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Dr. Marko Jachtorowycz has long specialized in the treatment of female incontinence and pelvic floor support disorders—an area that only a handful of Chicago physicians are expert in.
Organized Medicine and a Changing Landscape

By now, you are well aware of changes in traditional practice models, as more and more physicians increasingly choose employment arrangements. Meanwhile, all volunteer organizations, professional and otherwise, are seeing a decline in participation and involvement. While some may view declining membership as unfavorable to physician organizations, I propose that it provides an opportunity for us to gain strength and unite to address the forces working to change the health care landscape and the physician-patient relationship.

As a practicing internist, I was once a member of both the American Society of Internal Medicine and the American College of Physicians (ACP). At the time, ACP was the group representing the academic community. As many of you know, these two organizations decided to merge into one stronger organization, of which I am still a member. Maybe now is the time for the multitude of physician organizations to consider opportunities to merge forces, in an effort to maintain membership and relevance.

While not meant to single out a particular specialty, my simple online search for gastroenterology returned multiple organizations, including the American Gastroenterology Association, American College of Gastroenterology, American Society for Gastrointestinal Endoscopy, and Society of American Gastrointestinal Endoscopic Surgeons, not to mention organizations for specific diseases or pediatric versions of these societies. While some benefit might accrue to having many organizations, consolidation of medical specialty societies to mirror the consolidation in the health care delivery system might be an idea whose time has come.

Traditionally, one’s specialty society has been a source of specialty education. The county and state medical societies have provided political advocacy at the local and state levels. With increased access to low-cost, high-quality CME, and the increased scrutiny of medical practice by government and third-party payers, the time is upon us to strengthen the advocacy of all physicians, regardless of practice mode.

Employed physicians practice under the same regulations and political forces as independent physicians. And the organization that signs an employed physician’s paycheck is dependent on fair pay for physician services. With this in mind, we must show our colleagues the value and benefit of belonging to the Chicago Medical Society and Illinois State Medical Society. It will take members of specialty groups to address the issues of internal politics and leadership when considering mergers. Individual members must be the catalyst to stimulate such discussions. And if groups don’t ultimately consolidate, they likely will be more focused in their mission to members.

We physicians should be looking for ways to speak with one voice to government and payers on key issues. When it really matters, we are stronger together. Please remind and encourage your colleagues to renew or join organized medicine.

Howard Axe, MD
President, Chicago Medical Society
Like Guatemala, Like Chicago

A medical mission reinforces the need for change at home, no matter how slow or laden with red tape By Kavita Shah, MD

JUST RETURNED from a weeklong medical mission to Guatemala as part of the organization Faith in Practice. This was my first medical trip overseas, and I truly enjoyed being part of it. It was wonderful to see people in the health care field from different religious backgrounds and with varied experience coming together to help the underserved. Knowing that all members of the group had a connection to Chicago was an added bonus. The group included surgeons, anesthesiologists, residents, CRNAs, nurses and nurse practitioners, scrub techs, translators, a pharmacist, and a pastor.

The week was packed with general and gynecologic surgeries as well as many clinic appointments. Patients had been waiting for weeks to see a doctor, often traveling great distances. The hope and gratitude in their eyes will be a memory I will always carry with me.

However, it also saddens me to realize that one doesn't have to go overseas to see long lines of patients waiting after suffering from their problems for many years. Just as the average woman in Guatemala with uterine prolapse had waited 10-plus years before seeking care, the long lines and delays in care are familiar here in Chicago as well. It is commonplace to walk into emergency room waiting rooms and see patients waiting for hours or even days. The embarrassment, social stigma, and lack of health care access prompts patients here in Chicago to wait for years before seeking care.

We, as physicians, can continue to walk past these waiting rooms unscathed or we can take notice by looking into our patients’ eyes, recognizing the need, and taking action. And that is what organized medicine is all about. It is being willing to take a stand, to be part of the change. When it is all too easy to bury our heads in the sand and just complain about the state of health care in this country, joining and being active in organized medicine is making the conscientious decision to do something constructive.

Change may be slow, laden with red tape, and it may not always be the change you agree with. But the more you, and other people with your views, join the process, the faster the wheels turn and the more the change reflects your viewpoints. Ask any county, state, or national society member who has been active for a few years, and you will certainly hear how he or she played a role in changing health care policy.

For me, it is being part of the process that sets guidelines for practicing medicine ethically—always keeping our patients at the center of care. For others, it is medical education and the various new initiatives to modernize how we train our nation's health care force. For still others, it is public health or malpractice insurance reform.

So I challenge you to be part of the change. Do not simply sit back and let the health care environment change around you, but instead have an active voice. In the process, you will make some great new friends, share amazing experiences, and know that you have helped shape policy that helps doctors help patients.

Dr. Shah is co-chair of the CMS Resident and Fellow Section.
Meaningful Use in Chicago
A look at the provider landscape and where the incentive dollars are going
By Anna Roberts and Abel Kho, MD, MS

By now you’ve probably heard about the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs created by the Centers for Medicare and Medicaid Services (CMS) to encourage and assist providers in adopting EHRs. If so, you may be wondering—how many providers are going for “Meaningful Use”? And how much money are they getting through the program anyhow? How are providers using the incentive payments to defray the costs of adopting and implementing an EHR system? Let’s take a look at the provider landscape in Chicago and see the impact of Meaningful Use incentive payments in Chicago, in Illinois, and nationwide.

The U.S. Census Bureau reports that the City of Chicago has 2.68 million residents and estimates that 20%—more than half a million people—do not have health insurance. To serve such a large patient population with a variety of health care needs, insurance, and care-seeking behaviors, Chicago offers the following: 42 hospitals, 19 Federally Qualified Health Centers (FQHCs), over 1,000 flu shot clinics, a number of large academic medical centers, and myriad small practices. Because it’s difficult to track the ever-shifting provider population in a large metropolitan area, our best guess is that there are around 6,000 primary care providers and 7,000 specialists working at the hospitals and clinics throughout our city.

Providers in Chicago
Let’s look at participation in the Medicare and Medicaid EHR Incentive Programs in Chicago. Citywide, more than 1,100 eligible providers had attested to Meaningful Use by the end of 2012. At CHITREC, we have helped more than 385 providers achieve Meaningful Use in both the Medicare and Medicaid programs, and many more are well on their way. CHITREC providers who have received incentive payments have collected $12 million, for their first year of participation in the programs or for Medicaid’s Adopt-Implement-Upgrade year.

Who is an eligible provider? For the Medicare program, it means a practice-based doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatry, doctor of optometry, or chiropractor. For Medicaid, it is physicians, nurse-practitioners, certified nurse-midwives, dentists, and physician assistants in FQHCs or rural health clinics that are led by a physician assistant.

Providers in Illinois
CMS periodically releases statewide and national reports on the amounts that have been paid out through the Medicare and Medicaid EHR Incentive Programs. Illinois ranks eighth in the nation in terms of the number of providers going for Meaningful Use dollars.

As of Feb. 28, 2013, roughly 10,280 eligible professionals in Illinois had attested and received a payment. As a result, they received over $185 million. So far, over two-thirds of incentive payments to Illinois providers have come through the Medicare program. This will change quickly, however, now that the Medicaid incentive program has been rolled out.

Providers Nationwide
By Feb. 28, 2013, more than $11.5 billion had been paid out to providers and hospitals through the Medicare and Medicaid Electronic Health Record Incentive Programs. Of this sum, $4.3 billion has gone to individual providers who have attested they are indeed meeting all the requirements of Meaningful Use. In January 2013 alone, more than 20,000 providers attested, receiving $375 million in incentive payments.

In addition to these incentive dollars, thanks to the American Recovery and Reinvestment Act of 2009 grant funding, CHITREC has been able to allot a small disbursement to its providers for reaching Go-Live and Meaningful Use.

How are providers using these dollars? We know the ones we work with have been spending funds on the following: EHR software (licensing fees, installation, implementation, training), data extraction and migration, privacy and security support and assessment, consulting, internal staff hours for EHR and Meaningful Use project managers.

We guess the larger incentive payments are being used similarly to further adoption, implementation, and Meaningful Use of EHRs. There is no shortage of items to spend incentive dollars on, but there is a time crunch; Medicare program incentive payments end in 2016, and Medicaid payments end in 2021.

More providers are achieving Meaningful Use every day, and it’s not too late to join them and bring more of those incentive dollars to Chicago.

To learn more about Meaningful Use and attestation, contact CHITREC by calling 312-503-2986; or emailing info@chitrec.org; or visiting www.chitrec.org.

Anna Roberts is data manager at CHITREC. Dr. Abel Kho is an internist and co-executive director of CHITREC, a federally funded organization that directly assists providers in Chicago to achieve Meaningful Use and reach their health IT goals.
Health Care Reform Opinions
A new poll shows that Americans are still unclear on the law

A recent poll from the Henry J. Kaiser Family Foundation found that three years after the passage of the Patient Protection and Affordable Care Act (ACA), a majority of Americans are unsure how the law will affect them, and few are paying attention to state-level decisions about implementation. Though opinion overall remains nearly evenly divided, most Americans say they do not expect to see much difference in their own or their families’ health care coverage but among those who do expect a difference, more say it will be worse than better.

Asked how much they have heard about their state’s decision on whether to create a state-run exchange, roughly half (48%) report hearing “nothing at all,” while only 7% claim to have heard “a lot.” Further, when asked what they know about their governor’s decision on expanding Medicaid in their state, the vast majority (78%) say they haven’t heard enough to report their state’s decision.

When it comes to overall opinion of the law, 37% of people hold a favorable view and 40% hold an unfavorable one. Asked why, the most common response among those who view the law favorably has to do with expanded access to health care and insurance (58%), while those who view the law unfavorably are most likely to cite cost considerations (30%), opposition to the individual mandate (15%), and concerns about government involvement in health care (13%).

A plurality (40%) say they don’t expect the law to make much difference for their families overall. Those who expect to see an impact are more likely to say it will leave them worse off (29%) rather than better (21%). The biggest area of concern is cost; more than half (55%) say the cost of health care for the nation as a whole will increase, and nearly as many (49%) say the same about their own personal costs. Americans are also much more likely to say things will get worse rather than better in terms of quality of care (45% vs. 24%) and consumer protection for the average person with health insurance (39% vs. 16%).

The one area where expectations are more positive is access to care for the uninsured: 40% expect it to get better, while 28% expect it to get worse.

For the full report, go to www.kff.org.

“When it comes to overall opinion of the law, 37% of people hold a favorable view and 40% hold an unfavorable one.”

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“Protecting Reputations ... One Doctor at a Time”
Treating Immigrant Populations

Cultural awareness improves care giving and helps patients feel respected

By Elise Oberliese

Whether you provide health care to immigrant populations today or not, you likely will in the near future. Here’s why: the number of Hispanics in the U.S. is now about 52 million, according to the July 2011 Census Bureau report. That number will likely increase to nearly 132 million by 2050, when Hispanics will make up about 30% of the U.S. population.

Here are ways you can better serve those populations.

First, know thyself. Want to give better care to all of your patients? With immigrant populations, first tap into your own set of beliefs and cultural attitudes, suggests Octavio N. Martinez, Jr., MD, a psychiatrist and executive director of the Hogg Foundation for Mental Health in Austin, Texas. “You must have the ability to understand your own biases and prejudices,” he says. He also acknowledges that we all have prejudices, and that’s OK.

Second, know your patients. Do you understand your patients’ values? Most people agree that family matters a whole lot, regardless of one’s culture. So don’t be surprised if the entire family shows concern for your patient, says Sandra L. San Miguel, MS, research instructor at the Institute for Health Promotion Research at the University of Texas, San Antonio. “It’s important for health care providers to understand that when Latinos show up to see the doctor, they need support and need their family with them. Sometimes they crowd the waiting rooms, and everybody wants to come into the consultation room. That’s OK. It’s all about making a family decision.”

Showing respect goes a long way as well, regardless of a patient’s culture, ethnicity or skin color. “We don’t want you to treat every patient the exact same way,” says Dr. Martinez. “Instead, we want you to be sensitive to the other person’s culture and respectful to the patient, as if you were a teacher.”

In a simple example, consider asking someone, “Do you prefer to be called Mr. Lopez? Or Larry? It shows a great deal of respect, says San Miguel. Older people typically prefer the more formal Mr. or Ms. or Mrs., she says, but not always. The key is to avoid assumptions.

Also, too, know your patients’ limitations, says San Miguel. For example, your patients may have transportation issues, lack insurance or have language barriers that make the information you are trying to give them hard for them to understand.

Try to anticipate issues ahead of time, when possible. “Try to perceive literacy issues. An older gentleman or woman who does not know how to read will tell the person at the front desk, ‘I forgot my glasses,’” say San Miguel. They may need your help filling out those forms.

As health care workers, you are no different than other people. Outside influences may cloud your thinking, but ultimately, everyone chooses what to think and believe. Thanks to stereotypes, unfortunately, even health care workers inadvertently make presumptions about people—based on how they look, talk, or dress. Dr. Martinez suggests overriding knee-jerk thinking. “We have an executive center in the brain that allows us to turn off those biases when we are giving health care,” he says.

Elise Oberliesen is a Denver-based journalist and contributing editor who currently writes for several print and online health care publications. This article was provided by Health Callings, a health care career service, which can be found at www.healthcallings.com.

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We think of it as an “ah-ha moment.” It’s that highly gratifying instant in our consulting work with practitioners when the veil drops, the mystery disappears, the light bulb ignites—and a big idea is understood in a flash. It’s rewarding for the client, seminar attendee or the audience we are addressing, as well as for ourselves as health care marketing instructors.

Here, in 15 words, is a sentence that frequently leads to an ah-ha moment:

There are only six ways to market any health care organization. Six and only six.

Admittedly, the broad topic of successful health care marketing is complex and sometimes confusing. There are hundreds of strategies and thousands of tactics, but understanding this six-point outline provides a manageable starting point for bringing it all together.

We organize our seminar presentations and our client marketing plans around these fundamental elements. If this is a back-to-basics list for you, perhaps it’s a useful refresher and something you can share with others.

If this is an eye-opener, we’re pleased. For many people, grasping these six elementary building blocks demystifies health care marketing in an ah-ha moment.

1 Professional Referral Marketing: A reliable and continuing stream of inbound patient referrals from other medical, dental or other professional sources is the lifeblood of many specialty providers. And whether it’s a primary or secondary channel, professional referral sources can’t be taken for granted. Doctor referrals do not happen by magic or simply because you are a good provider. Success requires a written plan and an unfailing system to preserve and grow the flow of professional referrals.

2 Internet Marketing: From websites and social media tools, to patient portals and mobile apps, online marketing is a mainstream channel for marketing, advertising and public relations. Exactly how you use the muscle of the digital freeway can be highly effective and profitable, or a huge waste of time and money.

3 Branding: This is all about standing out from the crowd in a positive way, and it includes virtually everything you do. A powerful, differentiating brand for your health care business is part of your reputation. Meaningful and effective branding does not occur without a deliberate effort to shape and express the right message at the right time.

4 Internal Marketing: This heading includes all the ways that you communicate with people who already know you, primarily current and former patients. Depending on the nature of your practice or situation, this influential audience can be a rich resource for referrals, additional services, testimonials and/or word-of-mouth advertising.

“A reliable and continuing stream of inbound patient referrals from other professional sources is the lifeblood of many specialty providers.”

5 External Marketing: These are the media that reach prospective patients who don’t know you. Advertising in newspapers, radio, television, billboards and the like target an audience that needs to know that you provide an answer for their health care need. There’s little margin for error in an external media budget that is expected to produce a measurable return-on-investment.

6 Public Relations: This heading includes, among other things, planning and generating health care publicity and free press exposure, such as newspaper articles or broadcast interviews. The end results look easy, and they can be a positive and powerful influence. But “free press” typically results from careful planning, good timing, a clear message and a deliberate effort.

Whether this is familiar territory or an “ah-ha moment,” there are only six ways to market any health care organization. Use this list to guide your marketing plan so you can achieve your goals.

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.
Cardiovascular risk factors are related not only to stroke but also to cognitive decline and dementia. Diabetes continues to be one of the most established and frequent risk factor for vascular disease, stroke, and mortality in both the U.S. and across the globe. In addition, diabetes appears to increase the risk of dementia by two-fold in many populations, yet little is known about whether this increased risk is similar among racial and ethnic minorities.

In one study, a total of 1,617 older Mexican-Americans ages 60-98 from the Sacramento Area Latino Study on Aging were followed for 10 years. They were evaluated for metabolic and cardiovascular risk factors and their relationship to cognitive decline and dementia. Enrollment began in 1998 and participants were evaluated and interviewed in their homes every 12-15 months, with phone calls made every six months between the home visits.

Of the 1,617 people in the sample, a total of 677 had diabetes during the study (n= 513 baseline diabetes cases, and 164 incident cases), with 940 remaining diabetes-free. Comparing those with treated diabetes to those without diabetes, the study found that people with diabetes were younger and more likely to have been born in the U.S. There were no relationships between educational level and diabetes status.

Among those who had diabetes, 62.2% met at least two criteria for diabetes (elevated fasting glucose, anti-diabetic medications use or self-report) and 37.8% had one (13.3% fasting glucose, 3.4% anti-diabetic medication use and 21.1% self-report). Among participants who reported a physician diagnosis of diabetes at baseline, the median duration of diabetes was 10 years, and at baseline, 64.7% of participants with diabetes were using anti-diabetic medications; 36.1% were using one medication; and 28.7% were using two or more. The proportion of participants taking a diabetes medication remained constant throughout the follow-up years.

Individuals who were treated for diabetes had a two-fold increased incidence of dementia compared to those without diabetes. In addition, people with diabetes were more likely to die than those without a history of diabetes. In addition, there was an increased risk of death in those with diabetes and dementia. This study is unique because it is the only U.S. population-based longitudinal study of Mexican-Americans that assessed cognitive function, dementia and mortality. The results demonstrated that among Mexican-Americans, the rates of risk for dementia were similar to those found in studies with predominantly Caucasian participants, and that diabetes is a risk factor for not only cognitive decline and dementia but also for mortality. Furthermore, treating diabetes appeared not to modify the dementia and mortality rates, thus suggesting a robust relationship between diabetes and dementia.

Whether the timing of treatment or aggressiveness of treatment may potentially modify these outcomes remains to be investigated. However, this study further alerts public health officials and health care providers to consider cognitive screening as part of their care management in addition to screening for and treating diabetes.

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.

Here are three additional resources:
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Take the Healthy Vending Challenge

Multipronged city agenda promotes food and beverages with less sugar, salt and fat

By Bechara Choucair, MD

T’S FINALLY springtime and you’re planning to lose a couple of pounds before heading to the lake to enjoy the sun. While at work, you head to the break room to see what vending machine snacks might suit your healthier goals. What you find are sugary soft drinks, and processed snacks high in fat and sodium.

Why are there not more healthy options for you? Maybe there will be soon, however. Mayor Emanuel has launched the Healthy Vending Challenge, which encourages Chicago’s businesses and organizations to provide healthier food and beverage options in vending machines. The Challenge asks organizations to change their current vending offerings to include items lower in sugar, salt and fat to align with guidelines based on the American Heart Association’s healthy food procurement standards.

Interested organizations can visit the Chicago Department of Public Health (CDPH) website to access the Healthy Vending Challenge toolkit and participation instructions. Once a business or organization has met the requirements of the Challenge, it will receive an official certificate to document its success.

The Challenge aligns with the City’s healthy vending policy, unveiled by Mayor Emanuel in November 2012 and approved by the Chicago City Council in December. According to the policy, at least 75% of all food and beverages in every vending machine in City-owned buildings will include healthier, affordable options. Already, 40% of the new vending machines have been installed in City-owned buildings, and will reach 100% over the next couple of months.

When the Park District installed healthy vending machines, people responded by purchasing more healthy options.

“When the Park District installed healthy vending machines, people responded by purchasing more healthy options.”

The Challenge was created as part of Healthy Places, a partnership between CDPH and the Consortium to Lower Obesity in Chicago Children (CLOCC), and is part of the City’s Healthy Chicago agenda, a comprehensive plan to make our City the healthiest in the nation. The plan identifies 16 health outcome targets and 12 priority areas including obesity prevention.

With recent surveys showing the prevalence of overweight or obese adults in Chicago is now roughly 63%, a large citywide effort is underway to “green” food deserts where access to healthy foods is limited and to encourage healthier living among residents. As part of this initiative, CDPH and its community partners have secured commitments for 17 new or planned grocery stores in communities with limited access to healthy food. New outlets include Aldi, Save A Lot, Walmart and Roundy’s. CDPH has also worked with owners of existing stores, including Walgreens, to add produce and other healthy options at 19 locations. A pilot project CDPH developed encourages neighborhood corner stores in Humboldt Park and Englewood to offer more produce and healthier food choices.

While implementing programs and services, CDPH has also influenced policy change. For instance, the passage of Chicago’s first urban agriculture ordinance gives residents and businesses more options for community gardens. These community gardens are now permitted to be as large as 25,000 square feet; new urban agriculture businesses have expanded to include vertical farms, aquaponics and apiaries. In June 2012, an ordinance was passed to allow produce carts to operate throughout Chicago. The ordinance requires that at least 50% of every licensed produce merchant’s business operates within a community with limited healthy food options.

Decreasing the availability of products that are high in calories and low in nutritional value, while improving access to healthy food and beverages are key steps in helping individuals make better choices.

Medical practices and health care facilities can get on board by installing a healthy vending machine, so the next time you’re in the break room hankering for a snack, you’ll be more confident about the choices you make.

For more information, please visit the CDPH website at www.CityOfchicago.org/Health. Also, you can follow the department on social media on Twitter @ChiPublicHealth and Facebook at www. Facebook.com/ChicagoPublicHealth.

Dr. Choucair is commissioner of the Chicago Department of Public Health. He was appointed by Mayor Richard M. Daley to the position on November 25, 2009.
Communication *saves lives.*
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*DocbookMD is a free benefit of your CMS membership.*
Learn more about the app at [docbookmd.com](http://docbookmd.com).
“The Mega Rule changes the definition of a business associate, so that actions themselves give rise to a business associate relationship rather than the mere existence of a contract.”

**The New Mega Rule**

Implications for the use of EHRs and protecting personal health information

By Catherine Barrett, JD, Adela Lucero, JD, and Erin Williams, JD

**Electronic Health** records (EHRs) are meant to help a wide variety of health care providers share medical information—and are central to the federal government’s effort to coordinate medical care, reduce preventable medical errors, clerical errors, and costs. The Health Insurance Portability and Accountability Act (HIPAA) Omnibus rule (Mega Rule), which was issued in January 2013, significantly revised HIPAA by strengthening the privacy and security rules designed to protect an individual’s protected health information (PHI) and the national standards to secure the integrity of electronic PHI. The Mega Rule implemented many of the changes required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The final Mega Rule became effective March 26, 2013, and compliance with the Mega Rule begins on Sept. 23, 2013. This article surveys the major areas where the Mega Rule has implications for the use of EHRs.

**The HIPAA Privacy Rule**

The Privacy Rule protects the privacy of an individual’s PHI, which is created or maintained by physicians, health plans and health care providers who transmit health information in electronic form. The Privacy Rule governs how health care providers may use and disclose PHI and grants individuals certain rights over their health information. EHRs will contain PHI; thus, EHRs must be appropriately protected as required by the Privacy Rule. Three major areas where the Mega Rule and EHRs intersect are discussed below.

**Notice and Breach of PHI**

The Mega Rule changes the definition of a business associate so that actions themselves give rise to a business associate relationship rather than the mere existence of a contract. Previously, a contract with a health care provider was needed to establish a business associate relationship and related liability. Therefore, EHR vendors who receive, maintain or transmit PHI will now be considered business associates.

Health care providers and business associates who adopt and implement EHRs also should be aware that the Mega Rule changes the definition of “breach” by removing the requirement that an individual suffer “significant risk of financial, reputational, or other harm.” Under the new criteria, the Department of Health and Human Services (HHS) explains there is no breach notification requirement if the health care provider or business associate can show “through a risk assessment that there is a low probability that the protected health information has been compromised.” The Mega Rule did not define the term “compromised” but HHS intends to issue additional guidance in the future. EHRs that offer a feature for documenting a chain of transmittals so that patient records are protected may assist health care providers in complying with the new breach notification rule.

**Patient Access to PHI**

Health care providers and their business associates who use EHRs must be able to respond to patient requests to restrict the use or disclosure of PHI. This may pose a problem since the patient request must be honored each time the health care provider accesses the patient’s PHI. For example, a patient who exercises his or her right to restrict disclosure of a mental health diagnosis must be made known to the health care provider using the EHR. Automatic prompts within the EHR to remind health care providers to restrict use or disclosure of a patient’s PHI might be needed. In addition, secure log-in requirements might be needed to ensure restricted data within the EHR is not shared with others.

The Mega Rule expands or introduces two patient-related rights: the right for a patient to request privacy protection for PHI and the right for a patient to have access to PHI. First, a patient has a right to request that a health care provider restrict the use and disclosure of PHI about his or her treatment, payment or health care operations. This is a change from the previous HIPAA regulations that did not require health care providers to agree to restrict use or disclosure of PHI. Now, health care providers are required to comply with a patient’s request to restrict disclosure of PHI to a health plan if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which the patient has paid the health care provider in full. This could be an issue in an EHR environment if the data is not carefully flagged and separated from other patient data. To avoid errors, the EHR may need to include features designed to allow health care providers to easily quarantine this data from the rest of the patient’s file.

In addition, the Mega Rule requires health care providers to offer access to PHI in the electronic form requested by the patient or, if that is not possible, in a form that both the patient and the health care provider agree on. Second, organizations that
operate EHRs must be able to comply with new “time and manner” rules, which provide that if a patient’s request for access directs the health care provider to transmit PHI directly to another person, the health care provider must do so. The patient’s request must be in writing, signed, and clearly identify the designated person and where to send the PHI. Thus, an EHR that includes a feature to allow a patient to make this request, including the ability to provide a digital signature, would likely comply with this new requirement.

**Notice of Privacy Practices**

Health care providers who use EHRs will need to ensure their organization’s notice of privacy practices (NPP) is updated with the new provisions in the Mega Rule and that the patient reads, understands, and acknowledges the NPP. For example, the NPP will need to include an explanation of how PHI is protected throughout the EHR system. The NPP will need to include an explanation of PHI data storage (both internal and external) and PHI data archiving and data transmission. The NPP must include language that a “covered entity is required to notify affected individuals following a breach of unsecured PHI” and if the entity is a health plan, the NPP must be updated within 60 days of a material revision to the privacy policy and provided to the individual.

The NPP must also include a statement that other uses and disclosures not described in the NPP will be made only with the patient’s written authorization. For example, the use and disclosure of psychotherapy notes, PHI for marketing purposes, and the sale of PHI require a patient’s authorization. Applied to the EHR environment, a prompt should be included to advise EHR users that PHI related to the above-mentioned areas require patient authorization prior to use or disclosure. The EHR warning feature should be described in the NPP that patients review and sign.

**The HIPAA Security Rule**

The major new HIPAA Security Rule requirement ushered in by the Mega Rule is that business associates and subcontractors of health care providers must fully comply with the HIPAA Security Rule. Significantly, EHR vendors who have access to patients’ confidential information—via Internet shared programs, installation upgrades, staff training, and the like—now meet the definition of business associates. This is an enormous new obligation; it takes time and resources to evaluate security programs, conduct an appropriate risk assessment, implement risk management strategies and prepare appropriate written policies and procedures encompassing a full information security program. As more health care providers adopt EHRs, the government has expanded the liability of persons or entities that do not properly protect PHI.

The Mega Rule also extends liability directly to a subcontractor who creates, receives, maintains or transmits PHI on behalf of the business associate. Business associates and subcontractors must now comply with the technical, administrative, physical and organizational safeguards and standards outlined in the Security Rule. Business associates include a person or entity that offers a personal health record to one or more individuals on behalf of a health care provider or a health information organization, e-prescribing gateway or others who provide data transmission services and require access to PHI on a routine basis. Health care providers, business associates and subcontractors must:

- Ensure the confidentiality, integrity and availability of all electronic PHI the health care provider or business associate creates, receives, maintains or transmits.
- Protect against reasonably anticipated threats or hazards to the security or integrity of PHI.
- Protect against any reasonably anticipated unauthorized use or disclosure of PHI.
- Ensure the workforce complies with requirements.
- Modify security measures as needed and update documentation to ensure reasonable and appropriate protection of electronic PHI.

To comply with the new Mega Rule, EHR features must be in place to prohibit health care providers from improperly accessing or transferring PHI.

In addition, the Mega Rule included changes to the implementation provisions of the Genetic Information Nondiscrimination Act of 2008 (GINA). The changes require that the patient’s genetic information be treated as PHI. Most health plans are prohibited from using or disclosing a patient’s genetic information for underwriting purposes.

Thus, EHRs need to be properly designed and implemented and users need proper training to ensure that genetic PHI contained in the EHR is not improperly shared with health plans.

**The Upshot**

The Mega Rule includes substantive changes to the way in which PHI must be protected, used, disclosed and stored by health care providers, business associates, their counsel and others. As the rate of EHR adoption rises, it is increasingly important for policies, procedures and technical standards to be in place to protect PHI contained in the EHRs and transferred between EHRs and other electronic forums such as health information exchanges.

Catherine Barrett, JD, (cabaret@mitre.org) is a lead health care consultant with MITRE, a not-for-profit organization chartered to work in the public interest. Adela Lucero, JD, (alucero@mitre.org) is a health policy analyst with MITRE. Erin Williams, JD, (erinw@mitre.org) is a principal health policy analyst with MITRE.

“As more health care providers adopt EHRs, the government has expanded the liability of persons or entities that do not properly protect PHI.”
Is Chicago Ready?

A world-class city takes a second look at its disaster readiness in light of the Boston Marathon bombings

By Howard Wolinsky and Lyz Hoffman

SINCE 9/11, horrific events that were once unimaginable have, unfortunately, become part of our culture. The response to the Boston Marathon bombing was superbly orchestrated and executed, and no doubt will be studied by major cities, including Chicago. Our city will incorporate those lessons learned from the Boston experience into our own emergency medical system, which many consider to be on par with Boston’s. The following article discusses these issues and more.

Howard Axe, MD
President, Chicago Medical Society

WHEN TWO pressure cooker bombs exploded near the finish line at the Boston Marathon on April 15, killing three and injuring more than 250, Dino P. Rumoro, DO, chairman of the Department of Emergency Medicine at Rush University Medical Center, thought of Chicago. Could the explosions be part of a bigger plot, originating in Boston and reaching nearly 1,000 miles away to Chicago?

“Anytime you see something like this, what you try to do is process the information to see if it could get closer to home,” said Dr. Rumoro, an expert on bioterrorism preparedness. “If it’s within your state, then you’re worried that it might hit your city. If it’s in your city, then you’re worried that it might hit your neighborhood.”

He quickly concluded from the types of bombs used that the attack would be limited to Boston. “It seemed more like a home-grown type of attack that was unlikely to be widespread. There were no
Chicago is no stranger to bombings and terrorist attacks, going back to the 1886 Haymarket Square Riot, when a bomb killed several police officers, through the Puerto Rican separatist FALN.

“How did the Boston medical community achieve such remarkable results?” he continued. “It began with coordination between first responders and hospitals, applying lessons learned from military medicine. The treatment of hemorrhage and shock has been refined incrementally since World War II to Korea, Vietnam, and finally the Middle East. Military surgeons have observed that rather than giving immediate wound repair in the field, more lives are saved by emphasizing rapid control of bleeding at the site, followed by stabilization and transport for definitive surgery. This was the primary focus at the marathon site.”

Dr. Franklin, whose book of essays, Chicago Flashbulbs: A Quarter Century of News, Politics, Sports and Show Business (1987-2012), published in April of this year, said the explosion victims in Boston benefited from high-quality triage: “It is an under-appreciated skill to rapidly sort out the seriously wounded requiring immediate surgery from those who need urgent but nonsurgical attention and from the less urgent walking wounded. The doctors and nurses in the emergency departments performing triage must think fast and use quick judgment; errors at that stage are frequently fatal. When the casualties arrived, they performed superbly.”

Dr. Rumoro said Chicago’s emergency medical system is up to handling an explosion such as in Boston—or worse. “Chicago is extremely well set up. I would say it’s no different than Boston’s and may, in fact, be better. The infrastructure is there to handle it, all the way from the security forces—Chicago Police—to the first responders, Chicago Fire, to the emergency departments, to the specialists who have to take patients from the emergency department. The infrastructure is very sound, very good.”

Eric H. Beck, DO, medical director of the Emergency Medical Services System for the City of Chicago, agreed, saying that the Office of Emergency Management and Communication, EMS System, Chicago Fire Department, Chicago Police Department, Chicago Department of Public Health, along with the network of 37 hospitals that receive fire department ambulances, are “well-trained and have rehearsed” to handle large-scale emergencies. “All of these pieces, first response, emergency response, triage, transport, and hospital care, have to work in concert to execute successfully,” said Dr. Beck, who is also assistant director of the emergency medicine residency program at the University of Chicago. “We are fortunate to have a very nimble network that’s able to adapt in real time.”

Physicians from the University of Chicago Medical Center, Northwestern Memorial Hospital, Illinois Masonic Medical Center, and John H. Stroger, Jr., Hospital of Cook County oversee Chicago’s 911 Emergency Medical Service. In the case of a bombing in Chicago with mass casualties, 911 emergency calls would go out from “ground zero,” and the Chicago Fire Department’s fire fighters, EMTs, and paramedics along with the police would assess the nature of the incident. EMS providers would be in touch with an assigned resource hospital that coordinates where casualties go based on such factors as severity and type of injury and the number of casualties. A central command at Illinois Masonic Medical Center, the so-called “POD” hospital, helps orchestrate and integrate the Chicago hospital pieces with neighboring EMS Regions and throughout the state. “You don’t want to overburden one hospital with a lot of patients,” said Dr. Rumoro. “You want to try to get patients distributed fairly evenly so they can be treated quickly.”

Dr. Rumoro said the city is even prepared to handle a “dirty bomb,” a conventional explosive device that disperses radioactive material. As part of a new emergency department that opened at Rush University in January 2012, an enclosed ambulance bay contains showers that could be used to decontaminate 100 people an hour.

No Stranger to Emergencies
Chicago is no stranger to bombings and terrorist attacks, going back to the May 4, 1886, Haymarket Square Riot, when a bomb killed several police officers, through the Puerto Rican separatist FALN, which carried out bombings in downtown Chicago in the 1970s. But the post-Sept. 11, 2001, world has created new concerns and stepped up response to terrorism.

Based on the Boston experience, experts predict the Bank of America Chicago Marathon and the city will make adjustments to the preparedness plan for the Oct. 13 race as well
as for this summer’s large-scale events, such as Taste of Chicago on July 10-14 and Lollapalooza on Aug. 2-4, both in Grant Park. More than 37,000 runners completed the 2012 Chicago Marathon, a loop that starts and ends in Grant Park. The Chicago Marathon, one of the major marathons along with those in Boston, New York, London, Berlin and Tokyo, draws more than 1.5 million spectators each year.

Carey Pinkowski, executive race director of the Chicago Marathon, said in a statement: “We want to reassure those registered for the 2013 Bank of America Chicago Marathon, and the family members, friends and volunteers who plan to support them, that we are in constant communication with the City of Chicago, the Office of Emergency Management and Communication, the Chicago Police and Fire Departments regarding the security plan that is implemented at the Chicago Marathon. As our top priority, we work in lockstep with these agencies to ensure the safest possible event for everyone involved. As we do each year and throughout the year, we will sit down with these agencies and conduct a comprehensive security review as part of the planning process for this year’s event.”

A touchstone for emergency preparedness in Chicago was the NATO Summit held at McCormick Place in May 2012 amidst large-scale protests in the city over the wars in Iraq and Afghanistan. There were injuries, including a police officer who was stabbed in the leg. But NATO was a virtual tea party compared with the police riot and massive street protests during the Democratic National Convention in 1968. On a 90-degree day, the city provided water, rest stations and cooling buses along the two-and-a-half mile protest route.

Dr. Beck said the team in Chicago prepared for the NATO Summit for over a year with planning, drilling and rehearsing. “And when the summit came, we spent a week in live emergency operations mode, even though there was not an emergency. We sort of braced for impact and it was a tremendous experience to really try out the system in a very high-fidelity way. This is something that Chicago’s no stranger to. We have large events on a regular basis here, from the marathon to Taste of Chicago. There’s always more preparedness to be done. There’s always more drilling, more planning. “We’re all eagerly awaiting some of the after-action reviews from Boston,” continues Dr. Beck. “It sounds like they executed phenomenally well. Just a terrific response and hats off to them. But obviously, even in a successful execution, there are always lessons learned, whether they are best practices that should be shared with other large metropolitan cities, or things they felt they could have done better.”
Learning From Others

Chicago Mayor Rahm Emanuel told a news conference that he has ordered his public safety team to incorporate lessons learned from Boston into the emergency medical plan developed for the NATO Summit. He told reporters: “The fact that they [Boston] had a well-rehearsed, well-thought out and well-developed emergency medical response was crucial in saving lives.... We have a very good plan. We did it for NATO. I’ve asked everybody to go back and look at it. I want to know the training schedules coming up. And as soon as Boston is done with the federal government in analyzing what worked, the best practices, I want to get our hands on that report and scrub what we have and make sure it’s up to that standard. That’s just one example. There are other things as well. But, that’s one clear example we are going to be looking at.”

Robin McFee, DO, MPH, of Worcester, Mass., is medical director and partner of Threat Science, a consultancy on emerging threats, preparedness planning, terrorism and weapons of mass destruction (WMDs). She said the U.S. had a tremendous investment in response capabilities following the attacks of Sept. 11, 2001, pouring “time, talent and treasure” into disaster preparedness over the next four years. But, she added, the country was increasingly becoming complacent, suffering from “9/11 amnesia” and generally not reinvesting in these efforts nor maintaining training and preparedness.

Dr. McFee, who chairs the Global Terrorism Council of ASIS International, and is a member of the U.S. Counterterrorism Advisory Team, praised Mayor Emanuel: “It is very telling when someone as smart as Rahm Emanuel says, ‘We have to relook at all our plans. Let’s make sure we can do what Boston can do.’

“That’s a profound insight,” continues Dr. McFee. “Chicago is no rube city. It is a squared-away, terrific place. What the mayor is saying by his actions is, ‘You know folks, maybe we all have a little bit of 9/11 amnesia. Maybe we can’t afford to have a little dust on our plans. Let’s test our assumptions, and plans. Maybe we need to get out there and practice, as well as reinvest.’ He made it clear that he wants to see the upgrades.”

Dr. McFee said every major city ought to retest their plans, have an honest “hot wash and assess what the city is capable of, how well different disciplines (law enforcement, private security, emergency medical services [EMS], and health care facilities) communicate and work together, and determine if the ability to handle a variety of mass casualty incidents has degraded. Are the plans workable? What are the terrorists capable of? Are the teams responsible for protecting our community collaborating effectively? Do we have the right expertise to critically evaluate and assist our community? Do we have the right training? Do we have the right people with true mass-casualty medical and surgical experience? Are we communicating to the public what can happen? “We had 9/11 amnesia,” she says. “And God willing, we won’t have April 15 amnesia.”

As the manager of medical administration and regulatory compliance for Chicago Fire, Leslee Stein-Spencer, RN, MS, said that the after-incident report from Boston will be helpful in strengthening Chicago’s emergency preparedness. “It’s a continuous process,” she said. “We’re always preparing to be prepared. I think we have systems in place that can be activated and do a good job.”

“Our EMS system in Chicago is one of the finest in the country,” she added. “We respond quickly and efficiently, and we have systems in place and standing orders that we know where to transport patients so they get to the right place in the right time.” An integral part of the city’s emergency preparedness is a system called MABAS, which stands for Mutual Aid Box Alarm System. Stein-Spencer said that in the event of an emergency, MABAS could summon ambulances and fire trucks from communities across the state to help out. There is also a system involving private ambulance providers.

The city’s new patient-tracking system, which finished rolling out on May 1, is the same one used in Boston after the bombings, Stein-Spencer said. Under the protocol, victims receive triage tags with barcodes, which help medical personnel to keep track of which hospital each patient gets admitted to. Local hospitals and EMS providers have all been trained in the system.

The Fire Department’s Simulation Training Facility is the largest such facility dedicated to EMS in the Midwest, Stein-Spencer said. Fire department staff train there, as do staff from the police department, area hospitals, and the FBI. Training sessions involve imagining scenarios—such as explosions or chemical releases—and then explaining the precautions for dealing with such events, detailing what signs and symptoms to look for, and how best to treat the victims.

The training, just like real-life situations, requires collaboration, Stein-Spencer said, adding that last...
Looking Abroad

Some emergency preparedness leaders are wondering whether the U.S. needs to undergo fundamental philosophical change in its thinking and approach to emergency preparedness, change that would alter our way of life and the way we view ourselves. Some look to Israel, with its record for handling suicide bombers, rocket attacks and bus bombings. Israel has become a destination for emergency preparedness experts from Chicago who are interested in learning how to handle complex emergencies and disasters, including terrorist attacks.

When he visited Israel with other emergency preparedness officials, Dr. Beck said he was impressed with the responsiveness of the system there and its ability to handle “surges,” meaning large numbers of victims, from attacks. That said, he added: “I would submit [the Israelis] are in a very different context. And their threats are very different, they are much more real, they come much more often, and as such, they have different health care delivery models in terms of the national model—police, military, all tightly controlled by the government.”

While studying for his master’s in public administration at the Kennedy School of Government at Harvard University, Cambridge, Mass., Raj B. Lal, MD, MBA, MPA, delved into disaster preparedness issues. He struck up a friendship with a fellow student Col. (Ret.) Isaac Ashkenazi, MD, former surgeon general of the Israeli Defense Forces. Dr. Ashkenazi is director of the Urban Terrorism Preparedness Project at the National Preparedness Leadership Initiative, a joint program of the Harvard School of Public Health and the Kennedy School. Invited by his friend, Dr. Lal has visited Israel several times, most recently in January 2012, when he attended “a dirty bomb exercise” involving three hospitals. “It was a well-executed exercise, with coordination between blood banks, ambulance services and IDF,” said the retired cardiovascular thoracic surgeon.

Dr. Lal also said the Israelis are primed for this sort of emergency because they cope with it as a society on a daily basis. “They’re such a small country, they [Israel] can do that easily as opposed to a big city like Boston or Chicago. The Israelis, more than Americans, have a culture of safety and awareness, which is so palpable when you go to Israel. Every house has a shelter, every kid is taught in school how to handle himself, they have gas masks and they know how to use them. Most important, after high school, every student, whether a girl or a boy, goes into the Army for two years, where they learn how to be a citizen. So their whole culture is not only about how to take care of oneself, but also how to take care of neighbors, friends, a brother or sister, and their family.”

Dr. Lal said Chicagoans and other Americans could learn from the Israeli experience by educating the public how to apply first aid—such as applying a scarf or belt as a tourniquet when someone is bleeding and keeping airways clear. “Bystanders are the first responders, and the community has to get involved. We have to start this at the school level, and in the churches.”

Yet Dr. Lal admits that Americans are unwilling at this point to accept the tight controls imposed in a society such as Israel. Still, he said, he hopes that in the future, spectators at events like the Chicago Marathon, will be more vigilant for unusual activity. Police officers on motorbikes should follow runners along the 26-mile course, he said. “More vigilance is needed, whether it is fire fighters, or ambulance drivers, or paramedics—everybody has to be on the lookout.”

Better Safe Than Sorry

When he was associate director of emergency medicine at Rush University Medical Center in the 1990s, toxicologist Jerrold B. Leikin, MD, found out firsthand the sort of preparation it takes to protect the public at major events. In his role, he worked in first-aid tents at the 1994 FIFA World Cup at Soldier Field and the Susan G. Koman Race for the Cure. Dr. Leikin, now director of medical toxicology at NorthShore University Health Systems—OMEGA, in Glenview, and a clinical professor at the University of Chicago, said such preparedness is necessary even though few patients came into the tents there. “At the World Cup, we saw zero patients,” he said. “But that’s OK. We were overstaffed—just in case. The goal is medical preparedness.”

As with other physicians we spoke with, Dr. Leikin said the response in Boston after the blasts was a model of on-the-scene response. He said “only” three died while the potential toll without proper preparedness would have been many times that. “Emergency preparedness paid off in Boston. It saved lives because the first-aid tents were within feet of the finish line,” said Dr. Leikin, co-editor with Dr. McFee of the book Toxico-terrorism: Emergency Response and Clinical Approach to Chemical, Biological, and Radiological Agents. “Paramedics, doctors and nurses were able to start IVs and perform resuscitation immediately.”

Howard Wolinsky is a Chicago freelancer and former medical writer at the Chicago Sun-Times. He teaches at Northwestern University’s Medill School. Lyz Hoffman is a Chicago freelancer.
Thank you for the honor you bestowed upon me by electing me as president of the Illinois State Medical Society (ISMS). I look forward to the opportunity I have throughout this year to take our message around the state, both to members and the non-member physicians who need to join us, and the lay public—our beloved patients.

I am a general internist caring mostly for geriatric patients down south in the city of Belleville, which is in St. Clair County, the county known to you for being consistently rated as one of the worst judicial hell holes in the nation. Of course, Cook County is no stranger to that list either. While I know my more rural background is very different from your day-to-day realities as physicians in the Chicago area, our common bond as physicians holds us together regardless of zip code.

I try to practice in the manner of the physicians who cared for me while I was growing up. A strong influence on my approach to medicine comes from Dr. Wilson DuComb. He was a second-generation general practitioner who provided care for three generations of my family in rural Illinois. When my father faced a bout of scarlet fever, it was Dr. DuComb who tended to him, sometimes traveling with my grandfather on horse and buggy because the roads were too muddy for car travel. I recall one year, after a visit to complete my school physical, he turned to my mother for a series of questions about her “condition.” That’s how I learned I was going to be a big brother. It was Dr. DuComb who extracted a lead pencil chunk from my brother who fell victim to a grade school prankster, and it was Dr. DuComb who was there for the birth of that same brother’s first child.

I highlight my family’s personal experience with Dr. DuComb because he is my example of the value of a knowledgeable primary care physician. But medicine has changed since that bygone era. The three-by-five cards Dr. DuComb used for medical records definitely wouldn’t qualify for Medicare Meaningful Use!

One of my goals for the year ahead is to talk with patients about the importance of establishing a relationship with a primary care doctor. I am also initiating an ISMS effort to partner with other medical stakeholder groups to educate our primary care members on the know-how they need to prepare for certification as a patient-centered medical home. I’d also like to make sure all our ISMS members are prepared for reimbursement changes as more payers move away from the traditional fee-for-service payment system. ISMS must be a leader in preparing members for success under evolving payment and practice models.

As your new president, I pledge to work hard to represent each and every one of you, regardless of specialty or region. Thank you again for allowing me the honor of serving you.

Dr. Eldon A. Trame is president of the Illinois State Medical Society.
Shaping the Future of Local Public Health

Dr. Werner is our nominee for the County health system’s governing board

By Philip B. Dray, MD

Fulfilling an essential public health duty, the Chicago Medical Society (CMS) recently selected William N. Werner, MD, MPH, as its choice to fill a vacancy on the Cook County Health and Hospitals System (CCHHS) Board. The former CMS president and immediate past president of the Illinois State Medical Society joined other nominees whose names were presented to Cook County Board President Toni Preckwinkle on April 12 by a special nominating committee on which CMS has served since 2008.

CMS participates on the committee to ensure that Chicagoans have access to a strong public health system. Indeed, the Society was founded in 1850 upon a mission to educate physicians and improve public health conditions during a chaotic time when physicians did not need to go to medical school or even have a license to practice medicine in Illinois.

The CCHHS is composed of volunteers with expertise in health care management, finance, and regulatory affairs as well as public policy, labor relations, clinical medicine and public health. Board members are charged with overseeing and managing the massive Cook County health care delivery system. The Board nominating committee convenes with representatives from various organizations, including CMS, to select candidates for President Preckwinkle’s consideration.

During the long deliberative process, the committee reviews candidates and the perspectives of the organizations they represent. The individuals may represent health, minority and patient advocacy organizations as well as civic and financial groups, public policy organizations and unions, hospitals and physician advocacy groups.

The full nominating committee considers a large list of candidates, and from that initial listing, the committee advances a smaller group of names to President Preckwinkle, who then may choose five possible nominees to fill CCHHS vacancies.

CMS selected Dr. Werner for his executive leadership ability, and long track record in hospital management, patient and physician advocacy. He has the skills and knowledge to positively shape the CCHHS and help guide the gigantic Cook County health care organization back to stability and fiscal responsibility. Dr. Werner is a public health expert, respected clinician and member of the physician community and of CMS, and a stalwart supporter for decades.

The full committee met April 12 in the County Building on Clark Street. The formal process was initially open to the public and committee members heard comments from citizens. The public was then excused when the committee went into executive session.

CMS is active in public policy, physician and health care advocacy, participating in local and regional activities that affect the lives of physicians throughout the county. We are proud to be your voice for physician advocacy and patient health care. CMS’ strength lies in its membership; your leadership works to improve the practice climate for physicians and advocate for changes in legislation and public policy that give all physicians the ability to provide high-quality medical care and improve the health of patients.

CMS was instrumental in selecting a physician who has advanced to consideration for a vacancy on the CCHHS. If chosen for the Board position, Dr. Werner will have a positive impact on the 1,000-member medical staff of the Cook County health care system and the care of hundreds of thousands of patients who depend on the system each year.

Dr. Philip B. Dray is on staff at John H. Stroger, Jr., Hospital (formerly Cook County Hospital). He is also a CMS trustee and the Society’s current treasurer.
With a bounty of resolutions, many creating new policies and directives, Chicago Medical Society (CMS) physicians played a prominent role at the annual Illinois State Medical Society (ISMS) House of Delegates meeting April 26-28 in Oak Brook. The House of Delegates is the legislative body for both CMS and ISMS, and it deliberated on nearly 20 measures brought by members in the Cook County area. The resolutions reflect the concerns of physicians in all modes of practice, from employed to solo to large group and in all specialties. Addressing shifts in medical practice and patient care, as well as public health trends, resolutions not only shape the destiny of ISMS, but also provide the impetus for new laws and advocacy. The State Society works to implement member proposals in the General Assembly or relay them to the American Medical Association for national action.

In addition to deliberating on resolutions, the House of Delegates inaugurated board-certified Belleville physician Eldon A. Trame, MD, as ISMS president. The Downstate internist assumed office along with William A. McDade, MD, PhD, a past president of CMS, who is now ISMS president-elect.

Here’s a recap of the proposals CMS members presented at the House meeting:

DNR Means DNR
With the input of CMS member Julie Goldstein, MD, the Peoria Medical Society advanced a resolution to protect the patient’s end-of-life DNR choices. With the goal of ensuring the original order is honored, the measure directs ISMS to support legislation that would prohibit anyone other than the patient or health-care surrogate or decision-maker from altering a DNR order already established by the patient.

Dr. Goldstein added her own imprint with language directing ISMS to encourage legislation that would permit advanced practice nurses and physician assistants to sign the revised Illinois Department of Public Health (IDPH) Uniform DNR Advance Directive form if delegated by their...
The IDPH Uniform DNR Advance Directive, also known as Physician Orders for Life-Sustaining Treatment (POLST), is a signed medical order that travels with the patient to assure the patient’s treatment preferences are honored across settings of care. The POLST Illinois Taskforce is launching educational and outreach activities within the state to encourage advanced care planning and advance directives in particular. Dr. Goldstein affirmed what the medical literature clearly documents—that many more people wish to complete advance directives, but they wait for their health care providers to broach the topic. More detailed than the previous version, the new form adds two clinical areas. The result is a very clear set of instructions, but there is a learning curve for proper use of the form, Dr. Goldstein said.

Action: Substitute Adopted

Protect Physician Certification

In rousing testimony delivered on the House floor, family practice physician Makis Limperis, MD, said organized medicine should fight back against insurers and hospitals that require physicians to needlessly retake costly recertification exams. Maintenance of Licensure (MOL) modules costing $1800, and developed by the Federation of State Medical Boards, are time-consuming to complete, and do not reflect actual conditions in medical practice, Dr. Limperis stated emphatically. State licensing boards, however, are free to adopt or reject them.

Both MOL and Mandatory Maintenance of Certification (MOC) programs attempt to control either physician certification or licensure, achieving near monopoly power over medical practice itself, he said.

The testing companies are in it solely for financial gain, he argued. This is a “new animal we have to compete with,” a problem “we have self-imposed.”

Even though AMA policy opposes the use of certification as a condition for medical staff membership or insurance plan participation, “we need laws with teeth,” Dr. Limperis emphasized. “This dangerous trend, which is no longer confined to just specialties, increases costs, hampers innovation, and potentially violates federal antitrust and interstate legislation,” he continued.

Experienced physicians are being driven out of practice because of onerous and costly recertification requirements, which in turn means that more patients will be forced to seek care from non-physicians. As the U.S. faces a looming physician shortage, legislation is already expanding the scope of practice of care to “mid-level providers.”

As many as 25% of all physicians in the U.S. have never been certified, and 50% of all board-certified physicians in the U.S. currently have lifelong certificates, Dr. Limperis testified. He was adamant that “no study has shown any improvement in patient care by requiring physicians to take certification or recertification exams.”

Amid the applause, other delegates advised caution. One young physician noted he sits on the Council on Medical Education. He countered that, “certification reduces errors and we should improve and educate ourselves. We can continue to fight or embrace this issue and be proactive in working with it.”

Another delegate, who serves on the American College of Graduate Medical Education, agreed that recertification is misused by testing companies. On the other hand, he said, “we can’t convince the public that physicians are qualified if they are board-certified only once.”

Still another delegate argued that the increasingly onerous regulations of the last 10 years have gotten way out of control. “Certification is different for every specialty, but we have to get a handle on this,” the delegate said. Others honed in on the issue’s complexity, and need for comprehensive study. As one physician pointed out, “whether you are certified or recertified, the hospital has to credential you. And insurers can decide the physician is spending too much money. It’s a complex issue.”
In the end, delegates said multiple components are involved, including state licensure, certification, and payment. 

*Action: Referred for Study and Report Back.*

**Energy Drink Limitation and Energy Drink Ban for Minors**

Two measures overwhelmingly passed by the CMS Council last March 12 generated more positive testimony at the House meeting. One resolution aims to limit the sale and distribution of energy drinks, while the other would impose a ban for minors under age 18. Delegates agreed the concept of a limit or ban is sound, but said many questions remain, such as how to define what constitutes an energy drink.

Brought on behalf of the CMS Executive Committee, following a series of widely reported adverse events, the measures also formed the basis of testimony before the Chicago City Council on March 5. That’s when CMS President Howard Axe, MD, outlined the dangers of super-caffeinated beverages to aldermen on the City’s Health Committee. (He was invited by Ald. Edward Burke who has introduced an ordinance for a total ban on energy drinks, and Ald. George Cardenas, committee chairman.) The products have been implicated in the deaths of several young people (see page 26 of the April issue of *Chicago Medicine* for more on this issue and CMS’ involvement). Unregulated and artificially caffeinated, the beverages also often contain caffeine-enhancing ingredients, and are targeted at young people as athletic performance enhancers, Dr. Axe testified. 

*Action: Referred for Decision.*

**Basic Life Support Knowledge and Skills for Physicians**

A resolution from Vemuri S. Murthy, MD, gained support from delegates who recognized the value of learning basic CPR. Dr. Murthy told his colleagues he would like to see every physician learn BLS to help cut down on the 300,000 deaths annually from sudden cardiac arrest. So many of these deaths are needless, he said. As leaders of the medical community, physicians should know CPR, which is considered evidence-based medicine supported by American Heart Association resuscitation science, Dr. Murthy testified. 

*Action: Adopted.*

**Delayed Medications**

Authored by Sanford Franzblau, MD, this resolution calls for an orderly, seamless process for medication ordering and administration during patient transitions to a nursing home or other facility from the hospital with follow-up by the receiving facility. The measure drew favorable testimony and reflects an expansion of existing ISMS policy. 

*Action: Adopted.*

**Patient Transitions and Continuity of Care**

Under this substitute measure, originally brought by Sanford Franzblau, MD, the ISMS will pursue legislation that would direct the Illinois Department of Public Health (IDPH) to develop and implement a uniform bidirectional patient transfer form for use by all hospitals, nursing homes, and assisted living facilities. 

*Action: Substitute Adopted.*

**Medication Management in Assisted Living Facilities**

Met by generally positive testimony, this resolution from geriatric physician Rajeev Kumar, MD, directs ISMS to work with multiple stakeholders (the Illinois Department of Aging, Illinois Department of Public Health, Illinois Medical Directors Association, Illinois Geriatrics Society, and Illinois Healthcare Association, among others) to create policy whereby nursing facilities manage and administer medications to residents in assisted or sheltered living, and dementia care facilities. The measure additionally directs ISMS to work for legislation that would accomplish these goals, and to relay the resolution to the AMA for policy adoption and federal legislation. 

While testimony generally supported the measure, delegates voted for additional research to adequately address the resolution’s intent and protect patients. 

*Action: Referred for Decision.*

**Prescribing Controlled Substances in Long-term Care**

Dr. Rajeev Kumar’s proposal to make controlled substances more available for long-term care patients drew favorable testimony. Dr. Kumar described the current difficulties in facilitating orders, waiting for a call from a pharmacy that may be part of some large conglomerate. He emphasized the resolution doesn’t give prescribing authority to anyone. Rather, the resolution allows nurses in long-term care to act as physicians’ agents in receiving and transcribing verbal orders for controlled substances. The language directs ISMS to encourage legislation that would permit nurses to act as such, and further requests corresponding AMA policy and federal legislation. 

*Action: Adopted.*
Residents’ Rights to Make Potentially Unsafe Choices in Long-term Care
Generating positive testimony, this measure brought by Dr. Rajeev Kumar supports the freedom of patients in long-term care to choose potentially unsafe treatment options, including the right to eat with severe dysphagia and the right to fall without restraints, after signed informed consent and waiver of liability. Dr. Kumar testified about a recent Illinois lawsuit that blamed a long-term care facility for aspiration, pneumonia and death stemming from a resident’s choice to eat while suffering from severe dysphagia—even after the resident had signed an informed consent and liability waiver. The state ruled that the long-term care facility did not protect the resident’s safety.

Action: Adopted.

Exclusion of Skilled Nursing Facility Physicians from Accountable Care Organizations’ Primary Care Physician Restriction
The sponsor of this resolution, Dr. Rajeev Kumar, a nursing home medical director, testified that physicians in skilled nursing facilities (SNFs) should have the right to participate in multiple accountable care organizations (ACOs) if their facilities also choose to be part of multiple ACO programs. Some physicians who gave testimony expressed support for a designation of SNFists as specialists in the nursing home setting because specialists are currently allowed to participate in multiple ACOs. Other delegates, however, thought it would be impractical for primary care physicians to serve in both the role of SNFist and specialist. Many agreed this is a complex issue with many medical specialty ramifications, requiring a thorough review of ACO rules and regulations.

Action: Referred for Decision.

Site of Service Differential
Generating mixed testimony, this resolution from the CMS Executive Committee called for policy supporting the concept of equal pay for physician services regardless of the site where the service is provided (hospital vs. private physician office). In addition, it directed both ISMS and the AMA to identify legislators who might introduce legislation that would enact a policy change within the Medicare program.

House testimony revealed that currently, physicians in private practice are paid based upon relative value units for practice expense and physician work. Services rendered in facilities are paid based upon the ambulatory payment classification system. Delegates agreed that site of service payment disparity should be studied so that payers don’t take the path of least resistance and pay the minimum allowable under either system.

Action: Substituted Adopted.

Electronic Prescription of Schedule II Controlled Substances
Two resolutions, one from Dr. Rajeev Kumar, and one from the ISMS Board of Trustees, reflected the concerns and frustrations over barriers to e-prescribing of controlled substances, even though state and federal laws allow for such electronic prescribing. Because the content of Dr. Kumar’s resolution was comprehensively outlined in the ISMS Board version, the latter was deliberated by the House. The resolution asked that the ISMS support the use of e-prescriptions for Schedule II controlled substances, and also work with the Illinois Pharmacy Association, Illinois Prescription Drug Monitoring Program, among others, including third party payers, to develop educational materials that outline the electronic prescribing process and identify and eliminate barriers to e-prescribing for Schedule II controlled substances.

Action: Substitute Adopted.

“Physicians in skilled nursing facilities should have the right to participate in multiple ACOs if their facilities also choose to be part of multiple ACO programs.”

Interference in Medical Practice
Brought by the CMS Executive Committee, this measure asked ISMS to reaffirm its opposition to governmental intrusion in the sacred doctor-patient relationship. This includes laws that override physician orders, or specify what physicians should discuss with patients, or require notification that certain health care services are provided. Services should be evidence-based or considered best practices if a guideline is unavailable. While this issue resonates strongly with physicians, ISMS has ample and extensive policy opposing governmental intrusion in medicine.

Action: Reaffirmed in lieu of existing policy.

National Climate Assessment Report Distribution
This resolution from Ann Marie Dunlap, MD, and Peter Orris, MD, directed ISMS and the AMA Boards to distribute via email to all members and constituent societies a notice that the National Climate Assessment Report was available online for critical review and comment until April 14, 2013. (The CMS Council adopted the measure on March 12 and notified the membership of the report’s availability.)

Action: The House voted not to adopt the resolution, however, because the deadline for action had passed.
Calendar of Events

JUNE

7 Illinois Society of Plastic Surgeons Senior Resident Paper Competition
Senior residents from area teaching institutions will present their research papers and ISPS members will rank the presentations. The top three will be awarded prizes. Registration: 6:30 p.m. Presentation: 7:00 p.m. Location: University Club, 76 E. Monroe St., Chicago. Speakers and titles TBA. For information, please contact Meredith 312-670-2550, ext. 338; or email oney@cmsdocs.org.

11 CMS Council Meeting & Annual Dinner
The Society’s governing body meets four times a year to conduct business on behalf of the Society. The policy-making Council considers all matters brought by officers, trustees, committees, councilors, and CMS members. Following the Council meeting, CMS will install new officers and trustees for 2013-2014 and recognize the recipients of this year’s CMS awards for public service, lifetime achievement, and outstanding physician of the year, among others. 6:00-9:00 p.m., Maggiano’s Banquets, 111 W. Grand Ave., Chicago; no cost to members. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

13-15 Physician Legal Issues Conference
This event is for all physicians and health care attorneys. The Patient Protection and Affordable Care Act promises, along with the Health Care and Education Reconciliation Act of 2010, to significantly transform the U.S. health care delivery system and culture of medicine. Other forces are also reshaping medical practice. They include a changing physician workforce and shift from private practice to large group practice and hospital employment. This program gives participants a medical-legal overview of changes in the health care delivery system, their impact on the practice of medicine, and various strategies to meet these challenges. The Chicago Medical Society is co-hosting the event with the American Bar Association’s Health Law Section. June 13 (1:00-6:00 p.m.); June 14 (7:45 a.m.-7:00 p.m.); and June 15 (8:00-11:35 a.m.). Location: Radisson Blu Aqua Hotel (Thursday and Friday) and Hyatt Regency Chicago Hotel (Saturday). Up to 14 CME credits; $150 for CMS member or staff; $95 non-member or staff. To RSVP, please visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

15-19 AMA Annual House of Delegates Meeting
The legislative and policy-making body of the American Medical Association meets once a year to transact business not otherwise provided for in its constitution and bylaws, and to elect general officers except as otherwise provided in the Bylaws. All day meeting; Hyatt Regency Chicago, 151 E. Wacker Dr., Chicago. Open to all members of the American Medical Association. To RSVP or learn more, please contact: www.ama-assn.org.

19 CMS Executive Committee Meeting
Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

19 CMS Board of Trustees Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 a.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

29 Advanced Cardiovascular Life Support (ACLS) Recertification Course
For all physicians, residents, and allied medical professionals. ACLS is a protocol for managing victims suffering from severe cardiac conditions and other medical challenges. Through ACLS training health professionals may develop the expertise and skills needed to use this life-saving process properly and safely. To qualify for ACLS training you must be a medical professional such as a registered nurse or physician. 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. 8:30 a.m.-4:00 p.m. Location: 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; $315 for residents. To RSVP, please visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

JULY

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

17 OSHA Workshop
This workshop is for any medical or dental professional who may potentially be exposed to bloodborne pathogens. Learning goals include: implement a training program for health care 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. 8:30-10:30 a.m. Location: Loyola University Medical Center, 2160 S. 1st Ave., Maywood. Up to 2.0 credits; CMS member or staff $89 per person; non-member or staff $129 per person. To RSVP, visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext.338.

24 Parliamentary Procedures Workshop
This workshop offers tools and techniques for sharpening leadership and meeting skills. CMS District and Council officers, Board members, executives, officers of specialty societies and hospital leadership are encouraged to attend. Joan Bundley, MPH, RN, PRP, a professional registered parliamentarian since 1995, will lead the workshop. 10:00 a.m.-2:30 p.m. (lunch included). Location: 33 W Grand Ave., Chicago. CMS member or staff $15, non-member or staff $45. Seating is limited to first 30 participants. To RSVP, visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext.338.
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**Practice for Sale**


**Office/Building for Sale/Rent/Lease**

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

  For sale: approximately 2,000 sq. ft. of built-out medical office space for $265,000. Parking lot in rear for six to eight cars. See website http://properties.svn.com/59264-sale; or call or email agent Laurie Ramirez 312-676-1861 (laurie.ramirez@svn.com) for more details.

  Medical building for sale: 2017 S. Western Ave. Very accessible to public transit and close to several local hospitals. Nick Steffes RE/MAX 773-936-8948 or nicksteffes@remax.net; for listing: chicagoassets.com/MRD8296430.

  Space for rent in downtown Winnetka Professional Center. Ideal location. Approximately 1,100 sq. ft. Large shared reception area, three examination rooms, private office, front reception/business office area. Call 847-446-0970.

  Downtown Elmhurst medical suites for rent, from 781-2,400 sq. ft. in the established busy Elmhurst Professional Center, with excellent parking, x-ray and lab facilities on site. Call Mickey at Prudential Realty 630-279-9500.

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**Welcome New Members!**

The Chicago Medical Society welcomes its newest members elected in May 2013. We are now five voices stronger!

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Ever since his residency, Marko Jachtorowycz, MD, felt he was destined to be an educator; he chose a path that culminated in one of his current roles as the director of graduate medical education at Presence Saint Francis Hospital in Evanston. Yet this physician of many talents also maintains a solid clinical presence in the small specialty field of female pelvic floor medicine and reconstructive surgery (FPFMRS). “When I was finished with my residency, it was clear to me that I wanted to be a clinician and take care of patients,” says Dr. Jachtorowycz. “But I also knew I wanted to teach and have a hand in shaping the doctors of tomorrow.”

Oddly enough, in his early years of medical school, Dr. Jachtorowycz had no initial desire to specialize in obstetrics and gynecology. But as a third-year medical student at Loyola University, he was sent to Saint Francis for a rotation during which he changed his mind, realizing that ob-gyn was, indeed, the specialty for him. His mentor at the time, John Henry Isaacs, MD, along with his newly hired partner, John Knaus, MD, encouraged Dr. Jachtorowycz to pursue residency training in obstetrics and gynecology and to later continue in the emerging subspecialty within ob-gyn that concentrated on treatment of female incontinence and pelvic floor support disorders.

Initially termed ‘urogynecology,’ the specialty that Dr. Jachtorowycz has been practicing has now been officially named female pelvic floor medicine and reconstructive surgery (FPFMRS). Dr. Jachtorowycz will be taking a board exam to certify in that specialty. Only a handful of physicians practice female pelvic surgery—he estimates that there may be only 20 FPFMRS physicians practicing in the Chicago area.

What does Dr. Jachtorowycz like best about his work? “I get tremendous satisfaction from taking people who come in feeling hopeless because of urinary problems or pain and bringing them to a cure or as much of a cure as I can,” he says. “Many people who suffer from incontinence don’t travel or feel like they can leave the house. They are miserable. After they get treatment, they become engaged in life again. In particular, I remember one 89-year-old woman who did not anticipate being able to go to her granddaughter’s wedding due to her severe and embarrassing incontinence. Yet, after two treatments she was good to go.”

Like so many physicians with packed schedules, Dr. Jachtorowycz laughs when asked about his hobbies. But he does admit to enjoying computers and history, reading about World War II, modern Europe, the Cold War, and, of course, medicine. He also enjoys spending time with his wife Natalie and their two boys Matthew (10) and Thomas (6) who Dr. Jachtorowycz jokingly refers to as “the heir and the spare.”

Ever humble, the humorous Dr. Jachtorowycz emphasizes that Presence Saint Francis Hospital where he works is not in a well-off neighborhood. “Our hospital cares for a lot of uninsured or underinsured patients,” he says. “One-third of my practice involves taking care of these patients. For me, it is a bit of giving back that all of us, as physicians, should strive to do.”

Dr. Jachtorowycz’ Career Highlights

A CHICAGO NATIVE, Dr. Jachtorowycz received a BS with honors from Loyola University in 1983 and subsequently earned his MD from Loyola Stritch School of Medicine in 1987. He quickly followed up with a residency in obstetrics and gynecology at Loyola University Medical Center and a fellowship in pelvic surgery at the Cleveland Clinic Foundation. Dr. Jachtorowycz currently holds numerous titles at Presence Saint Francis Hospital including director of graduate medical education, and director of the transitional year residency program. He is an active member of the teaching staff for ob-gyn residents and medical students at Saint Francis Hospital in Evanston. He is an assistant clinical professor at the University of Illinois College of Medicine. His private practice is in Morton Grove with Metro Chicago Surgical Oncology.
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