PHYSICIAN RATINGS

Like it or Not, Physician Profiling is Quickly Becoming a Way of Life

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CMS Invades Washington, DC

Medicaid Expansion: Go or No Go

How to Terminate a Patient Relationship

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MESSAGE FROM THE PRESIDENT

Being an Advocate

**RECENT EMAIL** announcement from ISMIE Mutual Insurance Company reported that the country’s largest trial lawyer group, the American Association for Justice, recently increased its lobbying expenditures by 42%. The intent behind this increase is to oppose legislation, including the SHIELD Act, which requires the loser to pay attorneys’ fees; the HEALTH Act, which limits compensation for non-economic damages in medical liability cases; and the FACT Act, which prevents ransacking of asbestos bankruptcy trusts. These Acts attempt to bring about meaningful reform by controlling health care costs.

Physicians work daily putting patients’ interests first, unlike trial attorneys who are merely guided by self-interest. We contend with an outdated payment system that has kept our pay stagnant, while the cost of providing care has increased more than 20%. We deal with growing administrative burdens, including pharmacy formularies, precertification requirements for certain diagnostic imaging, billing and coding updates and modifications, and quality concerns and recommendations. We practice under the continued threat of huge reimbursement cuts called for by Medicare’s SGR formula, and continued liability risks.

It’s no wonder that physicians often don’t get involved in the political process. But it is exactly because of these mounting challenges that we must tell our elected officials how their legislation compromises the practice of medicine.

After recently visiting Washington, DC, where my colleagues and I spoke with members of the Illinois Congressional Delegation, I am optimistic our message is being heard. There is strong support for fixing the fatally flawed SGR formula. The difficulty is finding offsets to pay for repealing the current pay formula. I was impressed with the response of many lawmakers who are aware of the looming physician shortage and the need to maintain funding for graduate medical education. Once again, finding an equitable way to pay for medical education, with funding from both private payers and the federal government, seems just outside our reach. We also discussed public health concerns such as preventing gun violence, decreasing the availability and misuse of prescription medicines, and the general safety of our patients. We emphasized the difficulty of prescribing narcotics in an era of EMRs, and the countless administrative duties that keep us from spending more time with patients.

Our advocacy visit to Capitol Hill laid a framework on which individual members of the Chicago Medical Society must continue to build. So please be sure to contact your state and federal representatives. Make an appointment to meet with your lawmakers when they are in their district offices and offer to be a resource on health-related matters. Rather than giving statistics, relay concrete examples of patient encounters, and show how legislative decisions affect patients’ lives. Share your personal stories, underscoring the barriers to providing high-quality, compassionate care. And be sure to make suggestions for addressing these issues. Well-intended legislation often has unintended consequences that add to the physician burden. Politicians are often not aware of the struggles we face daily; many would appreciate hearing from us. After you make this connection, please let us know.

We have created a “Key Contacts” program to train physicians to form these personal connections. We provide talking points on pending legislation and mentor physicians on building and maintaining relationships with representatives. You will find communicating with lawmakers more rewarding than just complaining to your colleagues. Collectively, we can shape the future of medicine and health care delivery. We must leverage the prestige of our profession to build a better health care system.

Howard Axe, MD
President, Chicago Medical Society
Experts & Advocates in Liability Protection

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

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

CMS Insurance
A SUBSIDIARY OF CHICAGO MEDICAL SOCIETY
“In only a few years, there will be more graduating seniors than residency positions, a circumstance that has never before existed.”

Health care reform is the order of the day. Indeed, each day brings new orders: penalties, incentives, billing codes, reporting requirements and reimbursement snarls. Health planners have identified the major problem, and it is waste. Moreover, they have determined that physicians are the cause. They believe that we seek volume (and profit) instead of value (and caring). Proof is no further away than your friendly Dartmouth Atlas of Health Care. It tells us that Medicare spends 50% more per enrollee in Chicago than in more efficient communities, such as Green Bay and Salt Lake City, and there are 30% more physicians per capita in Chicago than in these more efficient places. So, politicians all agree—waste is the problem, and the last thing we need is more physicians.

I confronted a similar situation while on the faculty of the Medical College of Wisconsin. Medicare spending in Milwaukee was 25% greater than in Green Bay and other Wisconsin regions, and there were 15% more physicians per capita in Milwaukee. The business community wondered whether physicians were causing the excess spending. The answer proved to be quite different. The greater spending in Milwaukee was due to the added care required by Milwaukee’s poorer and sicker inner-city patients. Utilization in the rest of the Milwaukee area resembled that of Green Bay’s.

This pattern of high use in association with poverty has been found in every city in which it has been studied, and it is true for Chicago. Even a rather crude analysis relating Medicare spending in various Chicago-area hospitals to the average household income of the ZIP code in which the hospital is located show that Medicare spending in the patients’ last two years of life ranges from $60,000 in areas with average household incomes of $25,000 to $30,000 in areas with average incomes of $150,000. Poverty and increased Medicare spending go hand-in-hand, and the demand for physicians follows. Nonetheless, policymakers view cities like Chicago, with higher health care spending, as wasteful.

These factors help to explain why there is no policy response to the physician shortages. But why are there shortages in the first place? It’s simply because not enough physicians have been trained. During the 1990s, planners believed there would be too many, and in 1997 Congress capped Medicare funding for added residency positions. Only a trickle of positions has been added since then.

Yet even faced with current shortages and projections of deeper ones, policymakers accept the belief that if health care everywhere were like that in Grand Junction, CO, (where minorities are rare and poverty and ghettos nonexistent) no more physicians would be needed. Regulatory enthusiasts concur, assuring Congress that value-based purchasing and accountable care organizations will stop the waste and free up enough physicians to meet future needs. The Academy of Family Practice and American College of Physicians agree, saying that if there were more primary care physicians and fewer specialists, care would be cheaper and better.

So, physician shortages deepen, with primary care being most affected. This is not because fewer graduates are choosing primary care. The numbers have not fallen appreciably. It is because too few primary care graduates are practicing office-based care. Many are becoming hospitalists, and others are finding niches, such as palliative care, that limit their patient loads. And there is no end in sight.

Although residency education has been relatively stagnant, medical education has not. Many medical schools have expanded, and additional schools have opened. The number of graduates will grow from approximately 18,000 in 2000 to almost 28,000 by 2020. But this growth will not lead to more practicing physicians. It simply displaces international graduates. In only a few years, there will be more graduates than residency positions, a circumstance that has never before existed. Moreover, if Congress decreases funding for graduate medical education, the number of residency positions will likely decrease.

While organizations like the American Medical Association (AMA) and Association of American Medical Colleges (AAMC) are calling on Congress to lift the caps, there really is no concerted effort to do so. Talk has shifted to shortening residency training and converting freed-up positions to new entry level positions, but there is little enthusiasm for that, either. Indeed, the residency redesign initiative in family medicine calls for adding one more year. And the shortages deepen.

Six years ago, writing about the urgent need to increase the number of residency positions, I said, “If we do not rise to meet the challenge, future generations will wonder what ours was all about, what purpose was served by allowing a great profession to stagnate and why they and their loved ones must experience illness without access to a competent and caring physician.” Those words are ever more poignant today.
Tips for the Step 1 Exam
Advice on studying from a fellow student  By James Wu

In the beginning of my second year of medical school, I searched for the best method to prepare for the U.S. Medical Licensing Exam Step 1. I read study guides, questioned third- and fourth-year students, researched forums, and began studying early. Having read that the Step 1 score was among the top criteria competitive residency programs use to narrow their pool of applicants, I made it a goal to give the exam my best effort. Now that I’m in my third year, I’ve completed the exam and acquired a feel for the types of questions asked. This article passes some valuable “do’s” and “don’ts” I collected along the way.

Do
• Concentrate on high-yield knowledge and concepts. Try to understand, especially, the ways in which the knowledge and concepts are connected. To test your understanding, see if you can comfortably explain the main points of a disease process to a friend; be sure you always know the diagnosis, pathophysiology, and management of a disease.
• Know that the USMLE is designed so that it is difficult to answer questions by simply regurgitating medical knowledge. The purpose of the exam is to assess “whether you understand and can apply important concepts in the sciences that are basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy.”
• Study First Aid and be sure you thoroughly understand the concepts. By a conservative estimate, First Aid contains between 80% to 90% of the knowledge base tested by Step 1. The bulk of questions asked will be found in core sections in First Aid.
• Use USMLE World. UWorld helps illustrate the significance of the high-yield facts and the circumstances in which they are important to consider. UWorld questions closely mimic the setup of the actual exam in that a single question may require you to simultaneously diagnose, understand the pathophysiology, and decide on a treatment.
• Read the explanation for every answer stem when reading question banks, even the wrong ones. It’s easy to answer a question correctly by chance and equally easy to eliminate answers for the wrong reasons.
• Resist the urge to move quickly through UWorld because you may unknowingly rob yourself of the chance to learn high-yield concepts. Once you’ve mastered First Aid and UWorld, use your time effectively by trying other question banks such as Kaplan Qbank to help identify gaps in your knowledge and to target those weaknesses.
• Try to develop test-taking habits that are beneficial when working on practice problems. Spend some time early in your study schedule considering which strategies work for you. Simple strategies such as reading the last line of the question before reading the question stem can help save valuable time.

Do not
• Emphasize rote memorization or measure your learning by the quantity of material you’ve studied.
• Be a perfectionist and try to read every book or watch every video within your allotted study time. It is impossible to learn everything that could potentially be tested and trying to do so only diverts your focus from more effective ways of studying.
• Leave a single question on the exam unanswered. This is an absolute rule. If answering a question seems to take an abnormally long time, guess an answer, mark the question, and come back to it at a later time.
• Second-guess yourself on questions that seem suspiciously simple or straightforward. There will likely be plenty of these questions on the exam. Overthinking a question requires both time and mental stamina, both of which will be a limited resource on exam day.
• Spend more than two or three minutes on a difficult question. A large portion of the exam is straightforward and can be answered quickly and easily. Answering these questions will improve your overall exam score far more than spending extra time on difficult questions. The goal is to obtain the highest possible score, which is accomplished more effectively by budgeting your time appropriately.

Find a study partner if it helps you stay motivated. Try to maintain a reasonable study schedule with time allotted for breaks. Preparing for the exam can feel overwhelming, but you are not alone in your struggle! In the words of Henry Ford, “Obstacles are those frightful things you see when you take your eyes off the goal.”

James Wu is co-chairman of the CMS Student District and a third-year student attending the Chicago Medical School at Rosalind Franklin University of Medicine and Science. He scored in the 90th percentile on the USMLE.
Put Benchmarking on Your To Do List

Measuring data will make your practice more successful—and it is easy to do

By Alina Baban

“Problem areas could include high operating expenses, decreased revenue, decreased provider productivity, staff retention, or overall quality of care.”

Every practice experiences change but practice managers can influence whether that change is positive or negative. One of the main ways to make positive change is to benchmark—that is, measure an internal value against an external standard. Benchmarking enables us to obtain a detailed understanding of our practice, as well as gain an overview of how our practice compares to regional and national industry standards.

To begin, look at current operational processes and identify issues that should be addressed.

Problem areas could include high operating expenses, decreased revenue, decreased provider productivity, staff retention, or overall quality of care. As practice managers, we have a tendency to want to address everything and anything at once. This will only result in placing benchmarking at the bottom of your endless To Do List. Once the problem areas of your practice are determined, choose only a couple to benchmark. Some areas that are frequently benchmarked include:

• Operating Expenses. Operating expenses could have an extensive list of sub-categories, such as outside services, equipment costs, malpractice insurance, and medical supplies. Focus on only four of the highest expense categories. After you have chosen your categories, calculate the percentage of change over two or three years to obtain an internal overview of your operating expense values.

• Physician and Staff Compensation. Compensation is usually one of the highest expenses a practice incurs. When benchmarking compensation, you must not only look at the rate of compensation, but also analyze the levels of staffing per full-time equivalent (FTE) provider. Overstaffing per FTE can be costly, but also keep in mind that understaffing and a low rate of compensation can also hinder a practice by affecting staff retention.

• Provider Productivity. Determine the level of provider productivity by looking at billed Evaluation and Management (E/M) Codes. Practice management systems can easily run reports on types of E/M codes billed by individual providers. When comparing your data to regional and national data, it is essential that FTE physicians and support staff in your practice be compared only to their full-time equivalents or counterparts.

• Patient Satisfaction. To benchmark patient satisfaction, you must have an effective method of administering and collecting patient surveys. If you have never done patient satisfaction surveys, the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) is a great resource, offering examples of letters that could be sent to patients, as well as key questions to include in your survey. The information compiled from your surveys should be used as the value for your internal benchmark.

After you decide what two issues to address, you will have to locate your benchmarking data. Internal data can be obtained from current and previous year budgets, practice management systems, or programs such as QuickBooks. Finding external data requires more time and effort. You can get benchmarking data from specialty-specific provider organizations and professional organizations like the American Medical Association or Medical Group Management Association.

Once you have your data in hand, you can begin your analysis. Compare your practice’s internal values with the external values to measure the current state of your practice. Is your practice where you would like it to be compared to those around you? If not, your benchmarking data will serve as the platform you can use to dive into action, closing the distance between where your practice is and where you would like it to be. As you develop a process to achieve your goals, remember it is very important to integrate benchmarking longitudinally to be effective. Once this process is in place, you can temporarily check benchmarking off your “To Do List.”

Alina Baban is chair of the CMS Practice Manager Section.

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

To download a membership application, please go to www.cmsdocs.org or call 312-670-2550.
Finding the Right Help
Cultivating a workforce to support health IT

By Rochelle Tapping, MPPA, and Abel Kho, MD, MS

You’ve been thinking about implementing or upgrading an electronic health record (EHR) system for quite some time, but you’re plagued with the same questions time and time again: Where can I get help and exactly what kind of help will I need? You are not alone. Some of the largest hospitals and health systems in Chicago face the same questions when it comes to health IT support.

While organizations are deciding what they need, an educated health IT workforce continues to grow. Unfortunately, a gap also continues to grow within this workforce: newly trained individuals have learned the concepts, but they lack hands-on experience. This is where small practices can benefit themselves, the workforce, and other health IT employers. Students who have completed health IT training and education programs are eager to gain hands-on experience. At CHITREC, we see this regularly as our internship program gets inquiries from people looking for a way to put their education or prior work experience to practical use. Applicants are seeking opportunities to watch health IT in action and contribute to its success. Many are willing to volunteer their time to get this experience. Backgrounds vary, but some individuals have a theoretical knowledge of Meaningful Use or health IT implementation or workflow redesign, while others have years of IT or health care experience, but not both.

What kind of help will I need?
Help is available in many different ways depending on the size of your practice and the level of comfort you and your staff have with health IT. Examples of projects that the workforce can help with include: assessing your staff’s computer and health IT literacy; training staff on basic computer and IT skills; assisting with set up of hardware; educating staff on Meaningful Use; transferring paper records into the EHR; assisting front desk staff during implementation of the EHR; or explaining the new system and its benefits to patients in the waiting room, with demos of a patient portal.

What qualifications are best?
This will vary depending on the scope of your project and the nature of your practice. In general, practices will benefit from volunteers who have a combination of education and experience in IT or health care. Project management skills or familiarity with an EHR system are also helpful. In reviewing hundreds of resumes, we’ve generally seen two camps emerge: experienced IT professionals with minimal health care experience, and individuals with health care experience but a limited IT background. As with any addition to your team, the key attributes of diligence, attention to detail, ability to work within a team, and professionalism can make up for deficiencies. Perhaps of equal importance is your practice’s ability to help volunteers gain missing health care experience. If you cannot do this, you may need someone with far more experience, but at a potentially greater cost.

How can I train my staff?
Various training opportunities and certifications are available. Local colleges have courses on basic computer skills. Your EHR vendor may also offer basic computer training. Local consultants are available to provide training. Organizations such as the Centers for Medicare and Medicaid Services, Healthcare Information and Management Systems Society, American Health Information Management Association, American Medical Informatics Association, National eHealth Collaborative, and Illinois Health Information Technology Regional Extension Center offer webinars and other educational opportunities. CHITREC hosts workshops and webinars and can work with you directly to customize a program to meet the needs of your staff.

For more in-depth training, staff can take the HIT-Pro Exam (Health Information Technology Professional) and the CPHIMS Exam (Certified Professional in Healthcare Information and Management Systems) offered by HIMSS, or the RHIA Exam (Registered Health Information Administrator) offered by AHIMA. Consider giving incentives to employees who pass an exam.

How can I find help?
A number of community colleges and universities within the Chicago area turn out individuals who are pursuing careers in health IT. The CHITREC internship program has relationships with institutions and has placed many students in internships at organizations throughout the Chicago area. If you are interested in hosting an intern or finding a volunteer, contact the institution directly and it will guide you to a career website or to a contact person who may advertise the opportunity to students.

To post a volunteer opportunity on the CHITREC website, call 312-503-2986 or email info@chitrec.org for details. To view CHITREC’s educational offerings, visit chitrec.org/events.

“Help is available in many different ways depending on the size of your practice and the level of comfort you and your staff have with health IT.”

Rochelle Tapping is the internship program manager for the Chicago Health IT Regional Extension Center. Dr. Kho is the co-executive director of CHITREC.
The Curious Case of Unwanted Email

Keep health care marketing in the safe zone

By Lonnie Hirsch and Stewart Gandolf, MBA

YOU MAY be surprised to learn that “spam” has a curious and slightly amusing history. It was first created as a tool for marketing a professional practice. But to everyone’s great relief, it was not the invention of physicians or health care marketing professionals. The dubious recognition for inventing spam goes to two lawyers.

In 1994, these enterprising chaps decided to promote their services by posting an advertisement to hundreds of USENET message boards. (Back then, bulletin boards were the online common-interest communities.) Understandably, this first-of-its-kind mass posting of legal advertising ignited a firestorm. We suspect that—then as now—it was a negative PR backlash. According to popular legend, the “online communities coined the term ‘spam’ in reference to the Monty Python skit where spam is mentioned 130 times.”

About a decade later, Congress enacted the CAN-SPAM Act of 2003, which established the first nationwide standards for sending commercial e-mail and required the FTC to enforce its provisions. We’re not offering legal advice here, but the cumbersome text boils down to honesty and common sense. Anti-spam regulations take aim at fraudulent, misleading, illegal and inappropriate uses of email, and we’ve never known a health care marketing client to have a problem with compliance. In fact, it’s relatively easy for health care marketers to know and observe the rules.

If you haven’t looked at anti-spam regulations recently, the Federal Trade Commission Bureau of Consumer Protection, provides an easy-to-read compliance guide for businesses. The CAN-SPAM Act rules cover all commercial messages, which the law defines as “any electronic mail message the primary purpose of which is the commercial advertisement or promotion of a commercial product or service,” including email that promotes content on commercial websites. Fortunately, you can stay safe by following the seven fundamentals below:

1. Don’t use false or misleading header information. Your “From,” “To,” “Reply-To,” and routing information—including the original domain name and email address—must be accurate and identify the person or business who sent it.

2. Don’t use deceptive subject lines. The subject line must accurately reflect the content of the message.

3. If it’s advertising, identify the message as an ad. The law gives you a lot of leeway in how to do this, but you must disclose clearly and conspicuously that your message is an advertisement.

4. Tell recipients where you’re located. Your message must include your valid physical postal address. This can be your current street address, a U.S. post office box, or an authorized commercial mail-receiving agency.

5. Tell recipients how to opt-out of receiving future email from you. Your message must include a clear and conspicuous explanation. Craft the notice in such a way that it’s easy for an ordinary person to recognize, read, and understand. Give a return email address to allow people to communicate their choice to you.

6. Honor opt-out requests promptly. Any opt-out mechanism you use must be able to process opt-out requests for at least 30 days from the time the message was sent. So if a message is sent on January 1, the recipient must have until January 30 to effectively opt-out. You must honor a recipient’s opt-out request within 10 business days.

7. Monitor what others are doing on your behalf. Even if you hire another company to handle your email marketing, you can’t contract away your legal responsibility to comply with the law. Both you and the company that actually sends the message may be held legally responsible.

Here are three additional notes:

1. A reputable “white list” email service provider will gladly help. Companies that help facilitate email mailings—via software or broadcast services—want their customers to stay safe. Many of the better known companies, such as Constant Contact, iContact and MailChimp, provide online compliance tips.

2. The Federal Communications Commission (FCC) also has regulations. The FCC has a ban on sending unwanted commercial email messages to wireless devices. The FCC also publishes an online reference guide.

3. Review with an attorney. Although CAN-SPAM regulations are fairly straightforward, an experienced lawyer can be a comforting safety net.

Lonnie Hirsch and Stewart Gandolf, MBA, are the founders of Healthcare Success Strategies (www.healthcaresuccess.com), a full-service health care marketing company. Reprinted with permission. All rights reserved.
# Opportunity Creators

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A lawyer CANNOT buy the distinction of being a Leading Lawyer. This distinction was earned by being among those lawyers who were most often recommended by their peers in statewide surveys. Respondents COULD NOT recommend themselves or lawyers at their law firm. For a complete list of all Leading Lawyers and to view profiles of the lawyers listed on this page, go to www.LeadinLawyers.com.
Physicians who are sued for malpractice are often heard to say, “I knew the person was bad news. I kept thinking he/she would just go away, or that I could change things. I didn’t terminate the relationship because I just didn’t want to be mean.”

In my risk management seminars, I advise physicians to document evidence of patient dissatisfaction. This evidence might include an angry note scrawled on your invoice for services, a pattern of failure to follow through with agreed-upon treatment recommendations, or chronic failure to pay for services provided. (Referring a patient to a collection agency does not constitute termination of the relationship, though many physicians are convinced that it does!) Observing a pattern of dissatisfaction over time may alert you that the patient might do better in the care of another physician. If you decide to terminate your relationship with a patient, check with your liability carrier to see if they have a protocol to be followed and a letter to be sent.

A commonly found protocol for terminating a patient relationship is as follows:

1. Send a certified letter, with a return receipt requested. Some attorneys suggest also using restricted delivery, meaning that the letter is signed for by the addressee only.

2. Keep a copy of the letter and attach it to the patient’s medical record.

3. Give no reason or a general reason for the termination.

4. Offer routine medical care for the first 15 days from the date of the letter.

5. Offer emergency care for the second 15 days from the date of the letter.

6. Offer to send copies of the patient’s medical records to a new physician, even if the patient owes you a balance. Don't specifically name other physicians for the patient to consider. Instead, provide the contact information for the medical society physician referral program.

7. State that the relationship will be terminated 30 days from the date of the letter.

8. Note any subsequent communication you have with the patient.

As in other relationships, the dumped party may be reluctant to let go. Be sure that your practice partners and support staff are all aware that the relationship has been terminated, so that the patient doesn’t re-establish the relationship by obtaining a prescription refill from someone on call. Physicians who have terminated relationships with patients report that some patients will ask for another chance.

What should you do when you’ve finally taken the difficult step of terminating the relationship and your patient contacts you, begging to return? “I’ve changed, I’ve changed,” the patient pleads. You give in, and guess what? The patient has changed…and gotten more annoying. If you are going to go to the trouble of terminating the relationship, don’t reinstate the patient if you have even the slightest reservation about doing so.


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Make Haste Slowly

Have a plan! By Judy Capko

DO YOU FIND yourself and your medical practice in a state of emergency when changes in the market arise? Do you have long-term personal, professional or financial goals that are in your head, but no plan to make them real? Are you relying on gut instincts—rather than metrics—to know if your practice is on track or in a state of decline?

Too many private practices are winging it—leading to bad decision-making and unnecessary panic in response to market events, and under-performance and delayed goals because there was no road map to achieving them. Don’t let this be your practice. Make 2013 the year you take control of your practice by developing a strategic plan. It’s easier than you think, and clear planning will not only help your practice become more stable and more profitable, it will also improve the morale of everyone on your team.

Get started with an honest, data-driven assessment of your practice. Tools and activities that can help:

- SWOT (strengths, weaknesses, opportunities, threats) analysis
- Benchmarking
- Modeling (e.g., scenario testing)
- Mission and goal-setting—for one year, five years, ten years

If you’ve got team members who are experienced and currently underutilized, these activities can be a great way for them to shine as well as help improve your practice.

Judy Capko is the founder of Capko and Company, a medical practice management consulting and market research company serving physicians and health care companies throughout the United States. You can reach her at www.capko.com.
7 Tips for Requesting Privileges

Hints for avoiding pitfalls By Philip Dray, MD, and Charlene Luchsinger, CPMSM, CPCS

Nearly all physicians request “privileges” that are connected to a medical staff appointment. Privileges are the professional actions a physician is permitted to undertake when interacting with patients within the hospital or hospital-owned satellite facility. Privileges are typically requested by the applicant and endorsed by the department chairperson, the credentials committee, and the executive medical staff committee. Physicians should note that only the hospital board can actually grant privileges. According to the Medical Practice Act, the state license grants physicians the right to “practice medicine in all its branches,” but in reality, individual physicians are constrained by training, current clinical competence, and hospital policies. The following tips will help you avoid pitfalls when filling out privilege request forms. When in doubt, ask your department chairperson or credentialing director for guidance.

1 Privileges can only be requested for skills that the physician has the credentials—documented training and experience—to perform. Privileges are the collection of professional actions merited by the credentials. Performance and quality data can and will be used to support the request. Privileges cannot be requested for procedures the hospital cannot perform (for example, robotic surgery in a hospital that has no robot).

2 Residents in training may either have a temporary or permanent state license but they are not on the medical staff and cannot request privileges. Fellows cannot ask for privileges in the subspecialty area for which they are currently receiving training. However, they may ask for any privileges that would typically be covered by previously completed residency training.

3 Physicians should not ask for “everything” because they think they should have it “just in case.” You will be asked to support your privilege request. The supporting documents can come from several sources—residency or fellowship procedure logs, practice logs, OR logs, or attestation from a former program director or mentor. In general, privileges are granted for the skills that would be considered part of a typical residency training program. All specialties have carved out privileges that require special training and experience. If you do not have the credentials, do not ask for the privilege.

4 Privilege request forms take different appearances. The “laundry list” style still exists and individual procedures are requested line by line. Some forms contain skill-sets assembled under one heading called “core privileges,” which are basic to the specialty practice and should be maintained by an active clinician. Be sure to comply with eligibility criteria for any privilege request. Remove any privileges that are inappropriate for your practice. A report to the National Practitioner Data Bank is not made for voluntary elimination of selected new privileges or voluntary relinquishment of a previously held privilege due to changing practice patterns.

5 Subspecialty privileges not covered by a residency or fellowship will require some type of evidence of current clinical competency. Documented past experience, hands-on training, recommendations by colleagues with direct knowledge of your skills, and even data logs from another hospital can be used. Again, make sure the request satisfies the organization’s eligibility criteria.

6 If a privilege is requested that cannot be supported by documented current clinical competence, then the hospital may either deny it or may require some form of intensive supervision, which is called proctoring. Denial of a new privilege may or may not be cause for a Data Bank report. For instance, if you are ineligible to request the privilege in the first place, then the request is voided and not reportable. But denial of an eligible privilege or involuntary removal of a previously held privilege will be cause for a Data Bank report. Proctoring, if required by the medical organization, is not reported to the Data Bank but will require the physician to disclose the activity on all applications to any medical staff. This is actually positive—assuming the proctoring went well, because you will have clear documentation of your clinical competence in that specific skill.

7 All initial applicants to a hospital medical staff, and all new privilege requests by a current member of a medical staff, are required to have a Focused Professional Practice Evaluation. This quality assessment measure is defined and conducted by the department to establish that your clinical activity meets department quality standards. Selecting the correct set of privileges can be confusing to a new physician. Using the guidelines and asking for help from your organization will avoid potential delays in processing your application.

“Physicians should note that only the hospital board can actually grant privileges.”
Reappointment Time

10 rules to obey By Philip Dray, MD, and Charlene Luchsinger, CPMSM, CPCS

1. T’S THAT time again. You must reapply for medical staff privileges every two years regardless of tenure or how priceless you are to your hospital—it’s the law. To reapply, you must use the state’s Health Care Professionals Recredentialing and Business Data Gathering Form, which includes updates that have occurred in the last four years. The form is divided into two chapters: Chapter A contains practice and professional information; Chapter B has business information. To avoid getting tangled in an administrative quagmire, you must follow the rules listed here.

2. Do not misrepresent yourself in any fashion. If you are board-certified, that’s great. If you have lost your certification or never had it, state the facts.

3. Include all your hospital appointments and professional work history. Each one will be verified by the Medical Staff Office (MSO) or a Credentials Verification Office (CVO). The MSO/CVO will query each employer to confirm your good standing. Omission of an organization is a red flag.

4. The Adverse and Other Actions section generally causes the most consternation for applicants. These questions are worded awkwardly and generally place applicants on the defensive. A common mistake is to answer “no” to a question that technically requires a “yes” such as voluntary medical staff resignation. Concealing any information in this category raises a professionalism red flag.

5. The question about Professional Liability Action is confusing. Reveal everything that ever happened to you, even if it means telling a story that is 25 years old—again. Omitting old historic information may not be an issue, however. To clarify, you may call the MSO/CVO and ask if they wish to have only updates or the entire history.

6. The MSO/CVO may consider new events (in the last four years) relevant if they fall under the sections on Liability Insurance, Criminal Actions, Medical Conditions, Chemical Substances or Alcohol Abuse, and Investments. Some organizations only want information since your last reappointment. A “yes” answer is not a death sentence but omitting a “yes” will indict your credibility and professionalism. Concealing information in these categories will make you subject to immediate summary suspension and dismissal.

7. When you fill out one of the explanation forms (Forms A through E), complete it so the reader will gain additional information and a clear understanding of the event or circumstance. You are writing it, so explain it the way you want it to be viewed using the facts and truth. Full disclosure is a positive and proactive approach.

8. Remember that the MSO/CVO will verify your information with the source and the AMA for the following: all past and current state licenses, DEA controlled substance license, hospital appointments, work history, alleged malpractice history, insurance, medical school and residency training programs—completed or not, fellowship, specialty boards, National Practitioner Data Bank, state licensing boards, and state Office of the Inspector General (Criminal Actions).

9. Ask for privileges that you actually have the credentials to perform and have met the criteria to perform. Performance and quality data can and will be used to support your request. Denial of privileges or restrictions placed upon a privilege can be a reason for a Data Bank report. Relinquishing a privilege due to changing practice patterns unrelated to disciplinary action is a common benign event and not reported to the Data Bank.

10. The risk of a failed reappointment due to an honest error is tiny. But concealing significant information will be unfavorably looked upon and cause either a delay or rejection of your appointment. A Data Bank report may be filed with a failed appointment and at a minimum will need to be revealed and explained on all future applications.

A supplementary hospital application, updated CV, as well as satisfactory CME are often required. Some applications are created online but they contain essentially the same information as the state form. You must take this task as seriously as any medical procedure on a patient. Welcome back aboard.

Philip Dray, MD, is the past chairman of the Credentials Committee at Stroger Hospital. Charlene Luchsinger is the system director of credentialing at Cook County Health and Hospitals System.
“As physicians, we have so many unknowns coming our way…

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

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

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

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

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

Latest studies reveal a higher incidence among those born in the U.S.

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

“The Latino population is the largest minority population in the U.S. and among adults age 65 and over, Latinos will make up 25% of this population by 2050.”

**The Latest** statistics from the American Heart Association on stroke in the Hispanic/Latino community reported that Mexican-Americans as a group may have a higher rate of stroke, TIA, intra-cerebral hemorrhage and subarachnoid hemorrhage than non-Hispanic whites do. The significance of these statistics cannot be overstated. The Latino population is the largest minority population in the U.S. and among the age demographic of 65 and over, Latinos will make up 25% of all older adults in the U.S. by 2050. In Chicago, Latinos constitute one-third of the total population, with Mexican-Americans and Puerto Ricans accounting for 80%.

To learn more about health outcomes specific to the Hispanic/Latino community, an increasing number of studies based in the U.S. have been initiated to examine medical and psychosocial risk factors for developing common diseases, and outcomes such as stroke. One investigation, the Health Retirement Study, designed to follow stroke-free individuals age 50+ from 1998-2008 (n > 15,000, 1,388 stroke events) examined stroke incidence. The investigation compared socioeconomic predictors for stroke and stroke incidence in Hispanics born inside and outside the U.S. to patterns in non-Hispanic whites in the U.S. Foreign-born Hispanics had a lower incidence of stroke than non-Hispanic whites and Hispanics born in the U.S., suggesting that foreign-born Hispanics may have a risk factor profile that protects them from stroke.

Another study, the Northern Manhattan Study (NOMAS), began as a prospective investigation of stroke-free individuals age ≥40 years (n = 3,000 participants) and accumulated data from more than 11 years of follow up. Some results of this study suggest that hypertension is a greater risk factor for stroke in Caribbean Hispanics than in non-Hispanic whites. Other findings suggest that Caribbean Hispanics have a higher incidence of intra-cerebral hemorrhage (ICH) than non-Hispanic whites, with most of the excess risk due to hemorrhage in deep structures of the brain.

Data from the Brain Attack Surveillance project in Corpus Christi (BASIC), confirmed the findings from NOMAS in regard to intra-cerebral hemorrhage, and also demonstrated that Mexican-Americans have twice the odds for small non-lobar hemorrhage than did non-Hispanic whites. It is not clear why Hispanics/Latinos appear at increased risk for hemorrhage; more studies are now examining health disparities in stroke type as well as vascular risk factors. One such investigation involving two hospital-based Hispanic populations, one in Miami and the other in Mexico City, (n = 928 patients, 520 Mexicans and 408 Miami Hispanics) reported an increased number of patients with cerebral venous thromboses (CVTs) and cryptogenic strokes were admitted in Mexico, while patients with TIs and cardio-embolic strokes were more frequently admitted in Miami. In addition, hypertension, dyslipidemia, and atrial fibrillation were more frequent, and diabetes mellitus was less frequent among Miami Hispanics than in Mexicans, highlighting the heterogeneity of this ethnic group and common stroke risk factors.

Population distribution estimates from the U.S. Census Bureau suggest that over the next 40 years the number of incident strokes will more than double, mostly among the elderly (age 75+) and in minority groups (particularly Hispanics). These increases are more than likely to present major logistical, ethical and scientific challenges in the future. In light of such projections, now is the time for us to begin expanding our knowledge and understanding of possible stroke risk factors in this heterogeneous minority group.

Dr. Neelum Aggarwal specializes in research related to strokes. Dr. Aggarwal is a cognitive neurologist at Rush University Medical Center, and the clinical core co-leader of the NIA-funded Rush Alzheimer’s Disease Research Center. Dr. Prabhakaran is an associate professor at Northwestern University, Feinberg School of Medicine. His research focuses on acute ischemic stroke, transient ischemic attack, and intracranial stenosis.
Healthy Mothers and Babies

Comprehensive health data in Chicago By Bechara Choucair, MD

One of the most important predictors for a healthy newborn is the health of the mother. Normal pre-pregnancy weight, adequate weight gain during pregnancy, multivitamin intake, including folic acid, and breastfeeding all have a long-term, positive influence on maternal and infant health. Improving the health and well-being of mothers and infants, one of the strategic priorities set forth in Healthy Chicago, is essential to becoming the nation’s healthiest city. And Chicago’s efforts are beginning to pay off.

The Chicago Department of Public Health report, “Births in Chicago 1999-2009,” provides comprehensive birth data by age, race-ethnicity, and geographic area. The report also shows the relationship between these statistics and maternal demographic characteristics, maternal health and health care service utilization, and infant health characteristics in Chicago over an 11-year period. The information assists CDPH in developing targeted programs to reach the goals set forth in Healthy Chicago. Among the findings:

- Chicago’s teen birth rate decreased 33% during the 11-year period. Though rates remain higher than the national average, Chicago’s decrease is outpacing the 21% nationwide decrease.
- The number of women initiating prenatal care during their first trimester increased by more than 10% between 1999-2009, to 84.3%.
- The percentage of babies delivered at low-birth weight decreased to 9.7% by 2009.
- The number of births to Chicago women who reported smoking while pregnant was cut by more than half to 3.8% by 2009.
- Birth rates for women ages 35-44 increased 40% during the 11-year period, increasing the most among non-Hispanic Asians and non-Hispanic white women.

Also of note, the percentage of women in Chicago initiating prenatal care increased the most among Hispanic women, at 19%, showing that 86.1% initiated prenatal care during their first trimester in 2009. And while the smallest increase was among non-Hispanic white women, at 8%, the 92.6% receiving early care was 23% higher than in non-Hispanic black women at 75.6% in 2009.

Despite a decline in teen birth rates, Chicago’s rate remains one-and-one half times the national rate. Additionally, teen birth rates for Hispanics and non-Hispanic blacks continue to be significantly higher than those of non-Hispanic Asians and non-Hispanic whites.

In addition, preterm births declined overall by 4% between 1999-2009, to 10.8%. However, this trend was not seen in all racial-ethnic groups. Among Hispanics, non-Hispanic Asians and non-Hispanic whites, rates of preterm birth remained the same or rose slightly. Rates decreased by 7% for non-Hispanic blacks to 14.7% in 2009. However, this rate was higher than for all other racial-ethnic groups by five to six percentage points.

The low-birth weight birth rate of 9.7% in 2009 represents a 4% reduction from the 10.1% reported in 1999. Despite this decline, the 2009 rate for non-Hispanic blacks at 14.7% is still more than twice the rate that same year for Hispanics at 7.1% and non-Hispanic whites at 7.0%.

The results indicate that although we have made progress, disparities persist and work is still needed to further decrease teen birth rates, infant mortality, preterm births, and low-weight births through inter-conceptional and prenatal care and better education.

To that end, CDPH has outlined policies, programs, educational and public awareness strategies in Healthy Chicago to accomplish these goals. For instance, in 2011, CDPH established the Teen Pregnancy Prevention Initiative in collaboration with the Chicago Public Schools (CPS) to teach adolescents how to use medically accurate information, find youth-friendly health care providers, and make safe, healthy and responsible choices. CDPH is also working with CPS to pilot a new condom availability program, implement comprehensive sex education at all grade levels, establish a data repository to track adolescent health, and launch a city-wide public awareness campaign. This initiative and others will help to significantly reduce the birth rate among Chicago teens by 2020.

Since 1993, CDPH has reduced infant mortality in Chicago through a program that ensures pregnant women have access to prenatal care throughout their pregnancy and that children receive child care and early and periodic screening, as well as diagnosis and treatment services. In addition to identifying and resolving service barriers and coordinating care, the program arranges for public health nurses to make almost 15,000 home visits annually to pregnant women and new mothers, to discuss family planning and inter-conceptional care.

CDPH’s collaboration with community partners will play a critical role in helping reach Healthy Chicago goals. To learn more, please visit the CDPH website at www.CityOfChicago.org/Health or follow us on Twitter @ChiPublicHealth and www.facebook.com/ChicagoPublicHealth.

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

“CDPH has outlined policies, programs, educational and public awareness strategies in Healthy Chicago to accomplish these goals.”
The Hospital Value-Based Purchasing Program

The Affordable Care Act initiates a pay-for-performance model **By Steven W. Postal, JD**

**“Of the hospitals located in Chicago, 11 will see payment increases, 14 will see penalties, and one will break even.”**

**LAST DEC. 20,** the Centers for Medicare and Medicaid Services (CMS) disclosed pending payment bonuses and penalties for approximately 3,000 hospitals, with 1,557 hospitals earning bonuses, and 1,427 hospitals receiving penalties. This is part of a pay-for-performance initiative for inpatient acute care services called the Hospital Value-Based Purchasing Program, established under the Affordable Care Act.

Of the hospitals located in Chicago, 11 will see payment increases, 14 will see penalties, and one will break even. Nationally, many regional and community hospitals fared better than their neighboring, more prestigious counterparts. Kansas, Utah, Idaho and Maine did the best, with at least 74% of their hospitals earning a bonus, while New Mexico, New York, Connecticut, and the District of Columbia did the worst, with at least 70% of their hospitals receiving a penalty.

Michael Rock, MD, of the Mayo Clinic, believes the program favors hospitals that perform more elective surgeries over those with more emergency cases. Hospitals with poorer patients, teaching hospitals, and larger hospitals performed the worst, while hospitals with wealthier patients, hospitals that do not train residents, and smaller hospitals did the best, according to Dr. Ashish Jha at the Harvard School of Public Health. While only 21% of government-owned hospitals can expect bonuses, and 57% of for-profit hospitals will receive them.

**Program Structure**

Under the Value-Based Purchasing Program, hospitals are given incentive payments and penalties based on certain performance standards. For FY 2013, there are 12 of these performance standards for “clinical process of care measures,” and eight for “patient experience of care measures” as compiled from patient surveys. Payment adjustments were based on a performance period of July 1, 2011, to March 31, 2012, and a baseline period of July 1, 2009, through March 31, 2010. The scoring system compares an individual hospital’s results from the performance period against its own baseline period as well as the baseline period of all hospitals.

CMS will withhold 1% of the base operating diagnosis-related group (DRG) payments from participating hospitals in FY 2013, totaling an estimated $964 million. Hospitals can re-coup up to the full 1% by meeting the performance standards. Clinical measures account for 70% of the score while 30% is based on patient experience measures. The ceiling for the withhold will increase by 0.25% each fiscal year until it reaches 2% for FY 2017 and later.

What impact could the reduction have on hospitals? Several groups argue the 2% withholding would be significant. Healthcare Financial Management Association (HFMA) has stated that 2% amounts to about 0.4% of a typical hospital’s profit margins. This doesn’t sound like a lot but considering the average hospital’s margin is somewhere around 3%, suddenly reducing the margin to 2.5% could have a real impact. The American Hospital Association agrees the program will cut into profit margins, and is one of four factors that will put roughly 10% of Medicare revenue at risk in 2017. With such a decrease in Medicare revenue, hospitals will likely face budget cuts, and turn to more efficiency-promoting programs.

Hospitals that are excluded from the program include: 1) those that do not participate in the Inpatient Prospective Payment System (IPPS), such as cancer and psychiatric hospitals; 2) those that do not participate in Hospital Inpatient Quality Reporting (IQR) during the performance period; 3) hospitals facing deficiencies that pose an immediate threat to patients; and 4) hospitals that lack the minimum number of surveys, measures, or cases. Hospitals in Maryland are excluded because of the state’s “unique reimbursement arrangement with Medicare.”

**Future of the Program**

On Aug. 31, 2012, CMS released a final rule giving details of the program for FY 2014 and FY 2015. In FY 2014, hospitals will be scored on 13 clinical measures, the same eight patient experience measures as in FY 2012, and three new “outcome measures.” The final weights given to the FY 2014 scores will be: 45% clinical process of care; 30% patient experience of care; and 25% outcome measures. CMS also included a proposed appeals process for hospitals to dispute their scores.

For FY 2015, the final rule proposes scoring hospitals on 13 clinical measures, with one added and one subtracted from FY 2014. CMS plans to periodically add measures that increase quality of care and prevent hospital-acquired conditions, and replace measures that achieve high compliance scores. The final rule also proposes the same eight patient experience of care measures and adds two outcome measures, and one efficiency measure.

Steven W. Postal, JD, is a legislative analyst at Strategic Health Care in Washington, DC.
**Medicaid Expansion: Go or No Go**

States must decide if they will expand their Medicaid programs

By Steven W. Postal, JD

**IN A MEMO** last Dec. 10 from the Centers for Medicare and Medicaid Services (CMS), the Obama Administration announced that states must expand their Medicaid programs under the Affordable Care Act (ACA) to cover people earning up to 133% of the federal poverty level (FPL), or forgo expansion entirely. The federal government will cover 100% of the cost for new Medicaid enrollees in 2014, 2015, and 2016, incrementally paying less until 2020, when it will cover 90% from then on. Although dropping to 90% is a decrease, it is still a higher federal match rate than in the existing program, which varies from 50% to 78%, depending on the state.

Under the American Recovery and Reinvestment Act (ARRA), states could receive increased matching funds only if they did not have “Medicaid eligibility standards, methodologies, and procedures” that were more restrictive than those in place in July 2008. This principle of providing federal matching funds to states only on the condition that states do not restrict eligibility was later codified in the ACA. Under the law, states can only receive federal matching funds if they do not make their Medicaid eligibility requirements more restrictive from the time of the ACA’s passage until the time the Secretary of Health and Human Services determines the health insurance exchange is “fully operational” in that state. Thus, the federal government was able to maintain leverage over the states in Medicaid reform.

**The Reactions**

Both hospitals and the government strongly support full Medicaid expansion. Dr. Bruce Siegel, president and CEO of the National Association of Public Hospitals and Health Systems, applauded CMS’ decision, stating that “[t]he agency’s guidance follows the letter and spirit of the law and takes an important step toward significantly reducing the ranks of the uninsured.” Molly Collins Offner, the American Hospital Association’s director for policy, said the group “would encourage states to continue going down this path.” According to a recent study by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, hospitals would capture more than $300 billion in revenues for 10 years beginning in 2014 under full Medicaid expansion due to a corresponding decrease in uncompensated care costs. Cindy Mann, of the CMS, lauded the “very significant federal support... [which is] unlike any other federal support that’s been provided to any other coverage initiative.” Stan Dorn of the Urban Institute stated that full Medicaid expansion is “a complete no-brainer,” which “has not hurt the states financially, [but] has helped the federal budget and helped improve access to care for poor people.” Dorn also explained that putting all new enrollees on Medicaid rather than health insurance exchanges is more economical for states.

But others expressed skepticism. Drew Gonshorowski, a policy analyst at the Heritage Foundation, noted that while states would benefit from the federal government paying 100% of the expansion in the first three years, states may have to use funding earmarked for other programs or increase taxes to pay their share. Some believe that 90% payment from the federal government is doubtful. Douglas J. Holtz-Eakin, former director of the Congressional Budget Office, questioned the ability of states to continue receiving 90% of the cost of the expansion forever, given that the federal government has no money. Gov. Bobby Jindal (R-LA) found the removal of the idea of partial expansion “as disheartening as it is shortsighted.”

**The Current Situation**

The reduction of Medicaid disproportionate share hospital (DSH) payments, which were originally given to states to defray costs of providing uncompensated care, may serve as a strong incentive for states to proceed with Medicaid expansion. Under the ACA the federal government will provide $17.1 billion less in Medicaid DSH payments from FY 2014 through FY 2020, using the circular logic that fewer people will be uninsured thanks to Medicaid expansion and health insurance exchanges. Therefore, a state that does not undergo Medicaid expansion would face continued uncompensated care costs without federal ameliorative assistance. An October 2012 report by the National Association of Public Hospitals and Health Systems projected that with decreased Medicaid DSH payments, as well as states rejecting Medicaid expansion, uncompensated care costs will be $53.3 billion greater by 2019 than originally predicted when Congress passed the ACA.

Since Medicaid expansion is optional, states have been deciding whether they want to undergo expansion. As of February 2013, a total of 17 states had declared their intention to establish a state-based exchange, while an additional seven states, including Illinois, had announced their intention to pursue a state-partnership exchange; and 26 states chose not to operate a state-based or state-partnership, thus defaulting to the federally facilitated exchange. Given the fact that the ACA was constructed on the assumption that states will run their own exchanges, the rollout of federal exchanges will likely raise new challenges.

Steven W. Postal, JD, is a legislative analyst at Strategic Health Care in Washington, DC.

“The federal government will cover 100% of the cost for new Medicaid enrollees in 2014, 2015, and 2016, incrementally paying less until 2020 when it will cover 90% from then on.”
De-identifying Protected Health Data

You can use HIPAA-covered information in some instances

By Jacqueline Klosek, JD, and Anna Hsia, JD

HIPAA’S PRIVACY rule generally prohibits disclosure of protected health data. But because some health information is valuable for purposes unrelated to patient care, the rule tries to balance those benefits against the need for privacy. Therefore, HIPAA-covered entities may use some data provided they effectively de-identify the information.

The Office for Civil Rights (OCR), a division of the U.S. Department of Health and Human Services, recently issued a report outlining the steps practices must take to de-identify data and still be in compliance. The report, “Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule,” explains how the OCR would enforce statutes related to HIPAA. The two ways medical practices can de-identify information are discussed below.

Expert Determination

Under this option, an “expert” determines whether the risk of identification by an anticipated recipient is “very small.” Experts must document the methods and results of their analyses. An individual does not need a specific academic background or experience to qualify as an expert. However, if the OCR starts enforcement proceedings, it will review the expert’s education and experience in de-identification.

- Properly de-identified information carries only a very small risk of identification by an anticipated recipient. While the OCR does not numerically define a small risk, the degree of risk depends on the identity of those persons. The OCR cautions practices to use experts who can adequately identify recipients in order to properly assess the risk.
- While attaching expiration dates to de-identified information is not required, practices should monitor previously de-identified data in light of changes in technology and information availability. Retaining thorough records of these periodic reviews is advised.

- The OCR requires experts to apply “generally accepted statistical and scientific principles,” but not a specific method. Experts should: (1) evaluate the extent to which health information can be identified by anticipated recipients; (2) suggest risk mitigation methods; (3) apply mitigation techniques on the data set; and (4) evaluate the new data set to confirm that the risk is “very small.”
- As part of the risk evaluation, experts should consider: (1) the degree to which health information remains consistently the same in an individual; (2) the extent to which data can be found in external data sources; and (3) the extent to which data can be distinguished in the health information.
- The OCR suggests the risk mitigation strategy: (1) suppress certain features of the data; (2) generalize specific data into more abstract data; and (3) replace specific values with equally specific, but different values.
- Experts may recommend data use agreements that restrict use of the data by the recipient.
- Practices may assign codes to de-identified records to enable re-identification by authorized persons. These codes may be disclosed if an expert determines the codes meet the de-identification requirements.

Safe Harbor Method

Practices may comply with the privacy rule by: (1) removing enumerated “identifiers of the individual or of relatives, employers, or household members”; and (2) not having “actual knowledge” the information could be used alone or in combination with other data to identify an individual. Note the following clarifications set forth in the Guide:

- The first three digits of a zip code may be included only if current Census Bureau data shows that: (1) the geographic unit formed by combining all zip codes with the same three initial digits includes more than 20,000 individuals; or (2) the initial three digits of a zip code for all geographic units including 20,000 or fewer individuals is changed to 000. Be sure to use the most current Census data as use of outdated data may launch an investigation.
- Parts or derivatives of any enumerated identifiers may not be disclosed. Since patient names must be withheld, patient initials must also be withheld.
- Practices may not disclose the day, month or other data more specific than the year of an event. Specific dates cannot be extrapolated by combining information in a data set. The disclosure of unique features that are not explicitly enumerated in the Safe Harbor list but could be used to identify a particular individual is not permitted (e.g., clinical trial record numbers, barcodes, and unique occupations).
- Actual knowledge means clear and direct knowledge that the remaining information could be used, either alone or in combination with other data, to identify a person (e.g., disclosing an individual’s unique occupation, or a publicized clinical event).
- Only the names of individuals associated with the corresponding health information, and of their relatives, employers, or household members, must be suppressed to comply with the Safe Harbor Method. While health care personnel may be identified, doing so should not give rise to a violation under the “actual knowledge” standard.
- Health data often includes free text fields where personnel may insert protected information about a particular individual. This data must be removed if the practice has “actual knowledge” it could be used for identification purposes.

Implications

As the health care industry continues to find new ways to leverage information, the De-identification Guide will help practices make use of health-related data without running afoul of HIPAA’s privacy rule. Practices have two clear options for ensuring that PHI is effectively de-identified. No matter which method is used, practices should maintain copious records of the de-identification process.

Jacqueline Klosek is senior counsel with Goodwin Procter LLP. Anna Hsia is an associate with Goodwin Procter LLP.
Communication saves lives.
Just ask Dr. Singh.

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

DocbookMD is a free benefit of your CMS membership.
Learn more about the app at docbookmd.com.
Physician Profiling:
A Win or Lose Proposition?

Physician reimbursement is at stake as profiling gains momentum  By Bruce Japsen

As health insurance companies and employers increasingly base their payment on quality and outcomes, shifting away from traditional fee-for-service, insurers are also escalating their use of physician profiles. In Chicago, the major plans such as Blue Cross and Blue Shield of Illinois and UnitedHealth Group’s United Healthcare of Illinois see the shift as a way to increase transparency and to better engage patients and consumers with their medical care treatment.

The physician profile strategy is also a way for health plans, employers, and governmental payers to reduce costs. Profiles generally work by placing a star or other mark next to a doctor’s name on the health insurer’s website if the physician meets certain quality benchmarks. Additional stars might be given for achieving other measures.

Though controversial with many physicians and medical societies, profiles are gaining momentum. They are another thing physicians need to closely monitor in both the private health insurance market as well as in Medicare, which is facing potentially dramatic cuts as Congress and the White House look to reduce the deficit and rein in federal spending. Nationally, some estimates predict the more than $2.8 trillion spent on health care today will mushroom to nearly $5 trillion by the end of this decade if cost-containment measures are not taken. With politicians in Washington and state capitols leery of spending, health policy observers expect profiling to only expand as lawmakers attempt to reduce the costs of government health programs while employers and private insurance companies try to do the same. Already, the Medicare program rewards hospitals that achieve certain quality standards.

The Popularity of Profiles With Consumers

“National consensus has already developed saying it’s time to move away from paying for the components of care and instead be paying for quality and outcomes of care,” Simon Stevens, president of global health for UnitedHealth Group, parent of United Healthcare of Illinois, said in an interview. “We need to have more transparency. Everybody knows there is variation in the quality of care but patients don’t have the tools to make smart choices.”

In United’s case, the insurer’s “premium designation” program has grown to include 254,000 physicians today in 41 states from 48,000 profiles of doctors in 2005. Nearly 20 million subscribers to UnitedHealthcare brand individual and employer health plans can access the data online at the insurer’s web site, www.myuhc.com. “Increasingly, (consumers) want to know how they can make choices that will make a difference in the total cost of care they are on the receiving end of,” Stevens said. “Physicians themselves want to know how they are doing.”

Other health plans, too, are escalating the use of physician profiles. The Blue Cross and Blue Shield Association, which represents 38 Blue Cross and Blue Shield plans that provide health benefits for 100 million people, launched an updated version of its “National Provider Finder” that includes profiles on physicians as well as hospitals. Launched last fall, its capabilities include cost estimates for more than 160 medical treatments. In addition, consumers can write reviews of their physicians.

And profiles are proving very popular with patients as well. From Oct. 1, 2012, to Jan. 31 of this year, the number of “read reviews” for providers on the national physician and hospital finder was more than 350,000. During that same time period, the national provider finder had more than three million visits from consumers, the Blue Cross and Blue Shield Association said. “Blue Cross and Blue Shield companies are putting information in the hands of consumers so they can find health care professionals who fit their personalities and with whom they can build a relationship,” said Scott.
## 2011 Blue Star Medical Group/IPA Report for Cook County

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1) Indicates not enough HMO members responded to the survey to report the results.
Serota, president and CEO of the Blue Cross and Blue Shield Association.

The Plague of Inaccuracies: Inherent Limitations

But the American Medical Association and other physician groups say physicians and their patients should be wary of physician profiling and the data used to create them. In some instances, studies have shown profiles can be inaccurate and may misrepresent physicians to their patients in the insurance company networks. “The accuracy of insurers’ profiles on individual physicians is compromised by the inherent limitations of working with claims data, including the time lag between the delivery of care and the availability of data, difficulties in correctly attributing care, and missing or incomplete information,” said AMA President Dr. Jeremy Lazarus. “While the American Medical Association supports efforts to improve health care quality and efficiency, it cannot support health insurer profiling programs that provide incorrect physician ratings and misleading information to the public.”

Similarly, in a 2010 study by RAND Corp. that was published in The New England Journal of Medicine, researchers found that current methods for “profiling physicians with respect to costs of services may produce misleading results.” The AMA and other physician groups say they are monitoring the use of doctor-profiling and working with the health plans to improve the data as well as its accuracy. “The AMA has sent letters to the nation’s leading health insurers asking them to work with the AMA and state medical associations to re-evaluate the use of any programs that involve profiling physicians based on their alleged cost of care,” Dr. Lazarus said. “The AMA recognizes the importance of providing performance information to physicians so they can verify the accuracy of profiling results. These data reports can serve as a valuable source of information to support physicians in data-driven decision-making. The AMA has also asked payers to make improvements in data reports that would assist physicians in better understanding and using their performance data.”

The profiles could be a win or lose proposition for physicians depending on how they are rated. The danger is that such profiles can be used as a basis for lowering a doctor’s reimbursement by ranking them generally through a star system that could market them more favorably or less so to patients through their employers or insurance companies.

Profiling is Here to Stay, Whether You Like It or Not

But United and other health plans defend their quality rankings, saying they are measured against national benchmarks and evidenced-based guidelines, which are often developed in consultation with specialty medical societies. Such profiles are also here to stay, insurance company executives say.

UnitedHealth’s Stevens said the insurer, like many other health plans, will increasingly pay physicians through bundled payments. Health plans are also negotiating contracts with accountable care organizations (ACOs), a rapidly emerging health care delivery system that rewards physicians and hospitals for working together to improve quality and rein in costs. ACOs began contracting with the Medicare program this spring under an initiative that is part of the Affordable Care Act, and now most private insurers like UnitedHealth, Aetna, Humana and most Blue Cross plans are also linking with ACOs to care for more patients. And measuring doctors is a part of all these efforts.

At Blue Cross and Blue Shield of Illinois, for example, independent practice associations (IPAs) that contract with the plan’s HMO are rated on several measures contained in a “Blue Star Report.” Most IPAs score well with seven medical groups, or 7% of those rated, receiving 10 out of 10 stars while another 33, or 35% of medical groups rated, received either eight or nine of 10 total stars. To see how hospitals and IPAs in Cook County fared, check out the reports on pages 22 and 24.

In the Blue Star report, Illinois Blue Cross said IPAs are rated “using established benchmarks” to measure how well they provide care for common conditions such as asthma and diabetes or how well patients control high blood pressure. “The benefits of these reports are that they’re available to members who can use them to make informed decisions when choosing a provider,” said Dr. Opella Ernest, vice president and chief medical officer at Blue Cross and Blue Shield of Illinois. “We’ve seen that such transparency also serves as a motivator for the groups to improve their own performance.”

The End Game

So what’s a physician to do? For now, physicians, hospitals and groups should monitor the current rating criteria and adhere to them as closely as possible. While doing so does not necessarily make you the best practitioner, it does ensure that you are rated as accurately as possible.

Bruce Japsen is an independent Chicago health care journalist, writer and blogger for Forbes at www.blogs.forbes.com/brucejapsen and contributor to the New York Times. He was health care business reporter at the Chicago Tribune for 13 years and is a regular television analyst for WTTW’s Chicago Tonight and CBS’ WBBM radio 780-AM and 105.9 FM. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com.
## 2012 Blue Star Hospital Report for Cook County

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Number of Blue Stars Earned</th>
<th>Number of Blue Stars Possible</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer Group 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loyola University Medical Center</td>
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<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Northwestern Memorial Hospital</td>
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<td>11</td>
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</tr>
<tr>
<td>Rush University Medical Center</td>
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<td>11</td>
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<tr>
<td>University of Chicago Medicine</td>
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<td><strong>Peer Group 2</strong></td>
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<td>Advocate Lutheran General Hospital</td>
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<td>Advocate Illinois Masonic Medical Center</td>
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<td>Resurrection Medical Center</td>
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<tr>
<td>Northwest Community Hospital</td>
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<td>Saint Joseph Hospital</td>
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<td>Vanguard West Suburban Medical Center</td>
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<td>Mercy Hospital and Medical Center</td>
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<td>Weiss Memorial Hospital</td>
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<td>Palos Community Hospital</td>
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<td>Advocate Trinity Hospital</td>
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<td>Westlake Hospital</td>
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<td>Advocate South Suburban Hospital</td>
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<tr>
<td>Our Lady of the Resurrection Medical Center</td>
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<td>Methodist Hospital of Chicago</td>
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<td>Jackson Park Hospital &amp; Medical Center</td>
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<td>Roseland Community Hospital</td>
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<td>Rush Oak Park Hospital</td>
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</tr>
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<td>Saint Anthony Hospital</td>
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<td>South Shore Hospital</td>
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<td>Holy Cross Hospital</td>
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<tr>
<td>Loretto Hospital</td>
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<tr>
<td>Provident Hospital of Cook County</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Norwegian American Hospital</td>
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<td>11</td>
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</tr>
</tbody>
</table>
The Blue Star Reports

EVEN WONDER HOW your hospital or group looks in the eyes of Blue Cross and Blue Shield of Illinois (BCBSIL)? The company creates annual Blue Star reports for both groups. These profiles are based on a variety of objective criteria the insurer deems important for gauging quality. The summary report tables are easy-to-read much like those in *Consumer Reports*. Here’s how groups in Cook County fared in the last set of reports. Whether your group is helped or hurt by the reports from BCBSIL, they serve as an example of how profiling works and how important it is for physicians to understand—and monitor—the process. To get the full PDF summaries of the reports for all of Illinois visit www.bcbsil.com.

The 2012 Hospital Report

The 2012 Blue Star Hospital Report—based on the 2012 BCBSIL Hospital Profile—summarizes the results of quality and safety performance measures for 111 Illinois hospitals. Hospital profiles are compiled using data collected from multiple sources, including: BCBSIL claims data, information provided by the hospitals, and publicly available information from entities such as the Centers for Medicare and Medicaid Services.

For the Blue Star Hospital Report, each hospital’s performance is reported for indicators in six categories: Structure, Process, Outcome, Patient Experience, Efficiency, and Informed Decision-Making. One blue star can be earned for each indicator, for a maximum of 11 blue stars. Of the 43 hospitals serving Cook County, 58% (25 out of 43) earned six or more stars, while 16% (seven out of 43) earned eight or more stars.

Hospital performance was evaluated for the following six categories and 11 indicators. To help make comparisons more valid, the hospitals in the report are divided into five distinct peer groups. The criteria and results for the hospitals are below.

**STRUCTURE**

- Structural Indicators: Hospital is accredited and has documented that at least 85% of active medical staff members are board-certified.
- Participation in State and National Quality Improvement Initiatives: Hospital submitted documentation that met criteria for participation in multiple state and national programs designed to improve the quality of patient care and/or patient safety.
- Participation in PREP (Preventing Readmissions Through Effective Partnerships): Hospital participated in at least one initiative designed to reduce hospital readmissions through the PREP program, an Illinois Hospital Association and BCBSIL collaborative.

**PROCESS**

- Hospital Quality Alliance (HQA) Indicators: For most process of care measures, the hospital scored at least 98%.

**OUTCOMES**

- Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators: Hospital was in the top 40% of hospitals within its peer group for mortality rates for five specific medical conditions.
- AHRQ Patient Safety Indicators: Hospital complication rates were lower than those at many peer hospitals.
- Central Line Associated Blood Stream Infections (CLABSI): The hospital had at least one ICU with a significantly lower CLABSI rate than expected.

**PATIENT EXPERIENCE**

- Patient Hospital Experience: The hospital’s results were better than the state average for at least five of eight questions about communication, care and service.
- Overall Satisfaction: The hospital’s results were better than the state average for two indicators: rating of hospital and recommendation of the hospital to family and friends.

**EFFICIENCY**

- Utilization Efficiency: The ratio of actual to expected length of stay for the hospital’s own case mix was in the top two (out of five) performance tiers for the peer group.

**INFORMED DECISION-MAKING**

- Hospital-Based Physicians: Hospital-based physicians have contracts with BCBSIL PPOs and with each of the HMO medical groups and IPAs that are affiliated with the hospital.

The 2011 Medical Group/IPA Report

The Blue Star Medical Group/IPA Report recognizes HMO contracting medical groups and Independent Practice Associations (IPAs) that have documented high levels of performance in providing patient care. Each year BCBSIL assesses medical group performance based on national clinical practice and preventive care guidelines.

Groups earn a Blue Star each time they meet or exceed the target care goal in one of the ten reporting categories. Of the 65 groups that serve Cook County, 63% (41 out of 65) received six or more Blue Stars and 43% (28 out of 65) received eight or more stars. Five groups were awarded all 10 stars. In addition, nearly all groups were awarded a Blue Ribbon, signifying that they scored at least 85% on selected questions from the 2010 HMO Member Survey.

Blue Stars were awarded in the following 10 categories based on the criteria listed below:

- Asthma: The percentage of members who received a written action plan and had an assessment for asthma control.
- Diabetes: Meeting at least five of seven care thresholds.
- Breast Cancer Screening: At least 71% of women ages 42-69 had a mammogram between 1/1/2009 and 12/31/2010.
- Childhood Immunization: At least 77% of children who turned two years of age received recommended immunizations by their second birthday.
- Mental Health Follow-Up: At least 68% of members had a follow-up visit with a behavioral health practitioner within seven days of hospital discharge for a mental health diagnosis.
- Influenza Vaccination: At least 50% of high-risk members had a flu shot during the 2009-2010 flu season.
- Controlling High Blood Pressure: At least 75% of members with hypertension had their blood pressure controlled (<140/90 mmHg).
- Colorectal Cancer Screening: At least 55% of members ages 51-75 were current on screening for colorectal cancer in 2009.
- Management of Cardiovascular Conditions: The percentage of members who had cardiovascular risk factors assessed and controlled.
- Cervical Cancer Screening: At least 74% of women ages 24-64 had a Pap test between 1/1/2008 and 12/31/2010.
Docs Strengthen Ties in DC
CMS in nation's capitol to advocate for physicians back home

By Elizabeth Sidney

Dr. Howard Axe, CMS President, greets Senator Richard Durbin. CMS leaders had many productive meetings with legislators on Capitol Hill.

OUR LEADERS at the Chicago Medical Society (CMS) accomplished multiple advocacy goals in their annual visit to Washington, DC, this past February. Meeting personally with key Illinois legislators to represent the needs and interests of physicians back home, CMS strengthened existing relationships and laid the foundation for new ones. In the first of a series of meetings to address the looming shortage of primary care physicians, CMS accepted an invitation to join Senator Richard Durbin's workforce issues panel to identify potential solutions. This productive session followed our participation in the annual National Advocacy Conference of the American Medical Association (AMA).

Led by CMS President Dr. Howard Axe and President-elect Dr. Robert W. Panton, the team included Past President Dr. Steven M. Malkin and longtime active member Dr. Raj B. Lal. The group aimed for meeting with one-third of Illinois' Congressional Delegation.

There is strong support in Congress for fixing the fatally flawed Sustainable Growth Rate (SGR) formula and lawmakers are indeed aware of the looming physician shortage. As Dr. Axe notes, the obstacles to reform are financial—identifying offsets to pay for repealing the SGR and more dollars for medical residency slots. The solution will likely require help from private payers in addition to the federal government.

The sweeping shift in medical practice is another cause for alarm, Dr. Axe told lawmakers. Economic forces—dwindling reimbursement and the high cost of malpractice insurances—are squeezing the profession at both ends. With the added cost of implementing EHR technology, solo and independent physicians are merging to form “super groups,” which in turn contract with hospitals. Other physicians and groups are giving up their practices for hospital employment.

A vivid example from Reno, NV, highlights the economic impact of hospitals buying up independent practices, particularly cardiology groups. After Renown Health, a local hospital system there, acquired a number of cardiology practices, converting them to outpatient hospital-owned facilities, the cost of a heart scan quadrupled. Although practicing in hospital-owned clinics can boost pay to physicians, the “facility fee” is an added burden on patients and drives up overall health care costs. Medicare and insurers pay substantially more for certain services if they are performed at hospital facilities.

The CMS group also sat on a workforce issues panel sponsored by Senator Richard Durbin. Joining them were representatives from the American Medical Association, American Hospital Association, and the Association of American Medical Colleges. Senator Durbin asked the panel for new ideas on how to rapidly train and increase the ranks of primary care physicians. Health reform relies heavily on primary care providers and physician extenders to care for the millions of newly insured. The panel looked at factors that shape a medical student’s choice of specialty. While they may have an interest in primary care, students’ goals change sometime in medical school as they amass debt and look toward an uncertain economy. The Affordable Care Act will expand the primary care workload in an era of changing lifestyle preferences. These two forces will no doubt influence students’ decisions in a major way. The challenge for the health care community is identifying the point at which medical students decide to go into primary care or not and at what point they change their minds. The group discussed studies by the AAMC showing the number of residency slots remains stagnant even as new medical schools open. By 2020, the number of graduates from MD and DO schools will have grown from 18,000 in 2000 to almost 28,000.

The AMA Conference focused on several areas key to reforming health care delivery. Repealing the SGR formula is the number one goal. Speakers noted that every year for more than a decade, physicians have faced steep Medicare payment cuts due to the SGR formula. Having temporarily averted an SGR-driven pay cut of 26.5% on Jan. 1, the threat of another cut looms large again at the end of the year. Medicare payments already have been nearly frozen for more than a decade while the cost of caring for patients has increased by 25%.

Other conference highlights: updates on efforts to combat Rx diversion and the push for national tort reform, including a $250,000 cap on non-economic damages, like those working in California and Texas.

Physicians came away from DC with renewed energy and a greater sense of inclusion in the political process.
A Battle Royale in the Works for Psychiatrists

Psychologists introduce legislation enabling them to prescribe medications

By Cheryl England

On Feb. 15, Illinois Senate President Pro Tem Don Harmon (D-Oak Park) introduced SB 2187, a measure that would allow psychologists to prescribe psychotropic medications to patients. Not coincidentally, Rep. John E. Bradley (D-Marion) introduced HB 3074 an identically worded bill to the House. It’s no wonder that groups such as the Illinois Psychiatric Society (IPS) and the American Psychiatric Association (APA) are fighting back—and hard—since patient safety is at stake.

IPS is moving quickly to combat the bills. In less than a month, the group has created a series of YouTube videos of physicians explaining the dangers of non-medically trained practitioners prescribing potent medications; met one-on-one with numerous legislators; developed talking points; and sent alerts to a variety of physician groups throughout the state. Many of the IPS discussion points highlight the fact that because psychologists are trained in social sciences, not medicine, they are ill-equipped to understand interactions between organ systems, much less the interactions between psychotropic medications and other prescription drugs. In addition, the IPS argues, psychologists are unable to spot medical conditions that may cause an altered mental state for which psychotropic medications may be ineffective and even harmful while the underlying condition goes untreated.

Conflict of interest has also reared its ugly head in the drafting of the bills. The bill proposes that after completing their doctorate, psychologists only need an additional 462 hours of training in order to prescribe medications, training that could be as simple as an online course. The training could be conducted by psychologists and oversight of these practitioners would be the responsibility of the psychology licensing board, not the medical licensing board.

The various psychology groups backing the bills are doing their best, however, to bolster their case with an “access to care” scare tactic. They cite the lack of psychiatrists in rural and underserved communities as a key reason the bills should be pushed through the legislature. But IPS President-elect, Linda Gruenberg, DO, pushes back, saying that access to mental health care in a community is not limited solely to the availability of psychiatrists. “Not only can psychiatrists prescribe psychotropic drugs,” she says, “but also interns, family practitioners, and pediatricians.”

In addition, she says, physician assistants and advanced nurse practitioners may also prescribe medications, but they do so only in collaborative agreement with a physician. In both bills, the wording is altered so that psychologists are required to have a “collaborative relationship” with a physician, which could simply be communication after a medication has been prescribed. No contracts between the physician and psychologist are required.

“Because psychologists are trained in social sciences, not medicine, they are ill-equipped to understand interactions between organ systems, much less the interactions between various medications.”

The IPS also notes that telemedicine is yet another solution for access to care concerns. Newer technologies allow physicians to interact face-to-face with patients as well as provide services such as heartbeat monitoring or even eye examinations remotely. In Illinois, telepsychiatry is widely practiced throughout the state by organizations such as the University of Illinois at Chicago, Veterans Administration, Southern Illinois University School of Medicine, the prison system, federally qualified health clinics, and more. Another Senate bill, SB 2366, sponsored again by Senator Don Harmon, is already in the works to require insurers to pay for covered services delivered through telehealth methods.

Proponents of the psychologist-backed bills are working diligently to get the measures passed in Illinois. Only two states so far—Louisiana and New Mexico—have passed similar legislation. Psychologists view Illinois as key to creating a domino effect, opening the door for similar legislation to pass in numerous other states.

The Illinois Senate Public Health Committee, where SB 2187 was assigned, has already voted 8-0 to advance the proposal. Whether or not you are a psychiatrist, now is the time for you and your colleagues and co-workers to contact your legislators and make it clear they should vote “no” on SB 2187 and HB 3074 for the sake of patient health and safety.
An all-day symposium explored Chicago’s diverse patient population and the complex factors contributing to health outcomes. Co-hosted by the Chicago Medical Society Student District and the Building a Healthier Chicago (BHC) coalition, the event attracted participants from every Cook County teaching institution. A panel of public health authorities addressed and answered questions from the more than 70 attendees at the Feb. 2 symposium, which took place at Prentice Women’s Hospital on the Northwestern Memorial campus.

With James Wu, co-chairman of the Student District, and Angelica Vargas, Student District trustee, as emcees, CMS officer Dr. Philip B. Dray, warmly welcomed the audience and outlined the history of CMS’ public health mission, including current initiatives to promote hands-only CPR and primary stroke center awareness. Following Dr. Dray, Assistant U.S. Surgeon General (ret.) Dr. James M. Galloway, looked at social determinants and how choices strongly affect health outcomes. He challenged students to help build a social movement focused on improving choices within communities.

Reflecting on his 17 years in the trenches at Cook County Hospital, keynote speaker Dr. David Ansell, gave his observations on the U.S. health care system and its profound inequities. He said he now advocates for a single payer system and urges others to do the same. Dr. Ansell is currently chief medical officer at Rush University Medical Center and author of the book, County, which details his experiences at the historic institution.

Returning to the theme of community, Rush’s Dr. Neelum T. Aggarwal, urged the next generation of medical professionals to consider its role and responsibility as community advocate. By making home visits, for example, physicians can identify needs within a specific community. Dr. Aggarwal’s initiative to educate Chicagoans on the use of primary stroke centers is a model for other physicians. Having resources available in the community is not enough, she said. People must know, trust, and have access to services.

City Health Commissioner, Dr. Bechara Choucair, explained the components of Healthy Chicago, the city’s agenda for encouraging healthful lifestyles. He invited medical students to join the Students for Healthy Chicago Committee.

Several patients described how they navigate the health care system and highlighted their experiences, both positive and negative. An HIV-positive man said patients often know within 90 seconds of meeting a provider if that person is judging them. This can affect the physician-patient relationship and health outcomes. A teen mother spoke about the major differences in care she received at private and public facilities. The office environment and a provider’s willingness to help in small ways make a huge difference, she said.

Dr. Tariq Butt, deputy medical officer of Access Community Health Network, the largest network of federally qualified clinics in the U.S., moderated the panel.

The CMS Student District conceived the “Patient Populations Symposium: A Look into Health Disparities in Urban Chicago” symposium. Future such programs are in the works.

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Service of the Month

CMS Career Center and Job Board

In this new practice landscape, the Chicago Medical Society (CMS) can expand your employment reach. Whether you are looking for a new position, or ready to take the next step, our online Career Center and Job Board connects medical professionals like you with employers nationwide. Our participation in a national network allows you to post your CV and view hundreds of positions at leading institutions and groups.

This resource is for physicians, physician assistants, nurse practitioners and administrative medical staff. The site’s services include career coaching, advice on preparing a CV and interviewing, and a content library. When you open an account, you can store your CV and search alerts in one place and sign up for special alerts when a new job matches your search criteria.

Recruiters from large health systems, private practices, government agencies, and academic medical centers can also find qualified candidates in a range of specialties and locations.

We urge you to get the most out of your membership by using the Career and Job Board. Please visit us at www.cmsdocs.org.
Calendar of Events

APRIL

3 District 5 Meeting Illinois Affordable Care Act (ACA) Implementation: Preparing for 2014. The speaker is Michael Gelder, Senior Health Policy Advisor, Office of the Governor. 6:00-8:30 p.m.; Maggiano’s Little Italy, 240 Oak Brook Center, Oak Brook. For more information or to RSVP, please contact Christine 312-329-7326 or cfouts@cmsdocs.org.

11 Illinois Society of Plastic Surgeons This is a Jeopardy style meeting where residents and members will compete against each other answering a variety of questions that pertain to the plastic surgery specialty. 6:30-9:00 p.m.; Metropolitan Club; 67th Floor of Willis Tower; 233 S. Wacker Dr., Chicago. For more information or to RSVP, please contact Amanda 312-670-2550, ext. 325, or aworley@cmsdocs.org.

17 OSHA Workshop This workshop is intended for physicians, physician assistants, nurses, practice managers, and other health care professionals who may potentially be exposed to bloodborne pathogens. Learning goals include: implement a training program employees who may be exposed to bloodborne pathogens; identify appropriate personal protective equipment; develop an emergency response plan; create a written exposure control plan for health care workers assigned as first-aid providers; and develop a strategy to prevent the spread of pandemic flu within the practice. The speaker is Sukhvir Kaur, Compliance Assistant Specialist. 8:30 a.m.-10:30 a.m.; Oak Lawn Hilton, 9333 S. Cicero Ave., Oak Lawn. Up to 2.0 credits; $89 for CMS members or staff; $129 for non-members or staff. To RSVP, please visit: www.cmsdocs.org or call 312-670-2550, ext. 338.

20 Advanced Cardiovascular Life Support (ACLS) Recertification Course This course is for all physicians, residents, and allied medical professionals. Through ACLS training health professionals develop the expertise and skills needed to use this life-saving process properly and safely. ACLS certification is required for health care providers working in acute care settings and also by providers of emergency services. The majority of hospitals and emergency services require that this certification be accredited by the American Heart Association. The speakers are Vemuri S. Murthy, MD, Program Coordinator and Teaching Faculty, Resurrection Healthcare Training Center, Chicago, and Dennis McCauley, EMT-P, Course Director, Training Center Coordinator, Resurrection Healthcare Training Center, Chicago, 8:30 a.m.-4:00 p.m.; Chicago Medical Society, 33 W. Grand Ave., Chicago. Up to 7.0 CME credits. $175 for CMS member or staff; $225 non-members or staff; $135 for residents. To RSVP, please visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

24 District 8 Meeting Update on Accountable Care Organizations. The speaker is Terrell J. Isselhard, Principal, Chuhak & Tecson, P.C., Chicago. 6:00-8:30 p.m.; City Tavern, 1416 S. Michigan Ave., Chicago. Up to 1 hour of CME credit; no charge to attend. For more information or to RSVP, please contact Christine 312-329-7326 or cfouts@cmsdocs.org.

26-28 ISMS Annual House of Delegates Meeting The policymaking body of the Illinois State Medical Society meets at the Oak Brook Hills Marriott Resort, 3500 Midwest Road, Oak Brook. Friday, 2:00-7:00 p.m. registration & credentialing; 4:30 p.m. dinner buffet; 5:00 p.m. HOD begins; Reference Committee A testimony; Saturday, 7:00 a.m.-3:00 p.m. registration & credentialing; 8:00 a.m. HOD continues; 1:45-4:00 Reference Committees B & C testimony; 4:15-5:15 p.m. Third District Caucus; Sunday, 7:00 a.m.-12:00 p.m. registration & credentialing; 7:00 a.m. Third District Caucus; 8:30 a.m.-12:30 p.m. HOD concludes. For more information, please contact www.hod@isms.org or call 312-853-4745 or 800-782-4767, ext. 4745.

26 CMS Executive Committee Meeting Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. Time TBA. Oak Brook Hills Marriott Resort, 3500 Midwest Road, Oak Brook. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

26 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. Time TBA; Oak Brook Hills Marriott Resort, 3500 Midwest Road, Oak Brook. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

27-28 Midwestern Association of Plastic Surgeons 52nd Annual Scientific Meeting Saturday, 7:30 a.m.-5:00 p.m.; Sunday, 7:30 a.m.-1:00 p.m. Northwestern Memorial Hospital-Feinberg Pavilion, Third Floor, 251 E. Huron St., Chicago. Up to 12.5 Category 1 CME credits. For more information or to RSVP, please contact Amanda 312-670-2550, ext. 325, or contact aworley@cmsdocs.org or visit the MAPS website www.midwestplasticsurgeons.org.

MAY

15 Chicago Gynecological Society Resident Paper Competition Selected resident abstracts will be presented and voted upon by the general membership. 6:00-9:00 p.m.; Maggiano's Little Italy Banquets; 111 W. Grand Ave., Chicago. For more information or to RSVP, please contact Amanda 312-670-2550, ext. 325, or aworley@cmsdocs.org.

22 District 4 Meeting Update on Accountable Care Organizations. The speaker is Terrell J. Isselhard, Principal, Chuhak & Tecson, P.C., Chicago. 6:00-8:30 p.m.; City Tavern, 1416 S. Michigan Ave., Chicago. Up to 1 hour of CME credit; no charge to attend. For more information or to RSVP, please contact Christine 312-329-7326 or cfouts@cmsdocs.org.
WHEN YOU admit a patient covered by Medicare to the hospital, are you asked if you want that patient covered under Part A or Part B? Probably not. But in reality, that is what should happen at the time a physician determines whether an individual should be admitted as a full inpatient as opposed to being admitted for observation or outpatient status. What may seem to be an administrative decision, rather than a clinical determination, can end up with surprising financial consequences for a Medicare patient.

Unless patients are in a dedicated observation unit, it may appear to the patient, family members, hospital staff and physicians that those patients are admitted to the hospital. After all, they are in a hospital bed receiving nursing and supportive care, having tests done, taking medication and being fed. But if they are being observed rather than admitted, Medicare considers their care to be a Part B benefit with different coverage than Part A.

Medicare regulations determine whether a patient is kept in observation status versus being admitted. For Medicare, presenting symptoms and the physician’s ability to support the medical necessity of the inpatient admission are what determine a patient’s path.

For inpatient admission, Medicare will bill the patient under Part A. The senior will usually pay a one-time deductible for all hospital services delivered in the first 60 days of the hospitalization. Part B will cover most physician services provided during an admission, although the patient pays 20% of the Medicare-approved amount after paying a Part B deductible.

With observation status, the patient will be billed for care under Part B. That can mean a copayment for each individual service because it is considered an outpatient level of care. Seniors may find a hefty bill waiting for them after discharge, with all care services and medications billed separately.

The situation can get more complicated if the patient requires rehabilitation services in a skilled nursing facility following an observation stay. Medicare requires a “three midnight in-patient stay” in order to qualify for coverage in skilled care. That means an observation stay would not meet the coverage requirement, and would add even more financial and placement pressure on the patient during recovery.

Medicare and other third-party payers have increased their scrutiny of short-stay, one- and two-day inpatient admissions, denying payment after the fact by determining that the care provided did not meet the standard for inpatient coverage. The distinction between inpatient and observation care has rapidly become an audit issue for the Centers for Medicare and Medicaid Services (CMS) via its contractors for the Recovery Audit Contractor (RAC) program, Medicare Administrative Contractors (MACs); and Comprehensive Error Rate Testing (CERT).

All of this means that hospitals, physicians and patients must communicate.

Hospitals are increasing the use of observation status to provide care in a safe environment while still being able to bill for outpatient services. Unfortunately, all too often the patient experiences sticker shock after receiving the bill for hospital services not covered by insurance. Medicare offers resources to help patients understand their obligations, but is this enough?

Hospitals should be advising patients of their observation status, but notification may be overlooked by worried and confused patients who may not understand whether their status is Part A or Part B. Physicians are the only ones who can determine and order the appropriate level of hospital services. We must direct the best care possible amid the realities of payer restrictions, and we must ensure that patients understand that important distinction: whether their care is considered Part A or Part B.

By William N. Werner, MD

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The Chicago Medical Society welcomes its newest members elected in February. Thanks to them, we are now 64 voices stronger!

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Edward S. Linn, MD, an obstetrics-gynecologist, is, unsurprisingly, a huge proponent of women’s health. But what is surprising about Dr. Linn is that his commitment ranges from his career in private health care system to his stints educating up-and-coming physicians to his work in a public hospital system. In short, he’s been there, done that and seen it all.

Currently, Dr. Linn serves as the system chair of the obstetrics-gynecology department at Cook County Health and Hospitals System. But that’s not all. He also pursues his academic interests as an associate professor at Northwestern University’s Feinberg School of Medicine. But it was a somewhat circuitous route that got Dr. Linn to his current position.

Dr. Linn served his first department chairmanship at Advocate Lutheran General Hospital, a position he held for 10 years. “That’s where I really learned about the value of a patient-centric organization,” he says. “Lutheran emphasized the multiple dimensions of humanity. The hospital knew how to be a success in the marketplace but it judged success more on how well it was meeting the needs of the patient.”

Next up, Dr. Linn moved to become chairman of the ob-gyn department at Rush North Shore Medical Center. Among his accomplishments there, he played a key role in changing the way women’s health care was managed, developing a medical center to focus on the needs of women beyond their reproductive years. “I left Lutheran to set up a center for post-reproductive age women due to interest from the community,” says Dr. Linn. “A team of us built the program.”

From there, Dr. Linn was recruited as interim chair at Stroger Hospital to guide the ob-gyn department, which was having challenges maintaining a high-quality residency program and caring for an ever-increasing uninsured population. In a strategic move, Dr. Linn initiated a partnership with Northwestern to create one of the top ob-gyn residency programs in the country. When he was asked to stay on as chairman, Dr. Linn accepted. “It’s appealing to me to work in the public hospital system,” he says. “It provides an opportunity for me to give back, helping a very important department for women’s health in Chicago. In addition, I was raised medically at Michael Reese Hospital and Medical Center, which set the tone for my career. Back in the late 70s, Reese knew how to balance charitable health care with private health care. It made me look for that balance in my career.”

An avid cyclist and devoted family man, Dr. Linn boasts of his 40-year marriage to his wife, Barbara, and his two married daughters, Stephanie and Robin. When asked to look back on his life, Dr. Linn finds that he has done it all. “I was in private practice where I was managing the practice with a partner; I was chairman at Lutheran General where I was responsible for the success of 90 physicians, 240 personnel and residents,” he continues. “I’ve been highly involved in academics, teaching students and residents to give quality care to patients even in these tumultuous times.” And, that indeed, is what the practice of medicine is all about.
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