Physician Vacancies on the Rise

Protecting Personal Health Information on Mobile Devices

Obesity, Diabetes and Brain Function

Midwestern University’s osteopathic college takes a Socratic approach to clinical courses

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MESSAGE FROM THE PRESIDENT

Value in the New Year

LAST SUMMER, Chicago Medical Society (CMS) leaders set a clear directive: this is not the year for membership studies or for pilot programs. It is the year to increase membership.

The current membership renewal season is off to a strong start. As of Dec. 3, 2013, at least 691 full dues-paying members had renewed for 2014, compared to 516 at this time last year, an increase of 33.9% in year-to-date renewals. In January, an additional 236 “continuous” regular members who pay monthly will be deemed renewed. This impressive start must be tempered with the realization that robust retention may not translate into membership gains without new member recruitment to balance the attrition.

In the past few years, recruitment has not been strong, with just 82 new dues-paying members in 2013. In 2014, we will bring to fruition the multi-year recruitment plan known as the Partnership for Membership Growth (PFMG). The PFMG program offered trial membership for 2011-2012, half-dues in 2013, with full-dues payment in 2014. The concept was that physicians who experience CMS/ISMS programs at no cost would be more likely to join as dues-paying members.

Of the 236 members paying half-dues in 2013, at least 31 have signed up for full dues in 2014. CMS continues to encourage PFMG participants to become full members.

The comprehensive 2014 recruitment plan has the following components:

• Systematic Renewal Process. CMS is again in direct control of the renewal process for individual members, resulting in a much more systematic approach to membership renewal, with more dues statements and more paper statements.

• Financial Incentives. For the first time in CMS history, we extended 5% dues discounts to much of the general membership—physicians who have been members for at least five years. CMS supports the continued use of incentives, including deeper, more broad-based dues discounts that are matched by ISMS.

• Targeting of Specific Groups. Through efforts spearheaded by ISMS, the psychologist prescribing bills were defeated in the Illinois General Assembly. As such, the psychiatric community is considered fertile ground for membership recruitment because of its ongoing need for advocacy and representation.

• Recruitment of Large Groups. The recent CMS/ISMS campaign to increase GME funding has been extremely well-received by the medical schools. Also, CMS/ISMS have been actively recruiting large groups by asking them to consider institutional sponsorship of individual memberships.

• Public Health and Education. Our promotion of CPR training, Building a Healthier Chicago FIT City, stroke awareness, not to mention our service on the Cook County Board nominating committee, are prime recruitment tools. Chicago Medicine magazine has received wide acclaim and distribution.

Loss of membership is an existential threat to our organization. A medical society that does not represent sufficient numbers of physicians cannot advocate on their behalf.

The steady membership decline began in 1998 with the waiver of the membership requirement for ISMIE liability insurance. Since then, only two years—2007 and 2008—saw increases in dues-paying members. The long-term decline accelerated with the Great Recession, with losses averaging 11% for each of the last four years. CMS’ relinquishment of direct control of the billing process in 2011, and a dues increase from $330 to $395 in 2011, compounded the losses.

Demographic shifts and changing physician employment structure present new challenges. Employed physicians traditionally have had lower membership levels but employment is becoming the predominant practice structure for young physicians.

Demonstrating value is a clear prerequisite for membership growth. The New Year will see a continuation of efforts to provide that value.

Robert W. Panton, MD
President, Chicago Medical Society
S.M.I.L.E.
(SAVING MORE ILLINOIS LIVES THROUGH EDUCATION)

A project of the Chicago Medical Society and the Illinois State Medical Society, supported by the American Heart Association

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TWO SIMPLE STEPS — HANDS-ONLY CPR:
1. CALL 911
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If you are interested in organizing a SMILE presentation in your community or interested in becoming a SMILE volunteer, contact Meredith Oney at the Chicago Medical Society 312-670-2550, ext. 326, or email oney@cmsdocs.org.
Advocating for a Single Payer System
Passionate students spread their message to their peers

By Anna Zelivianskaia

MAGINE THESE all-too-likely scenarios: Lisa Palmson recently lost her mother to breast cancer. Due to her family history, the physician recommends tamoxifen as a chemoprevention therapy. However, Lisa is unable to afford the co-pay. Paul Johnson has felt a burning sensation around his stomach for several weeks and it has recently gotten worse. Visits to his primary care physician are mostly covered by his insurance but his PCP refers him to a gastroenterologist whose services are not covered until Paul reaches a large annual insurance deductible. As a result, Paul cannot afford a visit. A year later he is diagnosed with gastric carcinoma due to Helicobacter pylori infection, a preventable cancer when caught early.

These types of scenarios happen every day in physician offices in America. Our health care system allows for high numbers of uninsured and underinsured, which prevents us from achieving the degree of care we are capable of. Medical decisions are no longer between the patient and doctor. Instead, every therapy and test must be approved by insurance companies, which operate with the goal of making a profit. Fortunately, many passionate medical students in Chicago are stepping up to advocate for changes.

Driven by the desire to improve patient care, medical students are educating other students and the public about the merits of a publicly funded, privately delivered, single-payer health care system. Scott Goldberg, an MS2 at the University of Chicago, has advocated for a single-payer system for several years and is now training other students to do so. He has set up workshops on how to write a political op-ed, trained students in community organizing, and even began educating undergraduates on the merits of a single payer. “For me,” he says, “it just made complete sense. Why can’t the richest country in the history of the world provide equitable, comprehensive insurance to all of its citizens? Until we eliminate private health insurance companies, we will never be able to fully achieve the ideal doctor-patient relationship in the American health care system.”

Similarly, Margaret Russell, an MS2 at Northwestern University, educates students on how our health care system works as well as teaches them the skills to change it. She recently presented an informational session on the federal bill for a single-payer system, HR676. For Margaret, the fight is close to home: “I have seen firsthand how our fragmented and unjust insurance system stands in the way of patients receiving adequate care when they need it...It is morally and ethically wrong for a patient’s insurance status to dictate the quality of their care.”

This passion comes from a fundamental belief that patients are more than their presenting symptoms and vital signs. These students realize that each patient has a unique set of circumstances but is part of a homogenizing system obsessed with profit. However, it is noteworthy that the most fervent student advocates, such as Scott and Margaret, tend to enter medical school believing in the urgent need for health care reform. As a medical community, we must try harder to make advocates out of other students who did not enter with such beliefs or background knowledge. Student-to-student advocacy is inspiring but not enough.

Medical education has changed drastically over the last several years in very commendable ways. Curriculum changes at some schools include education on systematic flaws. However, classroom information often stops at the problems and not at potential solutions or opportunities for student advocacy. Medical schools should constantly improve training in this area since student empowerment is a key step toward patient empowerment. Every medical school should provide systematic education on the inner workings of the medical system and reform options. We need to fix the system together for the sake of our patients.

Anna Zelivianskaia will graduate in 2016 from the University of Illinois at Chicago College of Medicine. The opinions expressed in this column are strictly those of the author and do not necessarily reflect those of the Chicago Medical Society. All members are encouraged to submit opinion pieces.
Benefit of the Month
Your society offers education for you

REPRESENTING more than 17,000 physicians, the Chicago Medical Society (CMS) is one of the largest and most active county medical societies in the country. There has never been a more important time to be a member of CMS and the Illinois State Medical Society (ISMS). When you join our two organizations, you become part of a dedicated network of Illinois physicians who are working together to achieve a unified health care front and fight against unfair insurer reimbursement practices, restrictions on physician autonomy, and the erosion of valuable legislation that protects physicians’ practices. CMS and ISMS can enhance your practice, improve your bottom line, and protect your autonomy as a physician.

As a member of CMS and ISMS you will have access to the wealth of resources both organizations offer as well as access to the extensive expertise of its staffs. CMS and ISMS offer physicians an opportunity to learn about trends in the practice of medicine through committee participation, policy development, educational seminars, and publications. In addition, membership provides networking opportunities, benefits and services, and a strong, solid voice in state and national legislative bodies on issues of concern to physicians.

Access to Events and Educational Programs
One key benefit of your membership—and the one we highlight this month—is access to events and educational programs. Both CMS and ISMS regularly host seminars, CME programs, webinars, conferences, meetings, and workshops on a variety of topics essential to running the business side of your practice. In addition, Chicago Medicine magazine runs a practice management section each month that includes tips and advice for you and your office staff.

You'll find programs on topics such as:
- Implementing electronic medical records
- Proper coding, billing and collection techniques
- Managing Medicare
- Practice management techniques
- Understanding and advocating for legislative and policy changes.

Coming up in February, for example, is an Advanced Cardiovascular Life Support (ACLS) Recertification Course for medical professionals. ACLS certification is required for health care providers working in acute care settings and also by providers of emergency services. Events are held throughout Cook County and Illinois. Please view the Calendar of Events at the back of this magazine for details.

Contact Us
Through our advocacy efforts, our physician leaders and staff work toward a common goal—that you spend more time treating patients and less time navigating the obstacles that threaten your autonomy and undermine the practice of medicine. Recognizing the diverse needs of current and prospective members, we offer specialized memberships for physicians, residents, medical students, and practice managers. In addition, we reward loyal five-year members with a 5% discount on their annual dues. For more information on the benefits of membership or to apply, please visit www.cmsdocs.org or call us at 312-670-2550.
We are here to serve you!

Welcome New Members!
The Chicago Medical Society welcomes its newest members. We are now eight voices stronger!

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Benjamin Kenisberg, MD

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Ila L. Englof, MD
Miriah D. Plawer-Volmerding, MD

District 3
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With the start of the new year, now is the time to review how well your practice maintains a consistent revenue flow. By Alina Mason

One of the most challenging aspects of running a practice is maintaining a consistent revenue flow while improving the bottom line. And January is the perfect time to review how well your practice achieves this goal. To get started, though, you will need to analyze and address various areas in need of improvement. Begin with the four basic activities listed below.

1. Co-pays and Account Balances. Determine if your staff is collecting co-pays and account balances at the time of patient visits. If they are not collecting these receivables at that time, find out why. Are staff members uncomfortable asking patients to pay their balance? Care is rendered. Consider developing a training program to equip staff members with the tools they need. For example, if staff members are not comfortable asking directly, they can print and hand out patients’ account balances at the time of check-in. Remember to also train staff to ask patients how they would like to pay their balance instead of whether they would like to pay.

Not collecting balances at the time of the visit will have a greater impact on the practice this year since health care is shifting to consumer-directed plans, which place higher responsibility on the patient, while minimizing the responsibility of insurance plans.

2. Evaluation and Management (E&M) Coding. Look for any undercoding or overcoding trends during the past year for provider services in the practice. It is simple to run a report in your practice management software program. If you outsource your billing, request a report from your billing vendor. Undercoding can result in a significant loss of revenue, while overcoding can place the practice at risk for audits. Remember that proper documentation is fundamental with E&M coding.

Evaluate both new and established patient visits for each provider and compare the data against benchmarking data to ensure your providers are meeting local standards.

3. Denials. Identify denials and filter for claims that were not paid. This is a time-intensive project, but can make a huge impact on revenue and productivity. Denials may result from internal problems such as staff not pre-certifying procedures, not filing claims in a timely manner, or improper coding.

Denial trends can stem directly from various payer groups based on CPT codes. Analyzing and addressing denials can increase productivity and revenue, and will have long-term benefits.

4. Average Days of Account Receivables (AR). This is a measurement of the average amount of time that a dollar stays in account receivables (payment due) status before being paid by insurance companies or patients. Lowering the number of AR days will mean a significant increase in your revenue.

No provider wants to wait over 60 days to get paid for services already rendered. You can decrease the number of AR days by filing insurance claims at least weekly, sending statements out regularly, checking eligibility prior to a patient’s visit, and collecting balances at the time care is rendered.

You cannot expect your practice to thrive if you do not have the means to measure and analyze performance. Start measuring the plethora of information you have on hand from last year and determine those areas that need improvement. As the year begins, look to the past to empower the future.

Alina Mason is chair of the CMS Practice Manager Section and executive director of Medical Arts Unlimited in Libertyville, Ill.

MEMBERSHIP in the Chicago Medical Society’s Practice Manager Section is an excellent way to expand your professional networking horizons. Practice managers employed in the offices of CMS physician members enjoy a discounted dues rate of only $99 per year. The nonmember rate is $395. To download a membership application, please go to www.cmsdocs.org or call 312-670-2550.
Simple Strategies to Combat Stress

Your questions answered confidentially By Daniel H. Angres, MD

The Chicago Medical Society’s new Physician Wellness Committee aims to help members cope with stress or deal with impairment issues, including substance abuse. Committee members come from all disciplines but have experience either professionally or personally with wellness issues. The Committee answers all questions confidentially. Questions with broad appeal will be published in Chicago Medicine, without the author’s name.

Q: The stress I am feeling in my practice is increasing. I’m not depressed and I don’t feel that the stress is bad enough to warrant seeing a therapist. Is there a simple way to manage this?
A: Two well-studied approaches to handling stress are relatively easy to do, time-conservative, and cost-effective: exercise and meditation. For exercise, it is recommended that you do 30-40 minutes most days of the week. The exercise does not need to be excessive—a brisk walk is an excellent way to get your heart rate up and thus reduce stress. Even more effective is to do 25-30 minutes of aerobic exercise followed by 10-15 minutes of resistance training, five or six days a week. In fact, aerobic exercise interventions have been clinically shown to reduce depressive and anxiety symptoms. Exercise has been further found to have benefits comparable to those of medication, group therapy, and cognitive behavioral therapy. Studies also show that exercise improves mood.

Meditation is also immensely helpful in reducing stress. Research shows that if you meditate 12-15 minutes every day for six or seven weeks, measurable changes in the brain help reduce stress as well as increase motivation, attention span, and decision-making ability. The type of meditation you do is less important than consistency. There are many types of meditation. One easy method is to sit upright in a chair and follow your breath. If a thought comes up, then simply acknowledge the thought without judgment and return to following your breath. It is this simple back-and-forth that allows us to cultivate mindfulness. The more we meditate, the easier and more effective it becomes.

Dr. Angres is medical director of Presence Behavioral Health. Inquiries about the CMS Physician Wellness Committee or confidential questions should be sent to Dr. Angres at dangres@presencehealth.org.

Q&A: Implementing Meaningful Use in an ACO
Joining forces with CHITREC By Eva Winckler, MPH, Samuel Ross, and Abel Kho, MD

John Venetos, MD, has been an independent physician since 1989 specializing in gastroenterology and hepatology. His passion for staying independent and competitive in today’s environment while helping other doctors do the same led him to create Independent Physicians’ ACO of Chicago in 2012. The accountable care organization (ACO) has grown from 100 members to nearly 300 physicians.

Q: How have you expanded the ACO so rapidly?
A: The ACO has grown through word-of-mouth and by working with leadership at provider organizations. Each physician contributes $500 to become an equal owner. That way, the new joiners know they are just as important as those who have been members since the beginning.

Q: What goals do you have for your health IT?
A: The goal is to have all doctors reach Stage 1 and Stage 2 of MU, which will be a very important measurement of the ACO moving forward. CHITREC has been crucial in meeting that goal. Sam Ross, our clinical implementation manager, has helped several doctors. He attended open meetings and provided useful info about MU measures and how to achieve them.

Q: How can physicians get more information?
A: Physicians are welcome to come to our open meetings. Our website is www.aco-chicago.com and office phone number is 773-989-6262.

Eva Winckler is the outreach manager at CHITREC. Dr. Kho is co-executive director.
The final Rule for the 2014 Physician Fee Schedule has been issued by the Centers for Medicare and Medicaid Services (CMS). While there are many proposed changes, here is just a sampling of what’s in store.

**Telehealth Services:** CMS has changed the criteria for eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the office of Rural Health Policy. The hope is that this will improve access to telehealth in shortage areas. CMS has also established a policy whereby geographic eligibility for an originating site will be reviewed and determined on a yearly basis consistent with other telehealth services. This will eliminate the need for mid-year changes that were confusing to both provider and beneficiary.

**Misvalued Codes:** CMS has been actively involved over the past several years in efforts to identify and correct potentially misvalued codes of the physician fee schedule. Around 200 codes were finalized and another 200 additional codes had their work Relative Value Units (RVUs) changed on a provisional basis for 2014. The rates for these codes are open for Public Comment until Jan. 27, 2014.

**Revisions to the Clinical Lab Fee Schedule (CLFS):** Current law dictates that once a payment rate has been established on the CLFS, that rate is to remain unchanged. The current fee schedule is 30-years-old. CMS feels that these payments rates are outdated and potentially excessive. CMS has indicated that it intends to review an existing statutory provision that would allow for CLFS updates based on changes in technology. As a result, CMS will now regularly review and update lab payments.

**Compliance with State Law for Incident-to Services:** CMS is cracking down on “incident-to” billing. The agency is requiring that incident-to services be furnished in compliance with applicable state law. This policy is intended to strengthen the integrity of the Medicare program by allowing denials or recoupment of payments when the provider fails to follow state law in providing incident-to services. CMS has also consolidated all providers who are able to bill Medicare directly for their services, requiring them to follow all the same rules for incident-to billing.

**Primary Care and Chronic Care Management:** CMS has emphasized primary care services over the last couple of years and once again, puts primary care at the forefront. Starting in 2015, Medicare will begin making a separate payment for what it calls Chronic Care Management Services. This will cover services that do not fall in the face-to-face category and which CMS has deemed above and beyond those services already included in the current E&M categories of payment. CMS is establishing policies that would pay separately for non face-to-face services provided to chronically ill patients with two or more significant chronic conditions. Chronic Care Management Services include the following: development, revision and implementation of a plan of care, communication to the patient, caregivers and other treating professionals, and medication management.

Nicole Channell is a health care consultant with Professional Business Consultants, Inc., (PBC) in Oak Brook. PBC offers business and management consulting and accounting services to physician practices. For more information, visit their website at www.pbcgroup.com.
When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela’s EKG, and sent an image of the recording to the on-call cardiologist via DocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quick thinking and the secure mobile app, DocbookMD.

DocbookMD is a free benefit of your CMS membership.
Learn more about the app at docbookmd.com.
Ensuring Diversity in Clinical Trials

Greater minority representation is critical for clinical trials

By Neelum T. Aggarwal, MD

“Another factor influencing minority participation is the concept of health and disease.”

OVER THE LAST few years, health disparities between white Americans and other racial and ethnic minorities have gained increased attention. When compared to whites, data from national health surveys consistently shows that racial and ethnic minorities have higher rates and greater severity of disease for most, if not all, leading causes of morbidity and mortality in the United States. Yet the majority of people who participate in medical research represent the educated middle class, married, white male population.

Major reasons given for the minority underrepresentation in clinical trials include mistrust of researchers; lack of awareness of clinical trials by minorities; inadequate involvement of minority investigators in the recruitment process; cultural differences, economic limitations; lower access to health care; and lower access to research facilities. Recent data show that minority participation in clinical trials is especially low among older people.

The major barriers to recruitment and participation have traditionally involved the physician’s concerns: for the patient, the conduct of the study, and the physician’s own role as both physician care manager and trial researcher. In surveys, physicians often cite the intellectual and emotional tension between their role as physician, which places the individual patient’s health interests first, and their role as researcher, which places the general benefit to humanity, as second. Patients’ concerns often involved time constraints, negative personal and family attitudes toward trials and their safety, and inadequate evidence of the benefits from trial participation.

Researchers also face the challenge of defining diversity, something that must be carefully considered in recruitment. The National Institutes of Health has developed one set of guidelines to ensure that women and minorities are included in trials; the guidelines use purely demographic categories. At the other end of the spectrum are epidemiologists and social sciences researchers, who define diversity according to age, marital status, sex, race, ethnicity, religious affiliation, educational level, socioeconomic status, and other socio-cultural attributes. Despite these efforts at characterization, no group is entirely homogeneous—many socio-cultural factors can converge and affect an individual’s decision to participate or not in a trial.

The concept of health and disease is another factor influencing minority participation. Chronic illness and disability are not always viewed as problems that are appropriate for intervention. For some groups, illness may be a burden the individual or family is expected to bear. Such beliefs have been shown to affect the probability that people will participate in trials.

With change in health care delivery, and the emergence of “population health” as a discipline, biomedical research and, more specifically, clinical trials, can have a prominent role in determining the most effective prevention and treatment methods for chronic conditions in all segments of the population. Encouraging more physicians and patients to participate in clinical trials gives us an opportunity to better understand treatment and prevention outcomes. The following article by Drs. Norman and Shah describes one large prevention study that is currently recruiting minority participants in the Chicago area.

Dr. Aggarwal is a cognitive neurologist at the Rush Alzheimer’s Disease Center and Rush University Medical Center and serves on the clinical trial Steering Committee for the Alzheimer’s Disease Cooperative Study group (ADCS).

Daily Aspirin May Greatly Aid African-Americans

Older participants needed for clinical trial evaluating the use of aspirin in reducing events in African-Americans By Raj C. Shah, MD, and Philippa J. Norman, MD

A COMMON DESIRE among all older Americans is to not only live longer but also to live without significant cognitive and mobility disabilities. However, older African-Americans do not live as long and have more years with disability than do older whites. For a 65-year-old African-American man, the average life expectancy is two years less than for a 65-year-old white man, with two more years spent with disabilities. A 65-year-old African-American woman has an average life expectancy of 1.2 years less than a 65-year-old white woman, with 3.1 more years spent with disabilities. Thus, there is a significant disability-free longevity gap for elderly African-Americans.

While many factors result in this gap, significant drivers include cancer, cardiovascular disease, and dementia. For all three conditions, older
African-Americans experience worse outcomes. For example, the rate of cognitive impairment in African-Americans ages 75-84 (19.9%) is nearly twice that in whites (10.9%).

Clinical research on potentially effective interventions is needed sooner rather than later. An intervention that overcomes barriers associated with income, geographic location, or access to health care is more likely to reduce the gap in outcomes between older African-Americans and older whites. One candidate for intervention is a daily intake of low-dose aspirin.

Inflammation may be a common pathogenic factor in the morbidity and mortality associated with cardiovascular disease, cancer, and dementia. Aspirin is a non-reversible cyclooxygenase (COX) inhibitor with a more preferential effect on COX-1 inhibition than on COX-2 inhibition. The COX-1 enzyme system has been implicated in many chronic diseases. Aspirin binds to the COX enzyme, blocking the conversion of arachidonic acid to cyclic endoperoxides, which are precursors of prostaglandins. Therefore, aspirin alters pro-inflammatory and anti-inflammatory prostaglandins in various tissues.

Aspirin could impact the major drivers of disability in aging, but clinical trials of low-dose aspirin in the primary prevention of cardiovascular disease, cancer, and dementia in middle-aged men and women have produced mixed results. A meta-analysis of five major randomized controlled trials testing aspirin's effects on cardiovascular outcomes showed a 32% reduction in myocardial infarction, mostly in middle-aged men. Cardiovascular protection also was observed in the Women's Health Study with results showing a 17% reduction in the risk of stroke, but not myocardial infarction. Due to aspirin's anti-inflammatory effect, its role in cancer prevention has been studied. Recent trials suggest that aspirin may play a role in preventing some common cancers. In a sub-group analysis of women ages 65-74, the Women's Health Study demonstrated a 22% decrease in the relative risk of all cancer mortality with regular aspirin use. The antiplatelet effect of aspirin has been investigated for its potential to prevent cognitive decline, but the majority of clinical trials have not shown a significant effect.

If aspirin has the potential to maintain disability-free longevity, why don’t primary care providers just tell their healthy, older African-American patients to take a low-dose daily? First, U.S. regulatory bodies have not approved aspirin chemoprophylaxis in primary prevention. A U.S. Food and Drug expert panel decided there was insufficient evidence to recommend aspirin in the primary prevention for all adults regardless of age, gender, or race. Second, the U.S. Preventive Services Task Force concluded that current evidence is insufficient to assess the balance of benefit and harm of aspirin for heart disease prevention in men and women age 80 and older. For men and women ages 45-79, aspirin is recommended if the benefit of prevention (MI in men, stroke in women) outweighs the potential for harm from gastrointestinal bleeding. Third, previous clinical trials demonstrate aspirin’s efficacy in primary prevention of heart attack or stroke, mainly in younger persons. However, studies have not fully addressed the aspirin’s potential preventive effects in cognitive decline and cancer.

There are risks inherent to extrapolating current data to reflect effects in older persons, especially in older African-Americans. While the risk of cardiovascular disease, cancer, and dementia increases in the elderly, the potential harm due to bleeding also increases. The morbidity risk with bleeding is not benign. Gastrointestinal bleeding accounts for hospitalizations in older persons at a rate of 6.8/1000 per year. Intracranial bleeding can be devastating to the well-being of an older person. Second, minority responses may not be the same as non-minority responses for certain pharmacologic treatments, as evidenced by the approval of BiDil for the specific treatment of congestive heart failure in African-Americans. Therefore, we do not yet know if aspirin is safe and effective in older adults.

The time has come for a pivotal clinical trial that evaluates the use of aspirin in healthy older people. ASPREE in Reducing Events in the Elderly (ASPREE) is a multi-center, double-blind, placebo-controlled trial that will randomize 19,000 healthy people age 70 and older (6,500 from the U.S. and 12,500 from Australia) to determine the efficacy of daily low-dose aspirin in promoting disability-free longevity. ASPREE allows us to closely monitor participants randomized to low-dose aspirin or placebo, and to gather data on its safety and efficacy. Individuals who are taking prescribed aspirin, or with a history of bleeding disorders or certain chronic diseases that increase the risk of bleeding or gastric ulcers, will be excluded. Participants will undergo evaluation, including physical exam, blood tests, and cognitive testing, initially and annually, during the five-year treatment period.

ASPREE is currently seeking older African-Americans to participate in this National Institute on Aging clinical trial. African-Americans must participate in sufficient numbers to generate meaningful understanding of aspirin’s potential role in primary prevention. Because primary care physicians are a vital link to older African-Americans, we encourage them to discuss clinical trials such as ASPREE with this patient population.

Dr. Shah is an associate professor in family medicine at the Rush Alzheimer’s Disease Center. He is on the International Steering Committee and Site Principal Investigator at Rush University Medical Center for ASPREE. Dr. Norman was involved in the education and recruitment core at the Rush Alzheimer’s Disease Center and currently is in private practice. Article references are available by contacting Dr. Raj C. Shah at Raj_C_Shah@rush.edu or at 312-563-2902. Information about ASPREE is available at www.aspree.gov or www.clinicaltrials.gov.
Obesity, Diabetes and Brain Function

A complex interaction of factors can lead to brain atrophy and cognitive decline

By Neelum T. Aggarwal, MD

The last few years have seen an unprecedented increase in the number of obese individuals—both adults and children—in the United States. The number is expected to nearly double by 2015. The effects of obesity on overall health have been well documented. What is less commonly reported, however, is obesity’s relationship with brain function and structure.

Obesity has been shown to cause a clear and distinct reduction in brain size—as much as a 2.5% reduction in brain volume compared to those who have a normal body mass index (BMI). The areas that appear especially vulnerable to “obesity-related atrophy” include the hippocampus (memory center), temporal lobes, and frontal lobes. In addition, an elevated BMI of 30 or higher has been shown to be related to a reduction in neuronal bundle length, which is believed to contribute to brain atrophy.

Central obesity, or abdominal obesity, is often determined by waist-hip ratios and has been shown to be associated with brain atrophy. The exact biochemical mechanism by which diabetes can affect the brain is thought to be through key brain structural proteins. Type 2 diabetes can cause damage through excessive glycation of key brain structural proteins. The production of advanced glycosylation end (AGE) products contributes to the development of atherosclerosis in individuals with diabetes due to increased oxidative stress. The interaction of AGE products with smooth muscle receptors causes drastic vascular cell changes such as alterations in vascular tone control. The extensive damage caused by these products on the vasculature in patients with diabetes in turn substantially increases the risk of vascular insufficiency and stroke, in addition to two common markers of neurodegenerative pathology—amyloid plaques and neurofibrillary tangles. How these proposed pathways can lead to brain dysfunction has been the focus of recent clinical trials in both diabetics and non-diabetics that investigated the relationship between factors that lead to decline in cognitive function and mild cognitive impairment.

One such trial, the Study of Nasal Insulin to Fight Forgetfulness, or SNIFF, is already enrolling patients in the United States.

The SNIFF Study

This multi-center, double-blind, placebo-controlled phase II/B study is sponsored by the National Institutes of Health and National Institutes on Aging. The goal is to find out whether a type of insulin, when administered as a nasal spray, improves memory in non-diabetic adults with mild memory impairment or Alzheimer’s disease. Growing evidence suggests that insulin carries out multiple functions in the brain and that poor regulation of insulin (and also glucose metabolism) may contribute to the development of cognitive impairment and Alzheimer’s disease. Therapies aimed at correcting this dysregulation may be beneficial. A total of 250 individuals, ages 55-85, with mild cognitive impairment or early Alzheimer’s disease will be enrolled across the United States.

To learn more, please go to the Alzheimer’s Disease Cooperative Study (www.adcs.org) for a list of participating recruitment sites.

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The incidence of congenital syphilis (CS) in the United States has declined substantially in recent years and the majority of reported cases remain preventable. However, in Chicago, this is not the case. In 2012, a total of 21 cases of CS were reported to the Chicago Department of Public Health (CDPH); a 50% increase compared to 2011. The majority (82%) of mothers giving birth to babies with CS in 2012 were young and African-American (median age 22). Opportunities for earlier maternal screening or diagnosis were missed in 60% of the cases. The majority of cases were reported in nine communities concentrated in the southern and western portions of Chicago.

Perinatal transmission of syphilis can occur at any time during pregnancy and at any stage of the disease. Effective prevention and detection of CS depends on the identification of syphilis in pregnant women. Therefore, the Centers for Disease Control and Prevention (CDC) recommends routine serologic screening of pregnant women for syphilis during the first prenatal visit. However, in communities and populations in which the risk for CS is high, repeated serologic testing and a sexual history also should be obtained at 28 weeks’ gestation and at delivery. Parenteral penicillin G is the recommended treatment for syphilis in pregnancy and prevention of CS cases.

In addition, Illinois state law requires that all pregnant women be tested for syphilis at the time of the first examination, and a second test be taken during the third trimester of pregnancy. All positive blood tests, diagnoses, or treatment for syphilis should be reported to the CDPH no later than seven days after laboratory notification of positive test result.

To enhance surveillance of congenital syphilis, the CDC has released a new congenital syphilis case investigation and report form. As a result, the CDPH STI surveillance unit has also created a revised local congenital syphilis case investigation worksheet, which can be found on the CDPH website at www.chicagohan.org in the document library. The CS worksheet should be completed for all pregnant females delivering newborns at your facility and reported to the CDPH STI Surveillance Unit no later than two days after delivery.

In addition to the surveillance worksheet, CDPH is also educating women, working with health providers to offer training and working with children’s organizations, especially through the use of social media to get the word out. To report a CS case, please fax the worksheet to 312-355-1915. If you have any questions, please contact the syphilis epidemiologist, Irina Tabidze, MD, MPH, at 312-413-8032.

FluMist Replacement Program

The Flumist Because the Quadrivalent vaccine has a short shelf-life, you may have doses that expire before you can use them. The Vaccines for Children (VFC) FluMist Replacement Program allows you to replace unused, expiring FluMist Quadrivalent doses at no cost. MedImmune has contracted with McKesson Specialty Health Distribution to implement the program.

The program will replace unused VFC FluMist doses with expiration dates of Nov. 18, 2013, through Jan. 31, 2014. Doses received more than 15 days prior to the expiration date will not be replaced. Doses will be replaced in increments of 10, the minimum number that can be replaced. Doses from multiple eligible lot numbers can be used to achieve a multiple of 10. Call 877-633-7375 or email medimmunereplacementprogram@mckesson.com to request vaccine replacement.

Once doses arrive at the distribution center, they will be validated against initial requests. If the doses received match the request, replacement doses will ship within 72 business hours. If doses received are in excess of the request, only those replacement doses that were initially requested will be shipped. Additional doses received in excess of the request will not be replaced. Any doses received after Feb. 14, 2014, will not be replaced.

Note: Chicago VFC providers must replace all unused, expiring FluMist even if your practice will not use the vaccine. If you know your practice will not use the replaced FluMist doses, contact Kevin Hansen at 312-746-9330.
HEALTH CARE providers and organizations should be aware of the processes and procedures used when interacting with electronic health record (EHR) systems. Given the exponential expansion of EHR systems, the federal government has started to take action to curb abuses. In September 2012, Secretary Kathleen Sebelius and Attorney General Eric Holder informed five national hospital and health center associations of their concerns about EHR abuse. Their letter to the organizations explains, “there are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled.” The American Hospital Association was quick to respond, arguing that better guidance on these rules would allow hospitals to focus more on care than on potential audits. Despite the response, the federal government continued its investigation of possible abuse.

This creates a dilemma for providers in which upcoding moves beyond a simple billing error to create actual overpayments due to improper billing methods, possibly EHR cloning or inappropriate use of templates.”

The 2013 Office of Inspector General (OIG) Work Plan listed EHR abuse as an area of focus. The OIG stated that it, “will identify fraud and abuse vulnerabilities and electronic health record systems as articulated in literature and by experts and determine how certified EHR systems address these vulnerabilities.” These enforcement measures include increased audits and extensive medical record reviews. In fact, in July 2013, an HHS official, speaking anonymously with a news source, explained that “targeted audits will continue and CMS is considering other steps.”

Cloning Concerns and Possible Abuses

In the letter, Secretary Sebelius and Attorney General Holder stated they have reason to believe that “potential ‘cloning’ of medical records in order to inflate what providers get paid” was occurring. (See “EMR Cloning: A Bad Habit” on page 7 of the November 2013 issue of Chicago Medicine.) Cloning, according to Palmetto GBA, “refers to documentation that is worded exactly like previous entries... [T]his type of documentation will lead to... recoupment of all overpayments made.” Here are two primary examples of how cloning may occur:

Template Example: A mother brings her two-year-old daughter to the local health clinic for a standard well-child exam. The provider copies her generic two-year-old well-child exam template onto the patient’s chart. The copied information states that the provider asked the family about certain symptoms and delivered appropriate patient education for a two-year-old child. However, the provider did not discuss choking hazards for two-year-olds as was documented in the template.

Copy and Paste Example: A patient comes to see a health provider due to a bothersome sinus infection. The same patient returns a week later with similar complaints and with no improvement of the sinus infection. However, at this visit, the patient sees a different provider within the practice. The new provider copies the first provider’s note with no changes.

Both these examples demonstrate how providers and health care organizations may be at risk for government enforcement and, at a minimum, recoupment of all overpayments.

Possible Evidence of EHR and Upcoding Abuses

A Department of Health and Human Services (HHS) report released in May 2012 shows the reason for concern. The report analyzed physician billing from 2001 to 2010, and found that physicians increased their billing of higher-level codes during these years. In particular, the three lowest codes for office visits decreased by 2%, 7%, and 8%, respectively. But the second highest billing code increased 15% over this period and the highest billing code increased 2%. The report concluded that continued education on proper billing must occur and the Centers for Medicare and Medicaid Services (CMS) should encourage contractors to review physician billing for these types of services. The report did not conclude that these billings were inappropriate, just that the increase is suspect.

Farzad Mostashari, MD, who recently resigned as the National Coordinator for Health Information Technology, explained at a hearing that, “we don’t know if the shift reflects appropriate coding or inappropriate coding.” What is clear is that money, resources and time are likely to be spent in an attempt to understand what this means and to curb
fractional activity. Providers, on the other hand, argue that any concerns or trends are the result of more accurate coding through EHRs.

The Risks Health Care Organizations Face
Since the Fraud Enforcement Recovery Act of 2009 (FERA), False Claims Act (FCA) liability has increased immensely. Health care organizations should be particularly concerned that FCA violations may occur due to the retention of overpayments. FERA amended the FCA to impose liability when a party “knowingly and improperly avoids or decreases an obligation.” Obligation is broadly defined to include an established duty arising from the retention of any overpayment. This is commonly referred to as a “reverse false claim” since “knowledge” may not have existed when the claim was filed but became known after the claim was paid. Knowledge, with respect to overpayments, is broadly defined to mean “actual knowledge... deliberate ignorance... or acts in reckless disregard of the truth.” In addition, the definition clearly stipulates that it does not require “proof of specific intent to defraud.”

An overpayment from a federally funded health care program can become an “obligation” under the FCA if the overpayment is not “reported and refunded” within “60 days after the date on which the overpayment was identified.” Identification is not defined; however, there are varying opinions about when an overpayment is “identified.” For example, some experts believe that an overpayment is not identified until the organization knows the amount of overpayment. However, then-New York State Medicaid Inspector General James Sheehan has stated that, “identified for an organization means the fact of an overpayment, not the amount of the overpayment, has been identified.”

This creates a dilemma for providers in which upcoding moves beyond a simple billing error to create actual overpayments due to improper billing methods, possibly EHR cloning or inappropriate use of templates. The case of U.S. ex rel. Keltner v. Lakeshore Medical Clinic, Ltd. (Lakeshore) is a primary example. In Lakeshore, a former employee (the relator) brought a qui tam case against Lakeshore. (A qui tam case is one in which a private individual who assists the prosecution can receive all or part of any penalty imposed).

The relator alleged FCA violations based on audits that highlighted upcoding. The medical group had identified and repaid some of the overpayments, but not all of them. In March 2013, the court denied Lakeshore’s motion to dismiss the case; the lawsuit is still pending.

Lakeshore may be just the first of other legal actions stemming from upcoding that lead to overpayments in which any inaction on the part of people with knowledge of the overpayments may lead to FCA liability.

Solutions to Mitigate the Risk of Upcoding and Other Abuses
• Develop a compliance plan. Medical providers and their counsel should focus on developing compliance plans that include regular internal audits. Often the plan itself is established, but organizations fail to follow through with training, education, and enforcement of disciplinary standards.
• Discuss fraud issues with EHR vendors. Often EHR vendors explain that their system is audit-proof and contains methods to deter upcoding. Providers and counsel should ensure that they have addressed concerns about upcoding, copy and paste, and templates with the vendor.
• Analyze EHR vendor agreements. Counsel for providers using an EHR system should review the vendor agreement. Often these agreements limit the liability of the vendor to the point where the provider may be at risk for overpayments or false claims, even if the auto-coding features installed by the EHR vendor are the primary issue.
• Audit notes and voice-transcribed notes. Organizations should understand the ways in which providers are interacting with their EHR systems. This includes auditing how notes are entered into the system from start to finish.
• If substandard care and upcoding is found in some cases, expand the audit. The Lakeshore case seems to indicate that if an organization knows of upcoding or EHR abuses, there may be an affirmative duty to act upon that knowledge.
• Educate physicians about EHR risks. Physicians are “sold” on EHRs in the belief they will save them time, thus permitting them to be more efficient. Physicians should be educated about fraud risks, including inappropriate use of templates and cloning. Provide examples to make the point.

Beware of Changes: Federal Goals Are Not Static
Attorneys and health care providers should keep abreast of the federal government’s changing aims when it comes to EHRs. The government is doing everything it can to reduce costs, increase transparency, and maintain compliance among entities that interact with federal health care programs.

EHR systems offer huge opportunities to increase care quality, efficiency, and reduce waste. However, understanding the risks and taking a proactive approach to limit liability are a necessity for health care providers given the federal government’s recent focus on potential EHR fraud and abuse.

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MOBILE DEVICES such as laptops and smartphones have become an increasing threat to the security of protected health information (PHI). Back in October, AHMC Healthcare Inc., based in Alhambra, California, reported the theft of two unencrypted laptops containing the PHI of approximately 729,000 patients. Reports of stolen laptops and other mobile devices containing PHI have not been uncommon in recent years. In fact, most breaches of PHI reported to the U.S. Department of Health and Human Services (HHS) are related to the theft or loss of mobile devices.

These types of reports are also not surprising given the rise in the use of mobile device technologies in the health care industry. Two recent studies have shown that health care professionals are increasingly using mobile devices such as smartphones and tablets for clinical purposes. A survey published in August 2013 by the Deloitte Center for Health Solutions found that more than 40% of physicians in the United States use mobile phones to access patient records, write prescriptions, and communicate with other health care professionals. BYOD Insights 2013, a survey conducted by a group of Cisco partner firms, points out that 88.6% of American workers in the health care industry use their personal smartphones for work purposes. Arguably the most troubling finding of the BYOD Insights 2013 study is that even the most basic protocols have not been adopted to ensure the security of these mobile devices. For example, nearly 60% of respondents in the health care industry reported that their smartphones are not password-protected, and more than half of respondents accessed unsecured or unknown Wi-Fi networks with their smartphones.

HIPAA Requirements for Securing Personal Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, the Privacy and Security Rules, as amended by The Health Information Technology for Economic and Clinical Health (HITECH) Act and the recent HIPAA Omnibus Final Rule, specify requirements for securing PHI. The HIPAA Security Rule specifically requires covered entities and their business associates to conduct periodic risk analyses of the potential risks and vulnerabilities to electronic PHI maintained on all their systems, including mobile devices, and to then adopt policies and procedures for addressing the threats and vulnerabilities.

Failing to comply with these security requirements could result in civil penalties of up to $50,000 per violation and a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.

Take the Necessary Steps to Secure Your Mobile Devices

In light of significant penalties under HIPAA for failing to adequately secure the confidentiality and integrity of electronic PHI, failure to comply with security requirements is a huge deal.
Adopt a mobile device management (MDM) system that

- Adopt access control policies that require authentication to access mobile devices, including use of complex passwords with a combination of letters and numbers. Some devices (such as Apple’s iPhone 5S) now offer biometric authentication measures to further secure mobile data from unauthorized access.

- Install or enable encryption on all mobile devices that store or access patient data or other sensitive information. Encryption is particularly important given that lost or stolen encrypted devices do not generally give rise to breach reporting requirements under HIPAA or most state breach reporting laws. Many newer mobile device models now offer full device encryption as a built-in option. This option should be enabled before the health care professional uses the device to access sensitive data.

- In addition to enabling encryption for data on the device, users must also be concerned about encryption for data that is transmitted via the device. Virtual Private Network (VPN) technology should be implemented before sending or receiving protected data via a mobile device. When a VPN is established between the device and a corporate network, all data transmitted between the two is encrypted to protect against interception by an unauthorized third party.

- Finally, SMS text messaging from mobile devices is inherently insecure. Unless text messaging of electronic PHI is expressly prohibited by organization policy, a secure HIPAA-compliant text messaging system should be implemented on all mobile devices with access to this sensitive data. A number of software solutions are available for securing text messaging in accordance with the requirements of the HIPAA Security Rule for electronic PHI.

- Enable or install firewalls to block unauthorized access. Some mobile operating systems have built-in firewalls that users can enable.

- Enable or install mobile security software to protect against viruses, malware, spyware and other malicious applications. A wide range of applications offer different levels of protection. Some features often found in security software applications include the ability to remotely wipe a device (in case of loss or theft); a remote alarm feature; and tracking capability via the device’s GPS system. It is important to keep mobile security software up-to-date.

- Disable or uninstall file-sharing software that can be used to access sensitive information or infect mobile devices with computer viruses or malware.

- Forensically wipe all stored health information before a mobile device is discarded or given to another user.

- Adopt a mobile device management (MDM) system that enforces security measures for all devices that connect to the organization’s network. A typical MDM system will register all mobile devices that seek to access data on the organization’s network; restrict access to non-compliant devices; manage security updates and access rights for user devices; roll-out approved applications; and provide IT administrators the ability to remotely wipe a device if it is lost or an employee is terminated.

**Securing Mobile Devices—More Than Just Good Practice**

Health care organizations and their business associates should remember that securing mobile devices that access or maintain electronic PHI is not just good practice, but is the law. The security measures described above are just a few that a health care organization should consider when adopting policies and procedures to protect PHI and other sensitive information on mobile devices. The Office of the National Coordinator for Health Information Technology (ONC), the federal organization within HHS charged with coordinating efforts to implement and use health information technology, provides additional advice on securing mobile devices on its website at www.healthIT.gov. Additionally, the National Institute of Standards and Technology (NIST) has published Guidelines for Managing the Security of Mobile Devices in the Enterprise (NIST Special Publication 800-124), which is intended to help organizations centrally manage and secure mobile devices. The publication can be found on the NIST website at www.nist.gov. The help you need to secure mobile devices is widely available, so take advantage of it!

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**The Socratic Approach to Learning**

Midwestern University’s new approach to educating future physicians uses a classical Greek method to encourage interactive learning

By Cheryl England

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**H, THOSE FOND** memories of medical school—a classroom or lecture hall filled with overworked students trying to grasp the all-new information the professor is tossing their way. Certainly, it’s effective. After all, medical schools in the United States pump out some of the brightest and most competent physicians in the world.

But in one classroom at the Chicago College of Osteopathic Medicine, Midwestern University, the scene looks a bit different. Small groups of students cluster together, talking animatedly about the case presented to them. Facilitators urge them on, asking open-ended questions, encouraging them to explain the rationale behind their conclusions and exploring whether a different diagnosis might be possible.

Midwestern is in the process of shaking up its curriculum by initiating an interactive teaching method known as Socratic Circles (See “A Socratic Circle Primer” on page 20). Devised by the ancient Greek philosopher, the Socratic Method, from which Socratic Circles are derived, is meant to stimulate critical thinking based on asking and answering questions that challenge beliefs or conclusions. Most experts consider the Socratic Method a positive tool for engaging students.

Currently, the college is using Socratic Circles in clinical classes taught to first-year students and is developing a new curriculum using symptom presentation for the 2014-2015 school year that integrates the Socratic Circle method in all clinical courses. “All sorts of versions of Socratic Circles and similar discussion groups are being used in education,” says Midwestern University-Chicago College of Osteopathic Medicine’s Associate Dean of Clinical Education, Glenn Nordehn, DO. “But, as far as we know, there are no medical schools doing it quite like us.”
**The Search for a Better Way**

Many educational studies over the years have proven that students can adopt either so-called deep or surface learning approaches. Surface learning includes memorizing and regurgitating information for tests whereas deep learning requires a critical understanding of the material. And, it’s also been well-proven that active student participation promotes deep learning.

All of this rings true for Dr. Nordehn, an internal medicine specialist who has been continuously involved in medical education since 1992. “I’ve spent a lot of time watching schools prepare students to become physicians,” he says. “There are a wide variety of ways to do this. I’m looking at our version of Socratic Circles not as an answer to a problem but as possibly a better way to educate our students.”

During his own rotations as an intern and resident, Dr. Nordehn remembers thinking to himself, “How do physicians retain all this information?”

Now, after having read much literature on the subject, Dr. Nordehn firmly believes that when a physician sees enough patients with the same diagnosis these experiences are placed in deep memory by groups. Further, experiences with a group sharing the same diagnosis are placed in a brain location that is readily accessible.

Of course, many groups form. When a new patient presents with symptoms, physical findings, labs and imaging studies, experienced physicians draw upon their memories of previous patient groups and form an analogy that fits in order to create a treatment plan. The ability to draw on previous categorized experiences— analogical reasoning—represents what we call expertise.

The deep, yet readily accessible, memory drawn upon by physicians is based on those patients they’ve already seen. “So I started thinking about the fact that first-year students are learning basic sciences but they aren’t learning them in the context of a patient,” Dr. Nordehn says. “I think that, from day one of medical school, as much of the curriculum as possible should be linked to the patient.” By linking to a patient, the basic sciences could potentially become integrated into the patient analogies that students will draw upon one day when operating at the level of an expert.

Enter Socratic Circles.

**Admission to the Inner Circle**

So how, exactly, do Socratic Circles work in the college’s clinical courses?

The first-year clinical classroom has about 100 students, who are all given some information on a patient, a reading assignment, and objectives.

During the next class, the students are divided into groups of 10. Each group discusses a question specifically tailored by the facilitator to reinforce the learning objectives. The 10 groups are termed “outer circle” groups. Then, each outer circle group selects one representative. The representatives gather in the center of the room, forming what is called the “inner-circle.” The instructor then facilitates a discussion around a question—only the instructor and students in the inner circle are involved. In this example, the instructor may ask the inner circle, “What diagnosis do you believe is correct?” Following the traditional Socratic style of discussion, the facilitator makes sure that everyone gets a chance to speak and no one dominates the conversation—essentially following common sense rules for politeness during group interactions.

The inner circle group then discusses the question at hand, referring to reading materials for their rationales, and eventually reach a decision on whether the patient has, say, condition A or condition B. The facilitator, again acting in a manner befitting the Socratic Method, probes—“You think it is A, but can you see how it could be B?” The goal is for the groups to look at both sides.

A detailed discussion among 10 people is much easier and more effective than a discussion among 100. Often, the groups go back and forth between the inner and outer circles as new information is brought up and new challenges arise.

Here’s a typical example of how a trail of questions might flow within the circle formation. The facilitator asks the inner circle, “What’s a likely diagnosis?” The inner circle reaches a consensus that the patient has had a stroke. The facilitator, to

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**A Socratic Circle Primer**

**BASED ON** the Socratic Method, the Socratic Circle is an educational approach that encourages ongoing discussion to understand information in a text. The process examines a text through questions and answers founded on the belief that all new knowledge is connected to prior knowledge, that all thinking comes from asking questions, and that asking one question should lead to asking other questions. The process is also based on the belief that students gain deeper understanding of concepts through discussion rather than memorization. The goal is for students to work together to arrive at a well-reasoned answer.

Socratic Circles can differ widely in structure, although they typically involve the following components: reading material that students must complete before the exercise and two concentric circles of students—an outer circle and an inner circle. The inner circle analyzes the text through questions and answers while the outer circle listens to the conversation of the inner circle and absorbs the discussion. When the inner circle has finished its discussions, the outer circle offers feedback.
foster critical thinking by having the group consider the other side, may follow up by asking, “Is there any reason to think it is not a stroke?” The facilitator may then ask, “What should you do to treat the patient?” at which point the 10-person groups re-form to answer this new challenge. The inner circle group re-forms and may decide the treatment is Drug B. The facilitator may then state “Not everyone uses Drug B. Why might that be a problem?”

While it may sound as if the goal is for the group to achieve consensus, that’s not true at all. The goal is for students to retain the material better and improve their ability to think critically and look at different sides of a condition. Certainly, some students will walk away thinking they would have done something slightly different based on their understanding. “Do we want consensus?” Dr. Nordehn asks. “No, we want suspense.”

The “Stickiness” Factor
For Dr. Nordehn, the way Midwestern approaches Socratic Circles has many advantages beyond the development of critical thinking skills. For example, students are required to actively prepare for class where the material is then reinforced. And, of course, a big bonus is that the material is always related directly to a patient. “In a lot of schools,” he says, “students are separated into small groups with different instructors. Here, everyone is in the same room so everyone hears the same information, making exams and access to resources more fair.”

Students, too, respond well. For shyer students, the opportunity to contribute in smaller groups with their peers allows them to listen more closely to discussions than if they were too busy worrying about performing in, essentially, a public debate. And, if at any time during the circle formation a member of the outer circle has something to contribute to the inner circle discussion, that person can simply hand the inner circle representative a note or a highlighted passage from the assigned reading. For the inner circle, many relish the opportunity to discuss issues publicly with their peers, the instructor, and the facilitator.

Dr. Nordehn acknowledges that the stakes are higher for students in this setting since they are simulating the treatment of a patient. "But they are very engaged," he says. “For many people, the attention span is not as long as the length of time that lectures in medical schools typically run.”

In addition, the material learned in the class sticks—Dr. Nordehn says that many students spend less time outside of class studying the material covered in the interactive sessions. He attributes this to the required preparation for class, the interactive nature of the class, and an element of the Zeigarnik effect, which was named after Bluma Zeigarnik, a psychologist who contributed to the establishment of experimental psychology in the Soviet Union after World War II. The Zeigarnik effect states that people remember uncompleted or interrupted tasks better than completed tasks.

There are varying accounts of how Zeigarnik stumbled upon her theory but basically she was in a restaurant when she noticed that waiters more easily remembered customer orders that were in progress than orders that had been completed. In the case of Socratic Circles, students are left with somewhat unfinished business. Since they had a chance to look at different sides they had an opportunity to question the decisions made. “If you have enough non-closure,” says Dr. Nordehn, “then you will remember better.”

It Takes a Team to Create a Course
While Dr. Nordehn has been a driver behind the Socratic Circles method of learning and is in charge of the curriculum change at the Chicago College of Osteopathic Medicine, he hasn’t done it alone. Dean Karen Nichols, DO, has been an especially strong supporter. “We’re responding to the needs of the medical student today,” she says. “The traditional medical school approach of attending a lecture, taking notes, and then taking an exam, has put our education methods behind.”

Clinical course directors Brian Poustinchian, DO, and Frank Serrecchia, DO, took on the task of implementing the Socratic Circles method in this year’s first course—no small task. John Graneto, DO, chair of clinical integration and director of the master faculty series program, took another step when he combined Socratic Circles and Twitter at a faculty development course he leads. During the course, the outer circle could tweet to the inner circle.

Whether social media will be implemented in student classrooms remains to be seen. However, discussions are already taking place about the use of technology. For example, in one scenario, students might request that a session be recorded and put online. “We are definitely thinking about making sessions available online if they are edited for the sake of efficiency,” says Dr. Nordehn.

A Bright Future
While Dr. Nordehn is quick to point out that the results of his specific style of the Socratic Circles teaching method are not yet known, he is optimistic that the outcomes will improve since research supports the value of student engagement in the classroom. Dr. Nichols agrees. “Brain scans have shown that learning is enhanced when students are put on the spot and don’t know exactly when they will be asked to participate.”

And as for Dr. Nordehn, it all comes back to the patient. “A significant portion of a physician’s memory has to do with knowledge of past patients,” he says. “People remember people better than they remember information in textbooks. The Socratic Circles style of symptom presentation ensures that students can tie the information they are asked to remember to a patient. Our curriculum is linking information to patients from day one.”

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As healthcare facilities brace for an influx of millions of patients with the ability to pay for medical treatment in 2014, physicians are more in demand. A new analysis by doctor staffing company AMN Healthcare shows physician vacancies in 2013 was at a rate even higher than that for nurses, a field long known for periodic shortages. With the implementation of the Affordable Care Act, the trend is expected to continue, as millions of Americans become eligible for subsidies to buy private insurance in addition to those who will gain access to coverage through the expanded Medicaid program.

In its 2013 survey of hospital executives across the United States, AMN reported the vacancy rate for physicians at hospitals was 17.6% in 2013 while the nurse vacancy rate was 17%. The vacancy rate for doctors is nearly double the 10.7% rate hospitals experienced in 2009 when nurses were also in short supply. At that time, four years ago, hospitals reported vacancies for nurses at just 5.5%. The sampling for the AMN analysis included responses from hospitals in Illinois and the Chicago area, where hospitals say they are aggressively recruiting doctors, particularly in the primary care field, as well as nurse-practitioners, physician assistants, and allied health professionals.

“Doctor staffing company AMN Healthcare says physicians are “by far” the most difficult type of health care professional to recruit, followed by nurses, physician assistants, and nurse-practitioners.”

“No matter what models of care are in place, it takes physicians, nurses and other clinicians to make them work, and the fact is we simply do not have enough of them,” AMN Healthcare President and Chief Executive Officer Susan Salka said. “Change in health care is a continuous evolution, but the one constant is people.”

The Physician as Quarterback
The employment picture for doctors becomes a key issue as the Affordable Care Act and pressure from insurance companies and employers to control costs create a shift away from fee-for-service payment of doctors to approaches that emphasize more accountable care and treatment based on quality and outcomes. Most of these new models use primary care doctors as a quarterback of sorts, calling plays with nurse-practitioners and physician assistants who assist in basic care and reach out to patients, making sure they are taking their medications, eating properly, and adheiners to doctors’ orders. Nurse-practitioners and physician assistants also work in concert with doctors and have the ability to do physicals and prescribe medications, among other treatments, with physician guidance.

But nurse-practitioners and physician assistants are also in short supply with hospital executives seeing a vacancy rate of 15%, according to the AMN Healthcare survey. The vacancies, combined with the need for more physicians, have become a critical issue. More than 70% of the hospital executives who responded to the AMN survey said clinical staffing is a “top strategic priority.” This is in sharp contrast to a 2009 survey when just 29% said staffing was such a priority.

What’s more, hospital executives see the health care provider shortage as persisting. The AMN said physicians are “by far” the most difficult type of health care professional to recruit, followed by nurses, physician assistants, and nurse-practitioners. Nearly 80% of hospital executives said there are shortages of physicians, followed by 66% who believe there is a nurse shortage, and 50% who believe there is a shortage of nurse-practitioners and physician assistants.

“Cost is the health care workforce issue of most concern to hospital executives, though they also find physician/hospital alignment, the move to quality-based provider compensation, high vacancy
rates, and the influx of insured patients through the Affordable Care Act to be of concern,” AMN Healthcare said in its report.

The Impact of Medical Homes
There are many reasons for the void in the number of doctors, according to AMN’s Salka and health care executives interviewed for this story. Salka said an improving economy can explain part of the reason for vacancies but there are other issues such as an aging clinical workforce—particularly physicians—and the impact of health care reform. “We are expanding access to health care and restructuring the delivery system to improve quality and reduce costs at the precise moment a wave of physicians and nurses is set to retire,” Salka said. “It will take collaborative and innovative new staffing models to ensure our workforce is aligned with the goals we all want to reach.”

To be sure, more doctors are being asked to take on quarterback-like roles and handoff duties to nurse-practitioners and physician assistants, particularly since several studies show that a shortage of primary care doctors looms. Some recent research indicates new models such as patient-centered medical homes, accountable care organizations, and “nurse-managed” health centers “could help eliminate 50% or more of the primary care physician shortage” in the U.S. by 2025, according to a November study by the RAND Corp. in the journal Health Affairs.

With accountable care programs, the insurer contracts with some providers that are forming patient-centered medical homes whereby physicians are paid to encourage patients to get medical care upfront in the clinic, health center, or doctor’s office where costs are lower than in a hospital, particularly an emergency room.

More than 40% of hospital executives say they are paying physicians based on the quality of care they provide, and an increasing number (8%) are paying nurses based on quality and outcomes, the AMN survey said.

Health plans are also linking to accountable care organizations (ACOs), which reward providers for working together to improve quality and to control costs. Most private health insurance companies such as UnitedHealth Group, parent of United Healthcare of Illinois, and Chicago-based Health Care Service Corp., parent of Blue Cross and Blue Shield of Illinois, are linking with ACOs and patient-centered medical homes.

“If nothing changes in the delivery of primary care, the United States may face a substantial shortage of primary care physicians and surpluses of nurse-practitioners and physician assistants by 2025,” RAND researchers wrote. “Yet plausible shifts in primary care delivery models substantially affect those projections,” RAND researchers said. “Increases in diffusion of the medical home and of the nurse-managed health center would both work to reduce demand for physicians.”

The War for Talent
But hospitals participating in the AMN study said doctors will have plenty of opportunities. “There is a war for talent and there are underpaid physicians today,” said Sean Gregory, president of Health First Holmes Regional Medical Center, a 400-bed hospital in Melbourne, Florida, that works with AMN. “Being in demand will be good for doctors. We are actively hiring and building up cores of physician assistants, nurse-practitioners, and primary care doctors.”

“The employment picture for doctors becomes a key issue as the Affordable Care Act and pressure from insurance companies and employers to control costs create a shift away from fee-for-service payment of doctors to approaches that emphasize more accountable care and treatment based on quality and outcomes.”

In Chicago, the largest community hospital systems such as Advocate Health Care, NorthShore University HealthSystem, and Presence Health all report an uptick in hiring doctors and other primary care professionals. Presence and Advocate, in particular, have been early adopters of the ACO model, contracting with Medicare to care for populations of patients. “As the paradigm shifts in health care, we do foresee a growth in primary care physicians due to the advent of patient-centered medical homes and health care exchanges among other new initiatives,” said Bonnie Kriescher, vice president of human resources for physician and ambulatory care at Advocate Medical Group.

Advocate and other providers also say they see other medical care providers with changing and, in some cases, expanding roles. “We anticipate a shift in the registered nurse’s role in the future given the increased focus on the outpatient environment,” Kriescher said. “We believe we will also need to increase the number of nurse-practitioners and physician assistants in office settings. This means every one of our licensed professionals will need to work at the top of their licensure to ensure we accomplish an integrated team care approach in support of population health.”

Bruce Japsen is an independent Chicago health care journalist and writer for Forbes magazine and contributor to the New York Times. He is also a regular television analyst for WTTW’s Chicago Tonight and radio analyst and commentator for several radio programs including WBBM radio 780-AM and 105.9 FM. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com.
MEMBERS of the academic community gathered on Dec. 7 for the Midwest Residency Program Directors’ Meeting in Oak Brook, an annual event hosted by the Illinois State Medical Society and Chicago Medical Society. Participants heard from a national panel of experts on the rapid evolution of Graduate Medical Education (GME). Technology, quality and patient safety issues, and regulatory requirements are reshaping the learning environment, along with the responsibilities of educators.

Now going into its sixth year, the meeting shifted from Chicago to the western suburbs to accommodate physicians from surrounding states. Between information-packed lectures, held on the McDonald’s Hamburger University campus, attendees were able to network and socialize. The event offered up to 3.5 AMA PRA Category 1 Credits.

Here’s a recap of the sessions:

**Protecting Patients**

This hard-hitting presentation offered approaches to dealing with disruptive behavior in the hospital setting, with panelists representing the regulatory, institutional, and clinical points of view. While most trainees become caring and competent physicians, personal issues sometimes interfere with the fast-paced learning environment. Working under someone with a short fuse can complicate the problem, setting off a chain reaction of events.

These complex situations must be dealt with promptly. “Early intervention is critical so that medical residents are prepared to grapple with daily challenges when they complete the program,” Bryan Becker, MD, chief executive officer of the University of Illinois Hospitals and Clinics, advised participants.

Stress is increasingly linked with behavior that compromises team function and patient care. Both hospitals and medical societies have responded with wellness committees. These nurturing environments offer support and coping mechanisms. Like practicing physicians, trainees benefit from a culture of compassion. “Being punitive drives the problem underground,” Daniel Angres, MD, a psychiatrist with Presence Behavioral Health, emphasized. He notes that financial worries, anxiety over health care reform, and increasing workloads challenge the medical profession as never before. A “tough love” approach to disruptive behavior results in excellent treatment outcomes, Dr. Angres said.

On the regulatory side, a highly publicized case this year helped spur new provisions to the Illinois Medical Practice Act. The changes protect residency programs and patients through new reporting requirements, according to the IDFPR’s Jay Stewart, director of the Division of Professional Regulation, and program speaker.

The law now requires program directors to report all separations to the disciplinary board.
The requirement applies to any resident who leaves any post-graduate clinical training program for any reason prior to completing the program. Revisions to the residency application will now ask questions about separation, according to Stewart. Moreover, the withdrawal of any application for a license or permit must be reported to the Federation of State Medical Boards if the applicant receives notice of intent to deny one.

The New World of Accreditation
In this nuts-and-bolts talk, participants heard about the ongoing implementation of the Next Accreditation System (NAS), and the appropriate steps for teaching institutions as they transition to the new system. NAS will reshape medical education for years to come.

Outcomes are the highest priority under this new order, Patricia Surdyk, PhD, of the Accreditation Council for Graduate Medical Education (ACGME), explained to the audience. The accreditation body will relentlessly promote outcomes, judging clinical competence by “doing,” not “knowing,” Dr. Surdyk said. What’s more, “the new clinical learning environment won’t be about conferences, lectures, or processes; it’s about integrating students into the clinical environment and integrating systems,” she said. Dr. Surdyk is executive director of the ACGME’s Institutional Review Committee.

Public accountability is another key feature of the new accreditation system. NAS will assess residents for meeting performance measures, including milestones, as they progress toward independent practice, Dr. Surdyk explained. The Clinical Learning Environment Review (CLER) evaluates how well U.S. teaching hospitals engage residents in the following six areas: patient safety; health care quality, including reduction in health care disparities; transitions in care; supervision; duty hours and fatigue management and mitigation; and professionalism.

CLER site visits have begun at all ACGME-accredited sponsoring institutions. These visits aim to encourage improvement in residents’ mastery of the six focus areas. The CLER program is a key component of the NAS, and every medical school will have CLER visits, Dr. Surdyk said.

The new responsibilities for educators will make their work easier in the long-term, she predicted. In addition to generating national baseline data to guide performance improvement, the ACGME hopes the CLER program will provide a new source of feedback for teaching institutions. “With annual data submission and annual institutional visits, improvement becomes a continuous process,” Dr. Surdyk explained.

Sharing her enthusiasm with the audience, Dr. Surdyk remarked that, “one can’t be pessimistic and be a teacher at the same time.” While the new accreditation system is a big adjustment, Dr. Surdyk said she could not be more optimistic about the future of medical education.

Harnessing Social Media
The University of Chicago Medicine has learned to make the most out of social media, according to several speakers from the internal medicine residency program. In this insightful look at the role of social media in medical education, participants learned how to implement a strategy for appropriate use by faculty and medical trainees.

Though not without pitfalls, social media has the power to connect, inspire, and inform. As such, it can be used to advance residency training. With patients and health care providers moving into the Twittersphere, the U of C reversed its decision to block the microblogging service, recognizing that faculty and house staff need this powerful tool. Twitter sends microblog messages of 140 characters or less to followers. The residency program is now linking to multiple social media platforms, including Facebook, Instagram, and RSS feeds, assistant program director, Vineet Arora, MD, reported.

Chief residents Paul Bergl, MD, and Akhil Narang, MD, described the many uses of Twitter in education. For medical trainees, who are constantly...
Sample Social Media Policies

Various organizations offer sample social media policies and tutoring. The Association of American Medical Colleges (AAMC), for one, offers a digital literacy toolkit in addition to policies. Both the Accreditation Council for Graduate Medical Education (ACGME), and the Federation of State Medical Boards (FSMB) post online social media policies.

The AAMC language reads: “all trainees with a public position are ambassadors for their institutions. The right to publish and converse publicly as a doctor comes with a responsibility. Trainees bear the responsibility of seeing that their content/dialogue is in-line with the expectations of their schools and programs.”

The FSMB policy for physicians addresses three areas: confidentiality, privacy, and boundaries.

A joint position paper from the American College of Physicians and the FSMB states: “Consider the content and the message it sends about a physician as an individual and the profession. Maintain separate personas, personal and professional, for online social behavior. Scrutinize material available for public consumption.”
Health Care in 2014: Up in the Air

More questions than answers exist

By Eldon A. Trame, MD

As Illinois physicians ring in the new year for 2014, the confetti drifting over Times Square is not the only thing that’s “up in the air.” Though the Affordable Care Act (ACA) is supposed to bring answers for many patients who previously did not have access to affordable health coverage, it has so far brought many more questions for the physicians they will be calling upon to treat them and keep them healthy.

The rocky rollout of Healthcare.gov, the federal government’s health insurance exchange website, has been well publicized and has done little to inspire confidence. As the trickle of consumers buying plans on the state and federal exchanges turns into a stream, physicians are wondering where they fit into the new health care landscape.

A few of the unknowns keeping physicians awake at night:

“What new networks will I be in? Will I be dropped from others? And how will I know?”

As health insurance carriers have scrambled to assemble and price policies that meet the various requirements for the new health insurance exchanges, physicians have been largely left in the dark as to their status in the various networks associated with these plans. The announcement that insurance carriers may continue to offer plans that do not meet the ACA’s requirements through 2014 will further complicate matters, as it is uncertain whether or how carriers will be able to reverse course on cancellations that had already been sent to patients.

“How will this change my billing practices? Will I end up sending more bills to collections?”

Many patients who purchase coverage on the exchanges or are newly eligible for Medicaid have never had health coverage before. They may believe that they are entitled to free health care, or have other misconceptions that could lead to payment headaches. Others may be unfamiliar with how health insurance works, and have difficulty navigating the different services and levels of coverage their new plans include. The high deductibles that come with many plans may also be a shock to patients, potentially leaving physicians holding the bag if they are unable to pay.

“What about Medicaid? How will the move toward a managed care model impact my bottom line?”

Illinois policy makers are in the process of crafting a waiver application that would allow Illinois more flexibility in trying new approaches in the Medicaid program that differ from federal rules. This waiver application will be centered around an expansion of our state’s existing Medicaid managed care system. Though the application has not yet been finalized, many physicians are concerned that their reimbursements under Medicaid, which already fall short of economic sustainability, could sink even lower.

“Will the Affordable Care Act increase the temptation for policy makers to look to allied health professionals instead of physicians to increase access to care and bring costs down?”

The pressure to save money at every level of our health care system has never been stronger, and it affects stakeholders at all levels—from nursing assistants to members of Congress. The unfortunate truth is that this pressure sometimes results in decisions that seem to prioritize cost savings over quality of care and even patient safety. ISMS is constantly working to maintain the proper balance between cost-effectiveness, quality and safety, and while the Affordable Care Act may present some new challenges in this area, we stand ready to meet them.

You have probably noticed that even this article has raised more questions than it has answered. That’s because the answers to most of these questions are not yet known, and even where they are known, at least in theory, they often have yet to be seen in actual practice. Fortunately, ISMS is committed to helping our members cope with this uncertainty and stay abreast of the latest developments.

A town hall conference call will be held at 7:00 p.m. on Monday, Feb. 3, to hear from physicians about their concerns related to the Affordable Care Act. ISMS will then use this physician feedback to shape an educational program at the 2014 ISMS House of Delegates meeting in April, and to continue to provide educational opportunities and materials as the year (and the law’s implementation) progresses. Please visit www.isms.org for information on how to register for the call.

Watch your inbox for more details and remember: ISMS’ Division of Member Advocacy is always at the ready to answer your questions. Call 800-782-4767, ext. 1470, or email advocacy@isms.org any time to let us know what ISMS can do for you.

Dr. Trame is the 170th president of the Illinois State Medical Society.
Illinois Weighs in on SGR, ICD-10, Insurance Exchanges

CMS members contribute at the AMA interim meeting

“The AMA will study current tools and develop metrics to measure physician satisfaction.”

CHICAGO MEDICAL Society (CMS) physicians joined their colleagues from across the country for the American Medical Association’s interim meeting on Nov. 16-19. As Illinois Delegation constituents, CMS members regularly advocate for patients and their peers back home through debate and testimony on critical issues. Each year, the Illinois Delegation advances proposals from grassroots members, many of which go on to inform new policies and action directives by the AMA.

The interim meeting took place in National Harbor, Maryland, only a stone’s throw from Capitol Hill. This close proximity allowed physicians to pay quick visits on their lawmakers to urge their support for SGR repeal, among other issues. The policymaking body meets twice a year. The AMA Annual Meeting is scheduled for June 7-11, 2014, at the Hyatt Regency Chicago.

While space does not allow us to report on all those measures adopted, here are highlights:

FOR PHYSICIANS
Medicare Payment Reform: The AMA will push for full Sustainable Growth Rate (SGR) repeal and continue to press for positive updates based on the AMA’s pay-for-performance principles and guidelines. The AMA will also encourage the development of alternative payment models, including private contracting options.

Medicaid Expansion: The AMA will advocate at the state level for the expansion of Medicaid eligibility to 133% of the Federal Poverty Level and for an increase in Medicaid payments to physicians. The AMA will also call for improvements and innovations in Medicaid that will reduce administrative burdens and deliver health care services more efficiently.

Payments of Penalties to Physicians for RAC Audits: The AMA will advocate for penalties and interest on Recovery Audit Contractors (RACs), payable to the physician when a RAC audit or claim appeal has been found in favor of the physician. The AMA will also continue to oppose the contingency fee compensation structure that encourages Medicare audit contractors to overreach. With an inaccuracy rate approaching 50%, RAC determinations are overturned nearly 50% of the time, according to the AMA.

ICD-10 Implementation: The AMA will continue to advocate for delay or cancellation of implementation. In addition, the AMA will seek federal funding to ease the financial burden on physician practices struggling with the costs of implementation, upgrades, and staff training. These policies were adopted in response to the Oct. 1, 2014, implementation deadline for the ICD-10 code set.

Health Insurance Exchange and 90-Day Grace Period: The AMA will: oppose mandatory physician participation in health insurance exchanges; support insurance ID cards that contain contact information for verifying eligibility and coverage; support a guarantee that authorization of eligibility and coverage will result in payment for services provided; oppose the preemption of state law by federal laws governing the federal grace period for subsidized health benefit exchange enrollees; and support the suspension of coverage in months two and three of the federal grace period for subsidized health benefit exchange enrollees who fail to pay premiums.

Use of Claims Data as Quality Measures: The AMA will strongly urge insurance companies to not use claims or other administrative data as the sole determinant of quality of care rendered or physician payment.

Principles to Guide Health Care Teams: The AMA adopted a set of principles to guide physician health care team leaders.

• Physicians who lead team-based care in their practices should be paid for services provided by the team; physicians should establish payment disbursement mechanisms that foster physician-led team-based care.

• Physicians should determine payment disbursement based on team members’ contributions, their profession, training, and experience, as well as volume, intensity, and quality of care.

• Payment systems should reflect the value provided by the team; savings accrued should be shared by the team.

• Payment systems should reflect the time, effort, and intellectual capital individual team members provide; payment should be adequate to attract team members with appropriate skills and training to maximize team success.

Definition of Physician-led Supervision: The AMA officially defined the term “physician-led” in the context of team-based health care: “The consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of contributions needed to help patients achieve their care goals.”

Graduate Medical Education: The AMA will study the effect of the ever-increasing number of
Match program participants against the stagnant growth of U.S. residency positions. The policy requires a report at the AMA Annual Meeting in June 2014. A second policy calls upon key stakeholders to explore the feasibility of extending residency programs through a pilot study that places medical graduates in integrated physician-led practices. In addition to increasing residency opportunities, the pilot also would increase the number of physicians providing health care access.

**Physician Satisfaction:** The AMA will study current tools and develop metrics to measure physician satisfaction. Findings from a recent RAND Corp. study sponsored by the AMA show that being able to provide high-quality health care is a primary driver of job satisfaction among physicians, and obstacles to quality patient care are a source of stress for doctors.

**PUBLIC HEALTH**

**Health Insurance Cancellations:** The AMA will work to ensure that individuals may renew or extend their insurance policies until comparable and affordable alternatives are made available through the Healthcare.gov Exchange. (As a result of the Affordable Care Act, millions of individuals received cancellation notices from their health insurers.) This effort calls for the AMA to work with the Obama Administration, U.S. Congress, and the Centers for Medicare and Medicaid Services.

**Opioid-Associated Overdoses and Deaths:** The AMA will develop a set of best practices to inform clinical use of these drugs in managing persistent pain. The policy also calls for the CDC to collect more robust data on unintentional opioid poisonings and deaths to develop appropriate prevention solutions.

**Streamlining Prescription Refill Schedules:** The AMA will encourage relevant organizations to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce travel barriers.

**Gun Violence:** The AMA will strongly urge U.S. legislators to fund further research at the national level into the epidemiology of risks related to gun violence.

**Expanding FDA Authority over Nicotine Delivery Products:** The AMA will urge the FDA to extend its tobacco regulations to include all non-pharmaceutical tobacco and nicotine products, including e-cigarettes, pipes, cigars, and hookahs.

**Culturally, Linguistically Competent Care:** The AMA will encourage greater cultural and linguistic competence when working with ethnic communities, including partnerships with ethnic community organizations, health care advocates, and media outlets.

**Legalizing Marijuana:** The AMA reaffirmed its opposition to marijuana legalization, but also endorsed a review of the “risks and benefits” of new legal markets in Colorado and Washington. The AMA will support “modification of state and federal laws to emphasize public health-based strategies to address and reduce cannabis use.”

**Modern Chemical Controls Policy:** The AMA will call on Congress to modernize the Toxic Substances Control Act (TSCA) of 1976, the only major environmental law that has never been updated since its adoption. The TSCA does not currently require toxicological testing of chemicals before they are used, and many toxic chemicals are in use today. Dangerous chemicals disproportionately affect vulnerable populations.

**Stricter OSHA Standards:** The AMA will support a proposed OSHA rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica (a fine dust used as an abrasive blasting agent in industries including mining, sandblasting, and construction.) Research has shown that exposure to respirable crystalline silica leads to significant respiratory disease, including silicosis, the AMA stated.

**Access to Screening for Disabled People:** The AMA will work with the National Council on Disability, the U.S. Department of Health and Human Services, and related agencies, to promote equitable access to health preventative screenings for disabled individuals.

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**Acclaim for Young CMS Members**

“**HEALTH CARE Reform Debate,**” a panel discussion hosted by the UIC College of Medicine, earned the AMA Medical Student Section’s November “Event of the Month” award. The Sept. 5 debate featured Robert Wah, MD, AMA president-elect; Claudia Fegan, MD, former president of the Partnership for a National Health Program; William Werner, MD, former president of CMS and ISMS and former assistant dean of the Chicago Medical School; and Ram Krishnamoorthi, MD, state director of Doctors for America. The monthly award recognizes recruitment, community service, education and AMA-MSS National Service Project events coordinated by individual AMA medical student sections.

Panelists reviewed the history of health care reform and the reform work that remains to be done. Discussion also focused on the best means of educating medical students about reform and the health care system throughout their careers. The debate was open to UIC medical students, residents, faculty, and the public. The AMA provided funding for dinner at the event.

In other news, CMS resident member Tina R. Shah, MD, is now chair-elect of the AMA Resident and Fellow Section. She takes office in June 2014. Dr. Shah is focusing on pulmonary medicine at the University of Chicago Medicine.
**Calendar of Events**

### JANUARY

10 **CMS Public Health Committee General Meeting** This meeting is intended for committee members, but is open to interested CMS members as well. 4:00-5:00 p.m.; conference call. To RSVP, please contact Liz at 312-329-7335; or esidney@cmsdocs.org.

14 **Winter Networking Night** Please join the Chicago Medical Society’s Medical Student District, Resident District, and Young Physicians Group at this annual gathering. Heavy appetizers and open bar included. 8:00-10:00 p.m. (Registration at 7:30 p.m.); Rock Bottom Brewery, One W. Grand Ave., Chicago. For information, please contact Meredith 312-670-2550, ext. 326; or oney@cmsdocs.org.

15 **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.; online. Questions, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

15 **Chicago Gynecological Society—OB-GYN Jeopardy** Residents from Chicago-area institutions will compete against each other in this annual event. Program directors and CGS members, respectively, will judge as well as compete against each other. Prizes are awarded to the winning resident team. 6:00 p.m. registration; 6:45 p.m. Jeopardy competition. Maggiano’s Banquets Chicago, 111 W. Grand Ave., Chicago. Members may attend for one dinner credit, guests $75. To RSVP, please contact Megan at 312-329-7332; or mwhalen@cmsdocs.org.

### FEBRUARY

1 **Polish American Medical Society 64th Annual Physicians’ Ball** TBA; Ritz-Carlton, Chicago. Please call 773-792-0209 or go to www.zlpchicago.org.

3 **Resolutions Reference Committee** This committee considers resolutions submitted by CMS members and makes recommendations on these resolutions to the Governing Council. 7:00 p.m.-8:30 p.m. In person/teleconference (Go-to-Meeting); Chicago Medical Society, 33 W. Grand Ave., Chicago. To RSVP, please contact Liz at 312-329-7335; or esidney@cmsdocs.org.

8 **Advanced Cardiovascular Life Support (ACLS) Recertification Course** Intended 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. Unlike BLS (Basic Life Support), which doesn’t require complex and extensive education and training, 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 (AHA). Speaker(s): Vemuri S. Murthy, MD, Program Coordinator and Teaching Faculty, Resurrection Healthcare Training Center, Chicago, and Dennis McCauley, EMT-P, Course Director, Training Center Coordinator, Resurrection Healthcare Training Center, Chicago. Schedule: 8:30 a.m.-4:00 p.m.; Chicago Medical Society, 33 W. Grand Ave., Chicago; up to 7.0 CME credits; CMS member or staff: $175; non-member or staff: $225; residents: $135. To RSVP, please visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

18 **CMS Board of Trustees Meeting** Meets every other month to make financial decisions on behalf of the Society. 5:00-6:00 (prior to the Council meeting); Maggiano’s Banquets, 111 W. Grand Ave., Chicago. Please contact Ruby at 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

### MARCH

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.; online. Questions, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

### APRIL

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

### MAY

14 **CMS Executive Committee Meeting** Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; online. Questions, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.
**Personnel Wanted**

MD at Home is a growing practice of physicians specializing in house calls to geriatric and disabled patients. We are seeking a full-time physician for the Chicagoland area. Please email your CV to Ipavelchik@MD-athome.com or call Lou Pavelchik 312-505-1995.

Physicians needed part-time in all specialties including: anesthesia, urology, ob-gyn, and gastroenterology for family planning centers in the northwest and western suburbs of Chicago. Please send CV by fax to 847-398-4585 or by email to administration@officegci.com.

Outpatient surgical center looking for part-time physicians in the following specialties: urologist to perform vasectomies, cystoscopies, TVT/TNT, and other minor procedures; gastroenterologist (GI); infertility specialist. Located in northwest suburbs of Chicago. Please send CV by fax to 847-398-4585 or by email to administration@officegci.com.

Outpatient surgical facilities/family planning centers looking for a gynecologist, urogynecologist or family practice physician with women’s health specialty to perform various procedures. Located in northwest and western suburbs of Chicago. Some travel between centers may be required. Please send CV by fax to 847-398-4585 or by email to administration@officegci.com.

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

For sale: 3,195 sq. ft. fully built-out medical condo in Doctor’s Building on St. Alexius Medical Center Campus in Hoffman Estates, Ill., just off I-90. Contact Olivia Czyzynski, Sperry Van Ness: 312-676-1862.


**Business Services**

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Organized Medicine Crucial to Her Practice
Anesthesiologist at the forefront of care

By Scott Warner

The U of C’s Tripti Kataria, MD, earned a master’s degree in public health from Harvard University to better understand the “business of medicine.” She found her education most helpful when she later served as an advisor from the American Society of Anesthesiologists to the AMA/Specialty Society Relative Value Scale Update Committee; she helped to establish policy on physician Medicare reimbursement.

ONE THING Tripti Kataria, MD, doesn’t do is put people to sleep when she talks about her specialty, anesthesiology. “It’s like that line from the Wizard of Oz—‘Pay no attention to that man behind the curtain,’ she says. “Well, we’re not just the ‘man behind the curtain’—or simply ‘in the operating room’—anesthesiologists are perioperative physicians; we’re there for physicians and their patients before, during and after surgery.”

An assistant professor in the Department of Anesthesiology and Critical Care at the University of Chicago, Dr. Kataria spends significant time teaching residents in two settings: at the U of C’s Duchossois Center for Advanced Medicine operating room, focusing primarily on the clinical aspects of anesthesia; and in the Anesthesia Perioperative Medicine Clinic, showing residents that they are perioperative physicians as well; that they are involved in the coordination of the patient’s care among primary care physicians, medical specialists, and surgeons.

“Patients must be optimized for surgery,” she tells her residents. “We let patients know the risks of anesthesia relative to their medical issues. If patients have hypertension, or their blood sugar is high because of diabetes, and if their surgery is elective, like hip replacement, we are likely to advise patients and their physicians to delay surgery to get such issues under control. And we want physicians and their patients to be comfortable reaching out to the anesthesia department.”

Dr. Kataria also tells her residents that medicine is much more than simply taking care of patients. She tells them they need to be involved in organized medicine, “so that it’s not just administrators and politicians who are setting health care policies—who knows better than physicians what is best for the patient?”

She points out that policies that come from CMS and ISMS work their way up to the AMA and gain national implementation and ultimately help physicians practice what’s best for patients. She also says that organized medicine helped her get a handle on the business and administrative side of medicine. “Overall, it has provided a way to cut across all specialties in order to improve patient care,” she says.

Dr. Kataria has long practiced what she preaches. She has served as a delegate to the AMA House of Delegates from the Young Physicians Section, on the ISMS Governmental Affairs Council, and as a councilor at CMS. Even Dr. Kataria’s husband, Harley Grant, shares her zeal for organized medicine; he works for the AMA as director of both the Young Physicians Section and the Women Physicians Section.

But Dr. Kataria is particularly passionate about her specialty, which she fell in love with while originally doing an internship in obstetrics and gynecology. It was during her rotation in anesthesia that she realized this field was for her, and she did her residency in anesthesiology at Brigham and Women’s Hospital in Boston. And she’s never had any regrets.

“Anesthesia is never boring—every patient is different, every surgery is different, and it’s so fast-paced and requires constant vigilance.”

“I love it!”

Dr. Kataria’s Career Highlights

DR. KATARIA is an assistant professor in the Department of Anesthesiology and Critical Care at the University of Chicago. She earned her MD from the University of Missouri-Kansas City, and was also a clinical fellow in the Department of Anesthesiology at Mount Sinai Medical Center, New York. Dr. Kataria earned a master’s degree in public health from Harvard University. She is board-certified by the American Board of Anesthesiology and was the recipient of the Young Physician Leadership Award from the AMA Foundation in 2005. Dr. Kataria was born in England and came to the United States to live in Michigan with her parents, when she was two.
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