makes it possible for physician members of participating medical societies to use the app at no charge.

Can You Text That to Me?

DocBookMD has been available since 2010 and currently more than 600 Dallas-area physicians use the app. Dallas nephrologist Ruben Velez, MD, uses the DocBookMD texting feature frequently. "It has made communication better and faster, particularly about patients in hospitals," he says. "I can also get a summary about discharged patients from the hospital." Dr. Velez also uses the app to find contact information for referring physicians.

One of the most popular features of the app is texting, as DocBookMD offers physicians one of the only ways to text patient information securely and in a way that meets HIPAA requirements.

"As we say, a photograph is worth a thousand words, and with DocBookMD, I can have the emergency department physicians send me all the information, with a photograph of a hand injury, or a face laceration," says Austin plastic surgeon Rocco Piazza, MD. "I know right where it is, and I can tell them right away what we need to do or where we need to go, assess whether it's something I need to see right now, or if it can wait until morning."

DocBookMD offers physicians one of the only ways to text patient data securely.

Texting features are one reason why medical professional liability carriers sponsor the app and support its use among physicians. Carriers believe DocBookMD can improve communication and help physicians practice safe medicine.

TMLT Chairman Stuart McDonald, MD, uses DocBook and is "particularly excited about the ability to contact physicians through a secure network to request consults or provide follow-up information. This saves a significant amount of time that would previously be spent on hold or waiting for a return call," Dr. McDonald says. "The ability to know whether or not my message has been read in a timely manner helps prevent delays in patient care."

Join DocBookMD

DocBookMD is available for iPad, iPhone, and Android devices and is provided at no charge to members of the Chicago County Medical Society. To register or for more information, please visit *www.docbookmd.com* or call 512-468-2070.

All Politics is Local

Chicago Medical Society's Key Contacts Program

THE CHICAGO MEDICAL Society's effectiveness in the legislative arena depends on members who are fully engaged, who advocate *with* their societies on key issues.

So vital is member participation that CMS is launching a "Key Contacts" program to encourage and train physicians to form personal connections with their local elected representatives.

As a Key Contact, members learn to cultivate meaningful relationships with lawmakers or someone running for elected office. Those who know a legislator, either personally or professionally, are encouraged to build on their connection. CMS will mentor Key Contacts who request support or guidance on building such relationships.

Specific duties of a Key Contact include periodically communicating information and conveying CMS' views on specific legislation or other advocacy activities, as well as CMS events and goals. Key Contacts also may interact with legislative staff and report on their efforts to their Districts and CMS leadership. The two-way information exchange keeps Key Contacts up to date on issues within their communities.

Physicians can get acquainted with an official by supporting a campaign, or by involving themselves in a campaign. Hosting a fundraiser in one's home for the candidate or elected individual is a prime example.

Key Contacts may access legislators through less formal routes. Elected officials often live in the same community as a Key Contact, frequent the same clubs, civic organizations, or religious institutions, have children in the same school, share some type of family relationship; be alumni of the same school or university; or have received the CMS member's personal support for their election to office.

Whatever the relationship, access creates an opportunity for more effective communication. And the greater our access, the more opportunities we have to influence health care policy. Our organizations' ability to shape health care delivery depends on a cadre of Key Contacts.

CMS encourages members to sign up for the Key Contact program. To learn more, please contact Christine Fouts at 312-670-2550, ext. 326; or email *cfouts@cmsdocs.org*.

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.

DATES: Sept. 29, Oct. 20, and Nov. 10 (choose one)

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.

Health Care Catapulted to Forefront

A word to students, residents, fellows **by Kavita Shah, MD**

THE LAST several months have been exciting for those of us in medical school and in training. As the medical system rapidly changes, the system we will enter in a few years will be profoundly different than what we know today. This shift was made evident by the passage of the Affordable Care Act, the growing acknowledgment that we are facing a physician shortage, and the push to bring politics into our exam rooms.

The landmark passage of health care reform in 2010 and the selection of Rep. Paul Ryan (R-WI) are sure to catapult health care into the upcoming November elections. While the passage of the ACA will improve health care access for millions of Americans and increase insurance coverage for preventative health services, the legislation did not touch on many issues central to us as students, residents, and fellows. For example, we still desperately need to reform the student debt program. Mounting evidence shows that our generation of trainees leaves school with far more debt, which in turn affects our choice of specialty and practice location. Still other problems— undergraduate medical education curriculum renewal, resident physician shortages, and lack of malpractice and tort reform, remain unaddressed.

A Great First Step

On a more positive note, HR 6352, "The Resident Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act," was recently introduced by Rep. Aaron Schock (R-IL) and Rep. Allyson Schwartz (D-PA). This bill acknowledges the shortages in graduate medical education and increases the number of residency slots nationally by 3,000 each year from 2013-2017, for a total of 15,000 additional slots. However, one-third of these new slots would only be available to training hospitals currently over their cap, so the actual number of new house staff eligible to train would still be less. This federal bill is a great first step in the right direction, acknowledging our growing physician shortage as well as constrained opportunities for further training of medical student graduates. However, the bill would require adjusting Medicare Indirect Medical Education (IME) payments by 2% based on a hospital's quality and performance measures. Because two-thirds of graduate medical education is funded by IME, the bill proposes an interesting but potentially thorny method of addressing the physician shortage and quality and performance of our teaching hospitals.

Not the Role of Lawmakers

Finally, the past year has brought an unprecedented number of attacks on the patient-physician relationship. While many of these attacks have focused on reproductive care and, thankfully, have been unsuccessful, all trainees and physicians should be alarmed. We students and physicians must stand united. It is not the role of politicians to mandate what physicians must counsel their patients. In many cases, they mandate that we counsel them with medically inaccurate information. It is not the role of lawmakers to require us to perform medically inappropriate tests on patients; and it is not the role of politicians to intrude on our sacred patient-physician relationships and our autonomy within the confines of our exam rooms.

For all these reasons, it's more important than ever for us to stay active and involved in organized medicine and continue to advocate for our patients and ourselves.

Dr. Shah is co-chair of the Chicago Medical Society's Resident District, and is also a CMS trustee from the District.

Political Landscape in Illinois

Elect a doc **by Jere E. Freidheim, MD, Chair, IMPAC Council**

"Voters will soon have a rare chance to elect a physician to the Illinois General Assembly."

RARELY DO VOTERS have the chance to elect a physician to the General Assembly. The roughly 27,000 office-based physicians in Illinois contribute $43 billion annually to our state's economy, yet there are currently no physicians in the Illinois legislature—and there hasn't been one for decades.

Voters in the 29th Senate district will have an opportunity to change that at the polls this year.

Dr. Arie Friedman, a pediatrician living in Highland Park, is running for the 29th Senate seat. Dr. Friedman wants to bring financial order to our state government. He will offer his expertise to reform Illinois' broken and unfair civil litigation system, as well as propose patient and physician friendly reforms to our Medicaid system. Dr. Friedman's familiarity with medical procedures and practices will give the legislature a more informed perspective on the many health care and medical practice issues that are introduced and considered each year.

This race is projected to be one of the most expensive Illinois Senate races of 2012, and Dr. Friedman will need support from his physician colleagues to come out on top in November.

All politics is local, but a wider awareness is needed for Illinois physicians to effectively speak with one voice. With that in mind, I would also like to tell you about another race going on at the southern end of the state that could have far-reaching consequences for you and your patients.

As experience has repeatedly shown, it is not enough for physicians to fight for sensible laws and policies in the legislative and executive branches of state government; we also must pay close attention to the courts which have the power to either uphold or strike down these laws and policies.

With that in mind, there is a vacant seat on the Illinois Appellate Court for the 5th District, which includes 26 southern Illinois counties. Judge Stephen McGlynn, a sitting circuit judge in St. Clair County, is running for this seat. He came to prominence in judicial circles a few years back as a leading advocate for reform of Illinois' judicial system that includes several of our nation's "judicial hellholes."

Judge McGlynn's opponent in this race is Judy Cates, a personal injury attorney and past president of the Illinois Trial Lawyers Association.

This is a very important race for physicians, as the Illinois Appellate Court is the court of first appeal for civil and criminal cases arising from the Illinois Circuit Courts. Furthermore, the Appellate Court is frequently a stepping stone for judges who eventually serve on the Illinois Supreme Court.

Only by standing together, as we did in 2004 with the election of Justice Lloyd Karmeier to the Illinois Supreme Court, can physicians elect an individual to the Illinois Appellate Court who will fight for fairness and balance in our court systems. That individual is Judge Stephen McGlynn.

The best part of all this? You don't have to live in the 5th Appellate Court district, or even the 29th Senate district, to help.

The Illinois State Medical Society Political Action Committee (IMPAC), acting on guidance from IMPAC members and the IMPAC Council, fully supports Dr. Friedman and Judge McGlynn, and is working hard to help elect them this November. If you have not yet joined IMPAC in 2012, now is the time. Just visit *www.impaconline.org* and click "Join IMPAC" to get involved today.

The Illinois General Assembly.

Contributions are not limited to the suggested amount. The Illinois State Medical Society will not favor or disadvantage anyone based upon contribution amounts or failure of a member to make PAC contributions. IMPAC reports are filed with the State Board of Elections, 1020 S. Spring St., Springfield, IL 62704. Voluntary membership contributions support candidates for public office in Illinois. IMPAC contributions can be made with a corporate or personal check. Contributions to IMPAC are not deductible as charitable contributions for federal income tax purposes.

Your Voice Counts!

We represent you, your patients and your practice **by Kathy M. Tynus, MD**

Dr. Kathy Tynus, CMS Council Chair, encourages you to help make policy.

AS YOUR Council Chair for 2012-2013, I look forward to a productive year working together to accomplish our shared goals. I also encourage you to participate in the Chicago Medical Society's policymaking process. On the following pages, you'll find opportunities for all members to make their voices count, and see their dues dollars at work.

Your involvement can be as simple as writing a resolution, giving testimony, joining a committee, representing your district, or just listening in.

Each of these activities makes our organization stronger, furthering policies and action on your behalf. Policymaking is our Governing Council's most critical function; and it is grassroots members like you who supply the substance of meetings. Within organized medicine, the CMS Council is the starting point for county, state, and national resolutions. After being debated and voted upon, resolutions are relayed to the legislative bodies of the Illinois State Medical Society and American Medical Association for further input and implementation. Their respective House of Delegates' may direct their organizations to support new laws in Springfield and Washington, DC, on your behalf.

Recent modifications to CMS' bylaws create new Council seats for Chicago's diverse physician community. With this expansion, hospital medical staffs and specialty groups may influence CMS' future. The resolutions process was streamlined so every member can bring resolutions to our Council, on issues affecting their professional needs and interests. Working closely with CMS' 14 committees, the Council will move swiftly on the concerns members relay to us. The electronic meeting format expedites committee discussion, as well as the dissemination of information on issues in medicine and healthcare delivery.

In welcoming you to CMS' revitalized governing structure, I urge you to be part of the action, putting your membership to work.

THIS REFERENCE Section outlines the Chicago Medical Society's organizational structure and the responsibilities of each component within the Society. CMS' committees, councils, and districts are made up of volunteer physicians whose sole responsibility is to represent the membership on issues brought by grassroots members. As councilors, delegates, or alternates, they are chosen by their peers to advocate on your behalf and the practice of medicine. All members are eligible to serve on a committee, council, or district.

Resolutions: Make your Voice Heard

REFORM BEGINS at the grassroots, through a resolution to CMS, your county medical society.

And while it may sound abstract or complicated, a resolution is really quite simple.

As an expression of opinion or statement of need, a resolution can outline a problem and desired solution. Resolutions may provide specific guidance to lawmakers, or direct your medical societies to act on a particular issue.

A resolution allows rank and file members to ultimately shape the agenda of the Chicago Medical Society, and of its state and national chapters, the Illinois State Medical Society and the American Medical Association.

All resolutions receive prompt attention by a CMS committee, which studies those issues raised by the member, who will also be invited to give testimony. The committee then makes its recommendation to the CMS Governing Council. At its quarterly meetings, the policymaking Council will vote to adopt the measure or direct some other action. After passage in the Council, the resolution moves upward to the ISMS House of Delegates, where CMS delegates advocate for its passage during the annual House meeting in April. Once approved, the ISMS may initiate legislative activity, and forward the resolution to the AMA for national implementation in the U.S. Congress.

Many laws and physician protections are the direct result of resolutions by grassroots members. Every year, initiatives originating at CMS and relayed by ISMS, inform new policies and advocacy by the AMA. CMS and ISMS work in unison for national reimbursement and tort reform through the AMA's national legislative body.

If you are new to the resolutions-writing process, CMS leadership will be happy to mentor you on using this powerful advocacy tool effectively.

Now is the time to get started on those issues you want to address.

Resolutions requesting action by CMS and ISMS should be submitted in September or November, a week prior to the Council meetings. (See deadlines on page 33.) ISMS will consider your resolutions in April 2013, and the AMA in June 2013.

To learn more about submitting a resolution, or to check existing CMS/ISMS/AMA policies, please call 312-670-2550, ext. 335; or email esidney@cmsdocs.org.

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DISTRICTS

CMS has divided Cook County into eight geographic districts, giving each region representation on the Society's Governing Council. In addition, CMS created a medical student section, which represents the seven medical schools in the Chicago area, and a resident and fellow section. Each district and section elects leadership annually in the spring.

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Makis Limperis, MD
Westlake Community Hospital
Niva M. Lubin-Johnson, MD
Mercy Hospital and Medical Center
Kimberly A. Pyle, MD
Elmhurst Memorial Hospital
Loren S. Schechter, MD
Advocate Lutheran General Hospital
Victor Romano, MD
West Suburban Medical Center
Olalekan Sowade, MD
St. Bernard Hospital
Howard Strassner, MD
Rush University Medical Center
Michael Thomas, DO
Little Company of Mary Hospital

ALTERNATE COUNCILORS REPRESENTING HOSPITALS

Kelly Guglielmi, MD
Advocate Christ Medical Center
Roy Weiss, MD
University of Chicago Medical Center

COUNCILORS-AT-LARGE

Edgar A. Borda, MD
E. Boone Brackett III, MD
Ann Marie Dunlap, MD
Brian P. Farrell, MD
Earl E. Fredrick, Jr., MD
Kuhn Hong, MD
Gerald E. Silverstein, MD
Michael J. Wasserman, MD
Cheryl D. Wolfe, MD

ALTERNATE COUNCILORS-AT-LARGE

Neelum T. Aggarwal, MD
Rafael Z. Campanini, MD
Zahurul Huq, MD

CHICAGO MEDICAL SOCIETY 2012-13 PRESIDENTIAL INITIATIVES

COMMITTEE ON ACADEMIC PHYSICIANS

Formed to improve CMS' representation of physicians involved in academic medicine, this committee addresses the unique regulatory and financial issues that affect academic physicians, and provides a forum to discuss them. The committee is responsible for researching the feasibility of policies, activities and services that ultimately enable CMS to better serve the needs and interests of academic physicians.

Jacquelynne P. Corey, MD
Chairman
Jose Biller, MD
Vice Chairman
Atul Jain, MD
Vice Chairman
Neelum T. Aggarwal, MD
Howard Axe, MD, *ex-officio*
Lawrence S. Chan, MD
Sarmistha Chaudhuri, MD
Rajyasree Emmadi, MD
Herbert H. Engelhard III, MD
Adrienne L. Fregia, MD,
ex-officio
Marla F. Hartzen, MD
Javad Hekmatpanah, MD
Jennifer I. Lim, MD
Kathleen E. Mandell
Student
Alfonso Mejia II, MD
Albert F. Miford, DO
Helen L. Morrison, MD
Robert W. Panton, MD,
ex-officio
Marcus L. Quek, MD
Tulio E. Rodriguez, MD
Jadwiga Roguska-Kyts, MD
H. Steven Sims, MD
J. Regan Thomas, MD
Kathy M. Tynus, MD,
ex-officio
Leonard A. Valentino, MD
Roy E. Weiss, MD
David K. Yoo, MD

COUNCIL ON MEDICAL STAFF LEADERSHIP

This council was formed in response to the growing demands on medical staff leadership, and is designed to address their needs and interests, as well as the unique issues affecting medical staffs and hospitals. The council is composed of medical staff presidents, presidents-elect, secretaries, and representatives of the American Medical Association's Organized Medical Staff Section. The services offered include: quarterly meetings to discuss issues affecting hospitals; the development of educational programs; the preparation of newsletters to inform staff of important medical, legal, and legislative updates; and research on topics of interest or concern.

Tulio E. Rodriguez, MD
Chairman
Mishail A. Shapiro, DO
Vice Chairman
Iqbal Akhter, MD
Lia A. Arber, MD
Howard Axe, MD, *ex-officio*
James R. Diesfeld, MD
Adrienne L. Fregia, MD,
ex-officio
Daniel Katz, MD
Hamdi Khilfeh, MD
Raj B. Lal, MD
James A. Lambur, MD
Helen L. Morrison, MD
Joseph L. Murphy, MD
Ernest G. Nora, MD
Robert W. Panton, MD,
ex-officio
Ramanathan Raju, MD
Bhagavatula Ramakrishna, MD
Jadwiga Roguska-Kyts, MD
Joseph S. Thomas, Jr., MD
Kathy M. Tynus, MD,
ex-officio

EMPLOYED PHYSICIANS COMMITTEE

This committee was formed to address the concerns of employed physicians through education and advocacy. Efforts in this area include educational programs on employment contracting, employee rights, and benefit resources.

Andrew M. Pavlatos, MD
Chairman
Howard Axe, MD, *ex-officio*
Mary Jo Fidler, MD
Adrienne L. Fregia, MD,
ex-officio
Joe F. Jacobs, MD
Rajeev Kumar, MD
Robert W. Panton, MD,
ex-officio
Kathy M. Tynus, MD,
ex-officio

WOMEN PHYSICIANS FORUM

The forum looks at the unique needs and interests of women physicians in Cook County. As the local counterpart of the Illinois State Medical Society's (ISMS) Women Physicians Forum, the group is structured to focus on three key areas: (1) representing and advocating on behalf of women physicians; (2) networking; and (3) offering services specific to women physicians. The Women Physicians Forums of CMS and ISMS provide the means for a strong representative voice on behalf of the growing number of women in medicine.

Barbara G. Jericho, MD, *Chairman*
Cynthia K. Rigsby, MD *Vice Chairman*
Tania Hossain, MD *Vice Chairman*
Emelie J. Ilarde, MD *Vice Chairman*
Howard Axe, MD, *ex-officio*
Adrienne L. Fregia, MD, *ex-officio*
Sandra W. Horowitz, MD
Regina L. Liebman, MD
Robert W. Panton, MD, *ex-officio*
Mumtaz F. Raza, MD
Claudia M. Rodriguez, MD
Kathy M. Tynus, MD, *ex-officio*
Qiong Zhao, MD

YOUNG PHYSICIANS GROUP

This group was formed to assist new physicians in their transition from training to a professional career. A young physician is defined as a doctor younger than 40 years of age or a physician within the first eight (8) years of professional practice following residency and fellowship training. This resource helps facilitate the transition process and provides networking, educational and mentoring opportunities.

Michael A. Hanak, MD *Chairman*
Jill C. Anderson, MD *Vice Chairman*
Erica A. Kuhlmann, MD *Vice Chairman*
Howard Axe, MD, *ex-officio*
Mai Britt Campbell, MD
Eileen F. Couture, DO
Adrienne L. Fregia, MD *ex-officio*
Joehar Hamdan, DO
Tania Hossain, MD
Atul Jain, MD
Barbara G. Jericho, MD
Kameron Matthews, MD
Robert W. Panton, MD, *ex-officio*
Claudia M. Rodriguez, MD
Kathy M. Tynus, MD, *ex-officio*

COUNCIL COMMITTEES

BYLAWS/POLICY REVIEW COMMITTEE

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

Thomas M. Anderson, MD *Chairman*
Yvonne M. Wolny, MD *Vice Chairman*
Howard Axe, MD, *ex-officio*
Parakrama DeSilva, MD
Adrienne L. Fregia, MD, ex-officio
Rajeev Kumar, MD
Ernest G. Nora, MD
Robert W. Panton, MD, *ex-officio*
Jadwiga Roguska-Kyts, MD
Kathy M. Tynus, MD, *ex-officio*
Edward A. Wojcik, MD

COMMUNICATIONS/TECHNOLOGY COMMITTEE

Purpose: Monitors the world of technology, and informs and educates members on the use of computers and technology applications in the clinical setting and for personal use.

Grady M. Wick, MD *Chairman*
SehJin Han, MD *Vice Chairman*
Erica A. Kuhlmann, MD *Vice Chairman*
Howard Axe, MD, *ex-officio*
Bruce A. Blacker, MD
Leo R. Boler, Jr., MD
Clarence W. Brown, Jr., MD
Ajay K. Chauhan, DO
Adrienne L. Fregia, MD, *ex-officio*
Craig M. Gardner, MD
Atul Jain, MD
Devin D. Mehta, MD
Robert W. Panton, MD, *ex-officio*
Kathy M. Tynus, MD, *ex-officio*

CREDENTIALS /ELECTIONS COMMITTEE

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

Clarence W. Brown Jr., MD *Chairman*
Parakrama DeSilva, MD *Vice Chairman*
Howard Axe, MD, *ex-officio*
Edgar A. Borda, MD
Sarmistha Chaudhuri, MD
Adrienne L. Fregia, MD, *ex-officio*
Audisho B. Khoshaba, MD
Raj B. Lal, MD
Ernest G. Nora, MD
Robert W. Panton, MD, *ex-officio*
Kathy M. Tynus, MD, *ex-officio*

CONTINUING MEDICAL EDUCATION COMMITTEE

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

Neelum T. Aggarwal, MD
Chairman
Khondker K. Islam, MD
Vice Chairman
Howard Axe, MD, *ex-officio*
Jose Biller, MD
Sarmistha Chaudhuri, MD
Ajay K. Chauhan, DO
Parakrama DeSilva, MD
Adrienne L. Fregia, MD, *ex-officio*
Alfonso Mejia II, MD
Robert W. Panton, MD, *ex-officio*
Ruth G. Ramsey, MD
Randall F. Randazzo, MD
Jadwiga Roguska-Kyts, MD
Hernando Torres, MD
Kathy M. Tynus, MD, *ex-officio*

HEALTH CARE ECONOMICS COMMITTEE

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

Lewis S. Blumenthal, MD
Chairman
Steven J. Charous, MD
Vice Chairman
Murad Alam, MD
Michelle L. Anderson
Student
Lia A. Arber, MD
Howard Axe, MD, *ex-officio*
Clarence W. Brown Jr., MD
Ajay K. Chauhan, DO
Rosa Hae Choi, MD
Jacquelynne P. Corey, MD
Evelyn Diaz-Jimenez, MD
Ann Marie Dunlap, MD
Adrienne L. Fregia, MD, *ex-officio*
Nancy Gryniewicz-Sika, MD
Joehar Hamdan, DO
Atul Jain, MD
Rajeev Kumar, MD
Robert W. Panton, MD, *ex-officio*
Sunil A. Patel, MD
Randall F. Randazzo, MD
Chad A. Roberts
Claudia M. Rodriguez, MD
Shirley A. Roy, MD
Mark J. Schacht, MD
Loren S. Schechter, MD
Virginia M. Schmidt, MD
Robert B. Shulman, MD
Gerald E. Silverstein, MD
Erwin G. Szela, MD
Kathy M. Tynus, MD, *ex-officio*
Edgar Vargas, MD

LONG-RANGE PLANNING COMMITTEE

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

Murad Alam, MD
Chairman
Clarence W. Brown Jr., MD
Vice Chairman
Chad A. Roberts, *Student*
Howard Axe, MD, *ex-officio*
Rosa Hae Choi, MD
Parakrama DeSilva, MD
Adrienne L. Fregia, MD, *ex-officio*
Sheldon S. Greenberg, MD
Audisho B. Khoshab, MD
Raj B. Lal, MD
Robert W. Panton, MD, *ex-officio*
Randall F, Randazzo, MD
Jadwiga Roguska-Kyts, MD
Kathy M. Tynus, MD, *ex-officio*

MEMBERSHIP/IMG COMMITTEE

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

Sujata S. Gaitonde, MD
Chairman
Khondker K. Islam, MD
Vice Chairman
Iqbal Akhter, MD
Howard Axe, MD, *ex-officio*
Edgar A. Borda, MD
Clarence W. Brown, Jr., MD
Parakrama De Silva, MD
Adrienne L. Fregia, MD, *ex-officio*
Fatima M. Mohiuddin, MD
Ernest G. Nora, MD
Ejikeme O. Obasi, MD
Robert W. Panton, MD, *ex-officio*
Randall F. Randazzo, MD
Mohammad A. Razzaque, MD
Kathy M. Tynus, MD, *ex-officio*

PHYSICIAN ADVOCACY COMMITTEE

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

Ajay Chauhan, DO
Chairman
Joe Hamdan, MD
Vice Chairman
Robert Shulman, MD,
Vice Chairman
Iqbal Akhter, MD
Lewis S. Blumenthal, MD
Leo Boler, MD
Clarence W. Brown, Jr., MD
Sarmistha Chaudhuri, MD
Evelyn Diaz-Jimenez, MD
Herbert H. Engelhard III, MD
Anne E. Hong, MD
Raj B. Lal, MD
John T. McMahan, MD
Alfonso Mejia, MD
Ejikeme Obasi, MD
Edgar Vargas, MD

PUBLIC HEALTH COMMITTEE

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

James M. Galloway, MD
Chairman
Neelum T. Aggarwal, MD
Vice Chairman
George T. Chiampas, DO
Vice Chairman
Vemuri S. Murthy, MD
Vice Chairman
Howard Axe, *ex-officio*
Michelle L. Anderson
Student
Lia A. Arber, MD
Ajay K. Chauhan, DO
Fernando Cinta, MD
Peter E. Doris, MD
Ann Marie Dunlap, MD
Adrienne L. Fregia, MD,
ex-officio
Kamala A. Ghaey, MD, MPH
Sheldon S. Greenberg, MD
Tania Hossain, MD
Susan B. Kern, MD
Louis J. Kraus, MD
Raj B. Lal, MD
Kameron Matthews, MD
Peter W. McCauley, MD
John T. McMahan, MD
Alfonso Mejia II, MD
Cesar E. Menendez, MD
Joseph L. Murphy, MD
Peter Orris, MD, MPH
Paschal J. Panio, MD
Robert W. Panton, MD,
ex-officio
Joseph Pulvirenti, MD
Ramanathan Raju, MD
Bhagavatula Ramakrishna, MD
Randall F. Randazzo, MD
Tulio E. Rodriguez, MD
Mark Rosenbloom, MD
Kathleen A. Ruggero, DO
Robert B. Shulman, MD
Kathy M. Tynus, MD,
ex-officio

RESOLUTIONS REFERENCE COMMITTEE

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

Susan B. Kern, MD
Chairman
Rajeev Kumar, MD
Vice Chairman
Robert B. Shulman, MD
Vice Chairman
Howard Axe, MD, *ex-officio*
Earl E. Fredrick, Jr., MD
Adrienne L. Fregia, MD,
ex-officio
Kamala A. Ghaey, MD, MPH
Joe F. Jacobs, MD
Peter Orris, MD, MPH
Robert W. Panton, MD,
ex-officio
Kathy M. Tynus, MD,
ex-officio

SENIOR PHYSICIANS GROUP

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

Joseph L. Murphy, MD
Chairman
Sandra W. Horowitz, MD
Vice Chairman
Raj B. Lal, MD
Vice Chairman
Billie W. Adams, MD
William A. Appelbaum, MD
Howard Axe, MD, *ex-officio*
Fernando Cinta, MD
Ann Marie Dunlap, MD
Earl E. Fredrick, Jr., MD
Adrienne L. Fregia, MD,
ex-officio
Joseph R. Kraft, MD
Chandrakant Modi, MD
Paschal J. Panio, MD
Robert W. Panton, MD,
ex-officio
Kathy M. Tynus, MD,
ex-officio
Mustafa Vidinli, MD
Raghu R. Vollala, MD
Katherine A, Wier, MD
Edward A. Wojcik, MD

SUBCOMMITTEE ON JOINT SPONSORSHIP

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

Howard Axe, MD, *ex-officio*
Ajay K. Chauhan, DO
Adrienne L. Fregia, MD
ex-officio
Robert W. Panton, MD,
ex-officio
Loren S. Schechter, MD
Kathy M. Tynus, MD, *ex-officio*

CMS Governing Council Meetings 2012-2013

Tuesday, Sept. 18, 2012, 6:00-9:00 p.m. Maggiano's Banquets, 111 W. Grand Ave., Chicago
Resolution deadline: Sept. 11

Tuesday, Nov. 20, 2012, 6:00-9:00 p.m. Maggiano's Banquets, 111 W. Grand Ave., Chicago
Resolution deadline: Nov. 13

Tuesday, Feb. 19, 2013, 6:00-9:00 p.m. Maggiano's Banquets, 111 W. Grand Ave., Chicago
Resolution deadline: Feb. 12

Tuesday, April 16, 2013, 6:00-9:00 p.m. Maggiano's Banquets, 111 W. Grand Ave., Chicago
Resolution deadline: April 9

Other Meetings

AMA House of Delegates (Interim Meeting)
Nov. 10-13, 2012, Hawaii Convention Center, Honolulu, Hilton Hawaiian Village

National Advocacy Conference (AMA)
Feb. 10-13, 2013, Washington, DC

ISMS Annual House of Delegates Meeting
Friday-Sunday, April 26-28, 2013, Oak Brook Hills Marriott Resort, 3500 Midwest Rd., Oak Brook, IL
Resolution deadline: March 12

AMA House of Delegates (Annual Meeting)
June 15-19, 2013, Hyatt Regency Chicago, 151 E. Wacker Dr., Chicago

PRACTICE MANAGEMENT LECTURE SERIES

The Patient Protection & Affordable Care Act (PPACA): The Supreme Court's Decision & Implications for Your Medical Practice

For physicians in all specialties and their practice managers

HOSTED BY the Chicago Medical Society, this lecture will guide you on absorbing the requirements of the massive healthcare reform law into your practice. The lecture will address implications such as coverage expansion; paradigmatic shift from episodic treatment to patient- and family-centered care; wellness and prevention; and greater scrutiny of physician practices that try to "game" the system.

DATE: Oct. 10
TIME: 6:30-7:30 p.m.
SPEAKER: Mark E. Rust, Managing Partner and Chair, National Healthcare Department, Barnes & Thornburg, LLP, Chicago
LOCATION: Chicago Medical Society, 33 W. Grand Ave., Third Floor, Chicago
CME: Up to 1.0 credit
COST: Free for CMS members or staff; $25 for non-members or staff
RSVP: Please contact Elvia Medrano 312-670-2550, ext. 338; or *emedrano@cmsdocs.org.*

Calendar of Events

SEPTEMBER

29 Advanced Cardiovascular Life Support (ACLS) Recertification 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. $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*

OCTOBER

5 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens. This workshop is intended for physicians, physician assistants, nurses, practice managers, and dental professionals who will learn to:

- Implement a training program for healthcare employees who may be exposed to bloodborne pathogens.
- Identify appropriate personal protective equipment (PPE).
- Develop an emergency

10:00 a.m.-12:00 noon; Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; Advocate Christ Medical Center, Oak Lawn; 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 Medrano 312-670-2550, ext. 338, or emedrano@cmsdocs.org.*

10 Practice Management Lecture Series The Patient Protection & Affordable Care Act (PPACA): The Supreme Court's Decision & Implications for Your Medical Practice For physicians in all specialties and their practice managers. This session will guide you on absorbing the requirements of the massive healthcare reform law into your practice. 6:30-7:30 p.m.; Speaker: Mark E. Rust, Managing Partner and Chair, National Healthcare Department, Barnes & Thornburg, LLP, Chicago; Chicago Medical Society, 33 W. Grand Ave., Third Floor, Chicago; participants may earn up to 1.0 credit; no cost to CMS members or staff; $25 for non-members or staff. *To RSVP, please contact Elvia Medrano 312-670-2550, ext. 338; or emedrano@cmsdocs.org.*

20 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. $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.*

Welcome New Members!

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

Student District
Shivani Katyal

Resident District
Sachin Jha, MD

District 3
Paul E. Savage, MD

classifieds

Personnel Wanted

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 to: 708-336-7420.

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

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

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

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

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

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

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

Office/Building for Sale/Rent/Lease

Medical offices for lease in Evanston. Walk to Evanston Hospital, 1000 Central, and public transportation. 600-2,250 square feet with men's and women's restrooms at 2530 Ridge Ave. Call 847-869-4200 or email *jim@schermerhorn-realestate.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.

Business Services

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

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Multipronged Involvement

Family practitioner says civic work key to improving health care **by Scott Warner**

Regarding his role as chair of the IDFPR Board, Dr. Tariq Butt says its work should not be perceived as punitive. "We're here to provide a structure to help physicians with their issues, especially if they are impaired.... And the patient ultimately benefits."

TO SAY THAT Dr. Tariq Butt takes a holistic approach to medicine is an understatement. "As physicians, we need to be engaged at all levels to help patients," says the family practitioner whose approach to providing health care may, at first glance, seem rather eclectic. For starters, he serves as chair of the Illinois Department of Financial and Professional Regulation Board; he was a longtime member of the Chicago Board of Education; and a founding member of the Asian American Institute; he's also deputy medical officer of Access Community Health Network, the largest network of federally qualified clinics in the nation. "Whether the patient is insured or not, we will treat them," Dr. Butt says. And that only scratches the surface of his multipronged activities, which he emphasizes is all to help patients.

"Our involvement as physicians does not stop at clinics and hospitals," Dr. Butt explains. He says he became involved with the IDFPR Board because he wanted to inspire physicians to perform at optimum levels. "Our work should not be perceived as being punitive," he says. "We're here to provide a structure to help physicians with their issues, especially if they are impaired, and suffer addiction problems for example. We can provide care counseling from their peers, so they can continue to perform as a physician, rather than see them lose their license, or face fines." And, once again, Dr. Butt emphasizes, "the patient ultimately benefits."

He says his 16 years of working with the Chicago Board of Education let him influence the health care curriculum in the schools in areas such as immunizations, and the asthma medication program, and allowed him to instruct schools on handling the obesity epidemic. "It's simple," he says. "Children's grades go up when they are healthier."

And his participation in other community organizations, such as the Asian American Institute, also enabled him to get a handle on health issues

affecting all kinds of populations. "If people don't have good health, they don't have anything—they don't have a job; health is a vital component of economics."

Dr. Butt also says his involvement with the Chicago Medical Society and Illinois State Medical Society has enhanced his role as a caregiver. "I learned so much about leadership skills from various CMS presidents. And serving as a CMS councilor, as well as on committees such as Public Health, showed me how to better advocate for our profession, and how we in turn can take better care of our patients."

He says he would urge all physicians to engage in organized medicine and civic life as well. "If we don't prepare ourselves better, we will have an abrupt collision with the future."

Dr. Butt's Career Highlights

BESIDES THE ACTIVITIES described above, Dr. Butt holds teaching appointments at Rush Medical College and at the University of Illinois' College of Medicine. He's a member of the Governmental Affairs Council of the Illinois State Medical Society, and serves as a preceptor in the Mount Sinai family medicine residency program—one of the first of its kind in the Midwest to be based in a community health center setting. He has received many awards, including the Horatio Alger Award, and the Loretta Lacey Advocacy Award for his work in child advocacy. Dr. Butt lives in Chicago with his wife and three children.

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