Ideal Medical Practices
A new model lets physicians reclaim autonomy and control. But is it for everyone?

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SGR Ritual Ends

AFTER YEARS of lobbying, the Chicago Medical Society and other advocacy groups, have cause to rejoice. Ending an annual and, many believe, fake crisis, full of threats and scaremongering, Congress approved and President Obama signed legislation repealing the SGR funding formula.

Multiple organizations brought vast resources—time, money, congressional visits, and physician outreach—to achieve this seeming milestone. Your CMS walked a fine line, keeping members abreast of legislative developments, urging them to contact their lawmakers, while taking care not to add to the SGR fatigue many physicians feel. We were cautious in last month's magazine issue, not wanting to assume Congress would put an end to the annual cliffhanger.

As we celebrate the SGR's demise, it's also good time to reflect on what the repeal portends.

We've heard a number of explanations for Congress' reaching this milestone. The conventional wisdom is that the 17 pay patches, and even the permanent SGR fix, are all budget gimmickry. Also, in recent years, the Congressional Budget Office came out with lower repeal cost estimates, making a fix more palatable. Meanwhile, with fee-for-service considered unsustainable and the health care landscape changing dramatically, the cost of doing nothing is more prohibitive than a fix. Finally, it's increasingly clear that the SGR is a distraction, diverting attention and resources from efforts to improve payment delivery through the development of new models.

Yet SGR repeal is a double-edged sword, ending one era and ushering in the transition to a “value-based” system. Some observers predict Congress will use the repeal as a tool to prod doctors into the value-based system. They point out that Congress didn't have to fix the SGR.

The Medicare Access and CHIP Reauthorization Act provides positive annual payment updates of 0.5% starting July 1 and through 2019. Claims that were held for the first half of April will be processed and paid at the rates that were in place before the 21% cut was scheduled to take effect.

To accelerate the shift to value-based payment, something known as a merit-based incentive payment system (MIPS) will be established beginning in 2019. Medicare's current quality reporting programs will be streamlined and simplified into the MIPS.

While the legislation supports physicians who choose to adopt new payment and delivery models, it also retains Medicare's fee-for-service model. Participation in new models is entirely voluntary. Incentive payments will be available for physicians who participate in these alternative payment models and meet certain thresholds.

Those who receive a substantial portion of their revenues through these models may earn a 5% bonus from 2019 through 2024. Providers who choose to participate in the MIPS will be subject to positive or negative payment adjustments based on their performance.

Simply put, the law opens the door to broader use of new alternative ways of paying physicians.

Last of all, the legislation includes protections so that medical liability suits cannot use Medicare quality program standards and measures as a standard or duty of care.

The Chicago Medical Society will be actively involved at each stage, shaping policies and representing you, our members. Please join us in meeting the future.

Kenneth G. Busch, MD
President, Chicago Medical Society
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The Shift from Solo Private Practice

Multi-specialty, interdisciplinary medical culture leaves little time for learning to run a business  

By Sameer Vohra, MD, JD

ONE OF THE GREAT privileges of being involved in the Chicago Medical Society is the ability to learn from older generations of physicians. The level of skill and dedication to the craft that these individuals continue to display is impressive, and I often find myself captivated by the stories they share. Particularly interesting are the changes in practice expectations. Compared to my own experience, the amount of work required of physicians then and the myriad skills they had to employ seem so different. I wonder how well I would have performed under these more arduous circumstances.

“Although the older physicians vary by specialty, a recurring theme is their reliance on their own individual skills and knowledge.”

Although the older physician members vary by specialty, a recurring theme is their reliance on their own individual skills and knowledge. At first, I always wondered why they did not just ask their colleagues and team members for help. In our current multi-specialty, interdisciplinary medical culture, many of their adventures would have been far less dramatic. However, older physicians practiced medicine very differently than my younger colleagues and I do. Many spent their entire careers in solo private practice.

In 1982, 40.5% of physicians were in solo practice. Today, 33 years later, this number has plummeted to 18.4%. Among physicians under age 40, the number in solo practice is even lower—10.0%. As a physician who chose a job in an academic group practice, this number is hardly surprising to me. My colleagues and I have no interest in solo practice. In fact, I am in awe of the 10% of physician under 40 taking on this challenge.

There are many reasons for this shift from solo private practice. One powerful factor was the introduction of health maintenance organizations and the changing reimbursement market. These monumental shifts in the health care delivery system resulted in greater consolidation between hospitals and physician practices. The increased demand for work-life balance discussed in last month’s column is another reason. Yet, one other powerful reason for this shift is that the younger physicians today do not feel either medically or financially competent to run their own solo practice.

Managers of a Complex Business

Training in a high-functioning academic medical center does not leave much time for individual practice. Based on the complexity of patients, either medical or social, much of training involves learning how to best partner with subspecialists, nurses, pharmacists, social workers, and case managers to provide care. Much of a physician’s education involves learning how to best manage and lead these health care teams to provide the most comprehensive, efficient, and cost-effective care possible. Big group practices, whether academic or private, allow for this multi-specialty, interdisciplinary care. In these settings, help and expertise are always available. Solo effort is neither requested nor required.

This medical and team-based training also leaves little time and energy to learn the financial and legal complexities of running one’s own business. The increase in state and federal regulations, the complexity of insurance reimbursement codes, and the fact that practicing medicine is complicated enough makes taking on this added solo role unappealing for my generation. Although physicians continue to assume some level of ownership in their practices (53.2% were either full or part owners of their practices), the 18.4% in solo practice shows that very few decide to take complete ownership of both the medical and business sides of the practice.

New Skill Sets, Same Goals

As I listen to the stories of my experienced mentors, I am often envious of the freedom and independence they enjoyed. The older generation was able to practice autonomous medicine during a simpler time, concentrating purely on their patients and on their practice. However, the landscape of medicine and the skill sets necessary to succeed have changed for my generation. Although this means that I will have fewer personally heroic stories to share, I hope to lead highly effective and efficient teams to make my patients healthier. In the end, all generations can agree that healthier patients are our number one goal no matter how we achieve it.

Sameer Vohra, MD, JD, is a fourth-year resident physician in pediatrics and public policy at the University of Chicago/Comer Children’s Hospital. Dr. Vohra currently serves on the Chicago Medical Society Board of Trustees. He has previously served on the National Administrative Board for the Association of American Medical Colleges Organization of Student Representatives. In 2014, Dr. Vohra was a recipient of the AMA Foundation Excellence in Medicine Leadership Award.
Laboratory Service Arrangements

Two recent advisory opinions from the OIG conclude that arrangements could violate the Federal Anti-kickback Statute

By Clay J. Countryman, JD

Recent Compliance guidelines from the Office of the Inspector General (OIG) illustrate the agency’s specific concerns over laboratory service arrangements with physician practices. The OIG has issued two recent advisory opinions concluding that a proposed arrangement for lab services for a physician’s patients could generate prohibited remuneration for referrals under the Federal Anti-kickback Statute. The OIG also issued a Special Fraud Alert in June 2014 that describes certain payment arrangements between laboratory companies and physician practices that may violate the Anti-kickback Statute.

On March 18, 2015, the OIG issued an advisory opinion on a laboratory company’s proposal to enter into an agreement with physician practices to provide all laboratory services for the practices’ patients. Under the proposal, the laboratory company would also waive all fees for the practices’ patients who are enrolled in certain insurance plans that require patients to use a different laboratory.

The OIG commented that the laboratory company would provide free services to certain patients to secure all business of the contracting physician practices, including federal health care program business. As a result, the OIG concluded that the proposed arrangement potentially implicates the Anti-kickback Statute and the prohibition on charging Medicare substantially in excess of the provider’s usual charges.

An interesting aspect of the opinion is that the OIG found that although the physicians would not receive direct payments, the following would amount to remuneration:

- Physician practices’ desire to work with a single lab due for convenience.
- The efficiency gained from maintaining a single interface with a single lab.
- The physicians would be relieved of any interface costs that might be charged by some electronic medical record vendors.

The OIG also commented that the proposed lab arrangement could constitute grounds for permissive exclusion for charging in excess of a physician’s usual charges. The OIG concluded that the proposed arrangement would relieve patients of any obligation to pay so that the lab company would receive referrals of federal health care program patients, which would be charged at a full rate for the lab services.

The OIG also released a Special Fraud Alert on June 25, 2014, that focused on arrangements under which laboratories pay physicians, either directly or indirectly (such as through an arrangement with a marketing or other agent) to collect, process, and package patients’ blood specimens, or similar types of arrangements.

The OIG described several different types of laboratory arrangements that included providing free or below-market goods or services to a physician who is a referral source, or paying physicians more than fair market value for their services, which could constitute illegal remuneration under the Federal Anti-kickback Statute. For example, the OIG cited concerns when a laboratory pays a physician more than fair market value for the physician’s services or for services that the laboratory does not actually need. Another common concern cited by the OIG is the payment by a laboratory to a physician that may constitute double payment for services because the physicians may be paid for the same services or expenses from another source.

The OIG also has commented in several advisory opinions that arrangements that “carve out” federal health care program beneficiaries or business from otherwise questionable arrangements implicate the Anti-kickback Statute through the payment of amounts purportedly related only to non-federal health care program business.

The OIG also described characteristics of a registry arrangement that may be evidence of an unlawful activity, such as:

- Compensation paid to physicians that are not fair market value for the physicians’ efforts in collecting and reporting patient data in a registry arrangement.
- Compensation paid to physicians is not supported by documentation submitted in a timely manner.

In these advisory opinions and in the Special Fraud Alert on laboratory arrangements with physicians, the OIG also emphasized that it had long-standing concerns about laboratory service arrangements.

The information in this article is intended for informational purposes only, and does not and should not be construed as legal advice. Clay J. Countryman, JD, is a partner with Breazeale, Sachse & Wilson, LLP, in Baton Rouge, Louisiana. He may be contacted at Clay.Countryman@bswllp.com.
ILLINOIS MANDATED that 50% of Medicaid enrollees be moved to Managed Care Organizations—HMOs or Accountable Care Entities (ACEs) by Jan. 1, 2015. As a result, the state has contracted with many new plans, creating short-term confusion among patients and providers. Physicians who want to retain these patients need to either secure direct contracts with these new plans or participate via IPAs/PHOs. Patient populations in the following plans are affected by Medicaid reform: Family Health Plan (FHP), also known as traditional Medicaid; Integrated Care Program (ICP), formerly serving the ABD population (Aged, Blind and Disabled); and Medicare-Medicaid Alignment Initiative (MMAI) or “dual-eligibles.”

In addition, Illinois sought proposals from ACEs and Care Coordination Entities (CCEs). Table 1 shows Medicaid enrollment in HMOs and Table 2 shows Medicaid enrollment in ACEs and CCEs in the Greater Chicago Area as of February 2015.

Cathryn Johnson is a senior health care consultant at PBC Advisors, LLC, in Oak Brook. PBC Advisors provides business consulting services to physicians. For more information, visit www.pbcgroup.com.

Table 1

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>FHP</th>
<th>ICP</th>
<th>MMAI</th>
<th>Total</th>
<th>% of Total</th>
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<tbody>
<tr>
<td>Aetna Better Health</td>
<td>77,676</td>
<td>29,130</td>
<td>9,386</td>
<td>116,192</td>
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<td>Blue Cross Blue Shield</td>
<td>112,352</td>
<td>5,998</td>
<td>13,086</td>
<td>131,436</td>
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<td>Cigna Health-Spring of Illinois</td>
<td>-</td>
<td>4,300</td>
<td>10,120</td>
<td>14,420</td>
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<tr>
<td>CountyCare</td>
<td>123,920</td>
<td>2,586</td>
<td>-</td>
<td>126,506</td>
<td>13%</td>
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<tr>
<td>Family Health Network/CCAI</td>
<td>213,537</td>
<td>7,793</td>
<td>-</td>
<td>221,330</td>
<td>23%</td>
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<tr>
<td>Harmony Health Plan</td>
<td>120,630</td>
<td>-</td>
<td>-</td>
<td>120,630</td>
<td>12%</td>
</tr>
<tr>
<td>Humana Health Plan</td>
<td>-</td>
<td>4,542</td>
<td>9,499</td>
<td>14,041</td>
<td>1%</td>
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<td>IlliniCare Health Plan</td>
<td>102,208</td>
<td>27,785</td>
<td>1,350</td>
<td>131,343</td>
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<tr>
<td>Meridian Health Plan</td>
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<td>4,332</td>
<td>8,875</td>
<td>100,368</td>
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<td><strong>Health Plan Totals</strong></td>
<td><strong>837,484</strong></td>
<td><strong>86,466</strong></td>
<td><strong>52,316</strong></td>
<td><strong>976,266</strong></td>
<td><strong>100%</strong></td>
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Table 2

<table>
<thead>
<tr>
<th>ACE or CCE</th>
<th>Traditional Medicaid Patients</th>
<th>Disabled Medicaid Patients</th>
<th>Total</th>
<th>% of Total</th>
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</thead>
<tbody>
<tr>
<td>Advocate Accountable Care (ACE)</td>
<td>75,948</td>
<td>-</td>
<td>75,948</td>
<td>26%</td>
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<tr>
<td>Better Health Network (ACE)</td>
<td>11,860</td>
<td>-</td>
<td>11,860</td>
<td>4%</td>
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<tr>
<td>Community Care Partners (ACE)</td>
<td>37,195</td>
<td>-</td>
<td>37,195</td>
<td>13%</td>
</tr>
<tr>
<td>HealthCura (ACE)</td>
<td>20,908</td>
<td>-</td>
<td>20,908</td>
<td>7%</td>
</tr>
<tr>
<td>Illinois Partnership for Health (ACE)</td>
<td>3,676</td>
<td>-</td>
<td>3,676</td>
<td>1%</td>
</tr>
<tr>
<td>Loyola Family Care (ACE)</td>
<td>22,060</td>
<td>-</td>
<td>22,060</td>
<td>8%</td>
</tr>
<tr>
<td>MyCare Chicago (ACE)</td>
<td>30,628</td>
<td>-</td>
<td>30,628</td>
<td>11%</td>
</tr>
<tr>
<td>SmartPlan Choice (ACE)</td>
<td>60,162</td>
<td>-</td>
<td>60,162</td>
<td>21%</td>
</tr>
<tr>
<td>UI Health Plus (ACE)</td>
<td>12,926</td>
<td>-</td>
<td>12,926</td>
<td>4%</td>
</tr>
<tr>
<td>La Rabida Coordinated Care (CCE)</td>
<td>595</td>
<td>-</td>
<td>595</td>
<td>0%</td>
</tr>
<tr>
<td>Lurie Children's Health Partners (CCE)</td>
<td>1,596</td>
<td>-</td>
<td>1,596</td>
<td>1%</td>
</tr>
<tr>
<td>Be Well (CCE)</td>
<td>-</td>
<td>1,380</td>
<td>1,380</td>
<td>0%</td>
</tr>
<tr>
<td>EntireCare (CCE)</td>
<td>-</td>
<td>2,584</td>
<td>2,584</td>
<td>1%</td>
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<tr>
<td>Next Level (CCE)</td>
<td>2,174</td>
<td>3,516</td>
<td>5,690</td>
<td>2%</td>
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<tr>
<td>Together4Health (CCE)</td>
<td>-</td>
<td>2,309</td>
<td>2,309</td>
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<td><strong>9,789</strong></td>
<td><strong>289,517</strong></td>
<td><strong>100%</strong></td>
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</table>
Skin Cancer Prevention Month

Resources for your patients

JUST IN TIME for the start of summer—when people spend significant amounts of time in the sun swimming, boating, barbecuing or reading on the beach—comes May’s Melanoma/Skin Cancer Detection and Prevention Month. The American Academy of Dermatology (AAD) offers a variety of resources that you can use to educate your patients about skin cancer. The group’s Spot Skin Cancer public education campaign includes a website at www.spotskincancer.org where you can download a variety of materials to give to your patients, even if you are not a dermatologist. Materials include:

- **Educational handouts.** The site offers 13 general education handouts on topics such as how to select a sunscreen, a skin cancer fact sheet, how to spot skin cancer and FAQs about sun safety.
- **Children’s materials.** Featuring a smiling giraffe with a sun hat, the 15 handouts are designed for kids, anywhere from kindergarten through the teenage years. To engage youngsters, the handouts include not only facts and tips but also games, coloring pages and stickers.
- **Classroom activities.** For teachers, Spot Skin Cancer provides lesson plans and activities for children 8-10 years of age and 11-13 years of age.
- **Flyers and e-cards.** Ten flyers use a variety of different methods, from showcasing top athletes to artistic renderings of the word “skin” to highlight the importance of protecting oneself against skin cancer.

The Skin Cancer Foundation (www.skincancer.org) offers a long list of bullet point facts about all types of skin cancer as well as facts about indoor tanning, sun damage, treatment costs and skin cancer broken down by men, women, ethnicity and children. Sample facts include:

- Each year there are more new cases of skin cancer than the combined incidence of cancers of the breast, prostate, lung and colon.
- Treatment of nonmelanoma skin cancers increased by nearly 77% between 1992 and 2006.
- Over the past three decades, more people have had skin cancer than all other cancers combined.
- One in five Americans will develop skin cancer in the course of a lifetime.
- One person dies of melanoma every 57 minutes.
- Young men account for 40% of melanoma cases, but more than 60% of melanoma deaths.
- Eleven states now prohibit indoor tanning for minors younger than age 18: Illinois, California, Vermont, Nevada, Oregon, Texas, Washington, Minnesota, Louisiana, Hawaii, and Delaware.
- Pediatric melanoma increased by an average of 2% per year from 1973 to 2009.

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Reminder for Medical Professionals
Docs asked to help curtail disability parking abuse By Scott Warner

LOIS SCOTT, Chicago’s chief financial officer, is calling on physicians to help stem an estimated $20 million annual cost to the city. And that cost comes from revenue the city pays for disabled drivers with special yellow-and-gray meter exempt placards who are allowed to park for free at metered spaces.

Ms. Scott estimates that the city has to reimburse the company that owns the parking meters as much as 50%, or $10 million, for those drivers who fraudulently use those spaces, or illegally allow others to use their special permit.

Furthermore, physicians may be held accountable, because they are the ones who sign off on these placards; the placards are only supposed to be issued to persons with permanent disabilities who have significant impairments that cause difficulty in physically accessing a parking meter. These are different from non-meter exempt permanent placards, which allow the authorized holder to park in spaces for persons with disabilities, but does not exempt the authorized holder from parking meter fees.

The city has sent a notice to medical professionals that falsifying information about the nature of a disability in order to qualify for a disability parking placard or license plates is a crime—whether committed by the applicant or the medical professional. The notice states that only people with a permanent disability who meet more stringent medical requirements qualify for meter-exempt parking. The notice further states that medical professionals who certify an application for any patient who does not meet the disability criteria face a Class A misdemeanor, a minimum fine of $1,000, and possible driver’s license suspension.

“There has been a dramatic spike in abuse of the permits,” Ms. Scott explains. “Unfortunately many doctors don’t understand how significant and costly an issue this is for the city. When Chicago Parking Meters, LLC, leased the parking meters from the city in 2009, metered parking cost only 25 cents an hour; that company has since raised the price to $6.50 an hour.

“We find that some people are misusing the placard when, for example some able-bodied person borrows their grandmother’s placard and parks all day for free, or uses a placard that was incorrectly issued and monopolizes a parking space for a week; some patients have been able to get physician to sign off on a permit when they don’t qualify, most likely because of a misunderstanding over the regulations by the physicians.”

Ms. Scott, whose father was a country doctor in New York State, emphasizes that she has enormous respect for physicians, and knows that they want to do the best by their patients. “We’re not trying to second-guess our physicians, physician assistants and nurse-practitioners” she says. “We just want them to understand the regulations, and know what a tremendous burden is placed on taxpayers when the disability placards are misused. Unfortunately, the city will soon be cracking down on violators, and we want physicians and their staff to be fully aware of the situation.”

Physicians who would like to obtain a form for meter-exempt parking for their patients can go to: http://tiny.im/ISP.

To help deter applicants from applying pressure on physicians to authorize their eligibility for a meter exempt parking placard, the Secretary of State’s office developed a poster (12” by 18”) that physicians may display in their office. To obtain a free poster, contact: tom.stevens@cityofchicago.org.

PUBLIC HEALTH

FALSIFYING DISABILITY INFORMATION IS A CRIME

A reminder for medical professionals:

Only people with a permanent disability qualify for meter-exempt parking/ yellow & gray placards. Signing off on an application for someone who isn’t entitled to meter-exempt parking may result in YOUR prosecution for a Class A misdemeanor, a fine of $1,000 or more and the suspension or revocation of your driver’s license.

The City of Chicago and the Illinois Secretary of State are taking aggressive enforcement efforts to stop placard abuse. Please help us by signing off on meter-exempt applications ONLY for those who meet the statutory standards.

For more information about the program, please visit: WWW.CYBERDRIVEILLINOIS.COM
State lawmakers could approve legislation mandating that Hepatitis C screening be offered to all individuals born between 1945 and 1965 and others at high risk who receive hospital inpatient services or hospital emergency department care. The legislation would also apply to Baby Boomers and high-risk groups who receive primary care services in an outpatient hospital department or from a primary care provider, unless the practitioner believes that certain conditions are not present.

Both the Illinois State Medical Society and the Chicago Medical Society oppose enforcement of such regulations by the General Assembly because it encroaches on physician autonomy. ISMS also points out that the legislative proposal does not offer immunity for health care professionals from criminal and civil liability and from professional discipline for failure to offer HCV screening. Nor does it put in place any guarantee that patients who test positive for HVC could access treatment. Not all insurers cover the cost of screening and treatment; many screened individuals would turn out not to have HVC.

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More hospitals are using telemedicine to deliver real-time clinical services to patients at locations beyond hospitals and physician offices. In fact, medical literature now supports the use of telemedicine to shorten and decrease hospital admissions, readmissions, and emergency room visits by treating patients with chronic conditions who may otherwise not seek treatment without the availability of telemedicine.

A hospital’s ability to use telemedicine to reduce readmissions enables the hospital to avoid costly penalties imposed for excessive readmissions. For example, hospitals can use telemedicine to treat patients in a skilled nursing facility or community mental health center setting instead of readmitting the patient to the hospital. Additionally, telemedicine facilitates better patient care in an initial hospital stay by allowing hospital systems to connect patients to specialists whom they would otherwise not have access to without telemedicine.

“In addition to ensuring that physicians providing telemedicine services have the appropriate medical license, hospitals must credential the physicians who provide telemedicine services to their patients.”

While telemedicine enables providers to better treat patients and expand access to care, the technology presents licensing, credentialing, prescribing, treatment, and reimbursement issues providers must be aware of.

Physician Licensing and Credentialing

As with physicians who treat patients at a hospital, hospitals should ensure that physicians providing care via telemedicine are appropriately licensed and credentialed. Physician licensing should not be an issue if an in-state physician is providing care via telemedicine because the physician should have a medical license to practice in the state in which the hospital is located. Licensing issues will occur when an out-of-state physician treats a patient via telemedicine because the physician needs a medical license from the state in which the patient is located, not the state from which the physician is providing telemedicine services.

Individual states have the discretion to determine what licensing out-of-state physicians must obtain to provide telemedicine within the state. Most states require that a physician hold an unrestricted medical license issued by the state in which the patient is located; however, 10 states allow out-of-state physicians to provide telemedicine with a limited telemedicine license. The Federation of State Medical Boards (FSMB) recently adopted an Interstate Medical Licensure Compact, which, if adopted by individual states, would facilitate physician licensure across state lines and ultimately increase the number of physicians able to provide care to patients via telemedicine.

In addition to ensuring that physicians providing telemedicine services have the appropriate medical license, hospitals must credential the physicians who provide telemedicine services to their patients. Generally, hospitals credential each physician who provides services at the hospital; however, credentialing physician telemedicine providers is labor intensive, since the physicians must be credentialed at the hospital where they usually provide services (the Distant Site) as well as the hospital to which they provide telemedicine services (the Originating Site). In 2011, the Centers for Medicare and Medicaid Services (CMS) enacted “proxy credentialing” so that the Originating Sites may rely on credentialing by the Distant Site when making a recommendation on a physician’s credentialing and privileges at the Originating Site. Proxy credentialing enables hospitals to quickly seek the assistance of specialists who are credentialed by another hospital. Without proxy credentialing, patients would have to wait to receive treatment from specialists while the Originating Site went through its full credentialing process.

To use proxy credentialing, the Originating Site must enter into an agreement with the Distant Site with assurances that: a) the Distant Site is a Medicare-participating hospital; b) the physician has privileges at the Distant Site; c) the physician holds a medical license from the state in which the Originating Site is located; and d) the Originating Site will send the Distant Site any
adverse actions and complaints related to the physician resulting from telemedicine services at the Originating Site.

**Physician Limits and Obligations**
Hospitals must consider when and how physicians provide medical care via telemedicine. Some states require that an in-person exam be performed before a physician provides telemedicine services, while other states only require in-person exams if patients seek telemedicine care from their home or other location where medical care is not traditionally provided.

Once the physician establishes a relationship with the patient to treat the patient via telemedicine, some states impose obligations on the physician to obtain patient consent to receive care via this method. For instance, Texas requires the physician to ensure the patient is seen by a physician for an in-person exam at least once a year. The FSMB recently adopted a Model Policy for Telemedicine which, if adopted by individual states, would remove some of the traditional limitations that states place on telemedicine, including the requirement that the initial physician-patient encounter must be in-person or at an established medical site.

In addition to treatment requirements, there are regulations governing when a prescription can be written based on telemedicine encounters. For example, the Idaho Board of Medicine recently disciplined a physician for calling in a prescription via phone because the physician did not first provide an in-person exam. Other states, such as California, Hawaii, and New Mexico allow physicians to prescribe medications after a telemedicine encounter without an in-person exam. Additionally, the U.S. Drug Enforcement Agency (DEA) has recently begun to enforce its interpretation of the federal Ryan Haight Act, which the agency contends places limits on physicians’ prescribing of controlled substances through the use of telemedicine. Hospitals must be aware of these laws to determine if their policies ensure that the physicians with whom they connect their patients for telemedicine services may write the prescriptions contemplated.

**Medicare and Medicaid Reimbursement**
Hospitals must also ensure that they are complying with telemedicine reimbursement policies. Currently, the Centers for Medicare and Medicaid Services (CMS) only reimburses for telemedicine services provided via real-time video conference to patients who are: a) located in a rural area; and b) located at a “qualified” Originating Site when they receive treatment via telemedicine. CMS considers hospitals, physician offices, critical access hospitals, rural health clinics, federally qualified health centers, and skilled nursing facilities as “qualified” Originating Sites. If these requirements are met, the Medicare reimbursement amount paid to the physician delivering the service via telemedicine is the same amount that a physician would otherwise receive as a professional fee if the services were delivered in-person. In addition, the hospital in which the patient receives the telemedicine service may be paid a facility fee from Medicare, similar to the technical fee that hospitals receive for in-person services.

Medicaid coverage for telemedicine services is more varied, since states can decide whether to cover telemedicine and, if so, what specific services should be covered. Currently, all states except Massachusetts, New Hampshire, New Jersey, and Rhode Island cover some form of telemedicine services. States have various requirements and restrictions on Medicaid coverage. For example, Tennessee only reimburses the provision of telemedicine crisis services, while Idaho only reimburses psychiatry services delivered via telemedicine. As some states expand Medicaid under the Affordable Care Act, they may increase their coverage of telemedicine services to realize the cost-savings they may achieve through reduced hospital admissions and readmissions.

**A View to the Future**
The provision of medical care through telemedicine will continue to progress and develop, allowing hospitals and providers to better treat patients. The federal CMS recently recognized the technology’s benefits by adopting rules to provide reimbursement for additional types of telemedicine services. Effective Jan. 1, 2015, CMS reimburses annual wellness visits, psychoanalysis, family psychotherapy, and prolonged evaluation and management services provided via telemedicine. As its use progresses, hospitals will be empowered to recognize cost-savings by forming networks with other hospitals to provide consultations and support to each other via telemedicine, communicating with discharged patients to prevent unnecessary readmissions, and providing remote treatment and monitoring to patients with chronic conditions, including diabetes and heart disease, to prevent unnecessary emergency department visits.

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Curbing Excess Antipsychotic Use in Nursing Homes

Regulatory agencies take aim at inappropriate prescribing
By Matthew R. Herington, JD, MPH

Dementia continues to be a major public health issue. While its prevalence can vary, an estimated 14% of the U.S. population age 71 and older in 2002 had dementia. By 2030 an estimated 72 million individuals age 65 or older will have dementia. If that projection is accurate, this group will represent 20% of the U.S. population at that time. With the aging of the population, it will be increasingly important for society to find safe and effective methods to treat dementia symptoms.

The behavioral symptoms of dementia include agitation, loss of inhibition, and inappropriate social behaviors. Dementia patients can also develop psychosis. As a result of these disturbing symptoms, it is not unusual for health care providers to prescribe antipsychotic medications to these patients. Because these patients are eventually unable to care for themselves, many end up living in nursing homes. In fact, more than half of U.S. nursing home residents are thought to have some form of dementia.

Improper and Widespread Prescribing
A study of Medicare beneficiaries residing in nursing homes during 2000-2001 found that almost 28% received an antipsychotic medication. Startlingly, almost 60% “took doses exceeding maximum levels, received duplicative therapy, or had inappropriate indications” according to guideline requirements. In more recent research, released in February 2015, an analysis of minimum data set data in 2011 found that approximately 24% of long-stay nursing home residents were still receiving antipsychotic medications. An analysis of long-stay older adults enrolled in Medicare Part D revealed that approximately one-third were prescribed an antipsychotic medication in 2012.

Both the newer “atypical” antipsychotic medications, as well as the first-generation “typical” ones, have been associated with increased mortality in elderly patients with dementia-related psychosis. Consequently, antipsychotics are not recommended for addressing behavioral problems associated with dementia unless: 1) non-pharmacological options have been unsuccessful; and 2) patients are a threat to themselves or to others. Because of these safety concerns, the FDA has mandated “black box warnings” for these drugs.

History of Reform Movement
An old problem, concern over the misuse of antipsychotic medications among nursing home residents goes back several decades. After increasing concern about nursing home quality in general, the Institute of Medicine (IOM) released a seminal report in 1986 titled, “Improving the Quality of Care in Nursing Homes.” The IOM noted that nursing homes may be using antipsychotic medications as a way to compensate for understaffing. The following year, Congress passed the Nursing Home Reform Act, whose goal was in part to promote nursing home residents’ quality of life and ensure they receive quality care. The 1987 Act substantially modified existing laws, and required that nursing homes participating in Medicare and Medicaid meet certain requirements.

The Department of Health and Human Services (HHS) subsequently promulgated regulations that flesh out these requirements in the Code of Federal Regulations. These include regulations governing residents’ rights; the administration, transfer, and discharge of residents; residents’ quality of life; resident assessments; quality of care; nursing services; dietary services; physician services; rehabilitation services; dental services; pharmacy services; infection control; the physical environment; and facility administration.

To determine whether nursing homes meet these requirements, HHS enters into agreements with state health agencies to conduct surveys. A “deficiency” occurs when a nursing home fails to meet the participation requirements found in the Social Security Act; the state agency then gives the nursing home notice of any deficiencies. Information about each of the deficiencies is provided, including data on the scope and severity level.

Clear Federal Prohibitions
The Code of Federal Regulations includes language on the use of antipsychotic drugs. After a comprehensive assessment of the resident, facilities must ensure that: 1) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and 2) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

As a result, nursing homes are not to use antipsychotic drugs as the first line of treatment for
most residents with behavioral problems. Rather, the use of the antipsychotic medication must be “necessary.” In addition, residents who receive antipsychotic medications are expected to receive behavioral interventions, in an effort to discontinue or reduce the dosage of the antipsychotic medication; gradual dose reductions are generally expected, as well. “Behavioral interventions” are defined as “individualized non-pharmacological approaches that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident’s distressed behavior.”

Nursing homes are required to complete a specific “plan of correction” when deficiencies have been identified. In certain cases, more severe consequences can result, including the imposition of civil monetary penalties or the denial of payments. The information cited in a “Statement of Deficiencies” also goes onto a website accessible by the general public, which contains the percentage of residents receiving antipsychotic medications at each nursing home. As a result, nursing homes have a strong incentive to reduce antipsychotic use.

**Major Public-Private Alliance**

The Centers for Medicare and Medicaid Services took action in 2012 by establishing the National Partnership to Improve Dementia Care. This initiative is a partnership among federal and state governments, nursing homes, advocacy groups, and caregivers. The stated goal is “to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings.” The initiative consists of: 1) providing enhanced training about antipsychotic medications for nursing homes and surveyors; 2) the posting of antipsychotic medication data online in order to promote greater transparency; and 3) emphasizing non-pharmacological alternatives to dealing with problematic dementia-related behaviors in nursing home residents.

Since this initiative began, the use of antipsychotics by long-stay nursing home residents has declined by 17% over a 21-month period. Buoyed by this success, the Partnership announced a goal to achieve a 25% reduction in the prevalence of antipsychotic medication usage by the end of 2015, and a 30% reduction by the end of 2016.

**Feds Target “Off Label” Use**

Also stepping up to deal with the issue, in recent years, the U.S. Department of Justice has brought action against pharmaceutical manufacturers for alleged violations. Many involve allegations that manufacturers were unlawfully promoting the “off label” use of antipsychotic drugs for elderly patients with dementia. Often these actions resulted from an investigation that ensues after qui tam actions are filed by relators pursuant to the federal False Claims Act. Some high-profile settlements include:

- In 2007 Bristol-Myers Squibb agreed to pay $515 million, in part for its promotion of Abilify (aripiprazole).
- In 2009 Eli Lilly and Company agreed to pay $1.415 billion for its promotion of Zyprexa (olanzapine).
- In 2009 Pfizer agreed to pay $2.3 billion for, in part, its promotion of Geodon (ziprasidone).
- In 2010 AstraZeneca agreed to pay $520 million for the promotion of Seroquel (quetiapine fumarate).
- In 2013 Johnson & Johnson agreed to pay $2.2 billion for the promotion of Risperdal (risperidone) and Invega (paliperidone).

Prescribing prescription medications for “off label” purposes is not illegal, making it probably more difficult to rein in an individual prescriber’s inappropriate antipsychotic prescriptions. However, the federal government has found a way to do so. On Feb. 3, 2015, an Illinois psychiatrist was charged with violating provisions of the federal Medicare and Medicaid anti-kickback statute for prescribing clozapine to thousands of elderly and indigent patients in the Chicago area in exchange for kickbacks and benefits from a pharmaceutical company. The psychiatrist’s prescriptions included those for nursing home residents. He pled guilty 10 days later, and also entered into a settlement with the federal government and the state in a separate False Claims Act case.

**Research into Antipsychotic Use**

Both the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH) have also recently funded research specifically related to antipsychotic use in nursing homes. Similarly, the NIH has funded research projects through both the National Institute on Aging and the National Institute of Mental Health.

**Predicting Future Progress**

Prescribers of antipsychotic medications should be well aware of the fact that regulatory agencies have increased scrutiny of antipsychotic medication use in the elderly. With public concern about the quality of care in nursing homes also at high levels, it is inevitable that regulatory agencies will want to push for further reductions in the inappropriate use of antipsychotics in nursing homes. Based on the significant progress already made by the National Partnership to Improve Dementia Care, this activity is likely to continue.

Matthew R. Herington, JD, MPH, is an administrative law judge with the Montana Department of Public Health and Human Services. The views expressed herein are the author’s own.
T WAS 11 A.M. on a Wednesday morning at the Roscoe Village Family Practice, a storefront on a corner in an affluent family neighborhood on the North Side of Chicago. The radio was playing light classical music, and the small waiting room was deserted, because Wednesdays are paperwork days. Two staff members were working in the office, but the atmosphere was relaxed.

“Listen,” said Lawrence Lindeman, MD, the only full-time physician in the practice, raising a finger to his ear. “Do you hear it? You’ve been here how long? Twenty minutes? How many times has the phone rung?” Not once.

“That’s right,” Dr. Lindeman said, and smiled. “We do everything possible so the patient doesn’t ever have to call.”

Dr. Lindeman has an “ideal” medical practice, which he opened as a solo practitioner in 2006, the kind of small, lean primary care practice described by L. Gordon Moore, MD, and John Wasson, MD, in a 2007 paper in *Family Practice Management*—a low-overhead, high-technology blend “wrapped around an excellent physician-patient relationship.” It’s the only practice identified as an Ideal Medical Practice (IMP) in the city of Chicago. There are, however, a few other official IMPs in northern Illinois, plus an unknown number of “micropractices,” often solo or two-doctor offices that rely on technology to make up for the fact that they have no staff, or small, often cross-trained staffs.

**Bucking the Employment Trend**

Medical practice is definitely going in the other direction. While more than half of physicians in 2012 were still self-employed, 29% either worked directly for hospitals, or were in practices owned wholly or in part by hospitals, up from 16% in
2008, according to a survey by the American Medical Association. In 2012, only 18% of doctors were in solo practice, down 6% from 2008, according to the survey. Even though working for a large practice may promise respite from the hassles of running their own businesses in the present environment, many doctors don't relish giving up their autonomy.

Wanda Filer, MD, president-elect of the American Academy of Family Physicians (AAFP), said that many members of her organization are feeling the tension between

Distinguishing Features

An “Ideal Medical Practice” marries the feel of an old-fashioned solo practice with the latest technology. Here are some of the identifying characteristics:

- Patient satisfaction is the top priority.
- The practice relies heavily on technology other than telephones for communicating with patients—online scheduling, patient portals and email.
- Patients have round-the-clock access to their doctors.
- Electronic medical records are essential.
- Overhead is low, with one to two staff members per doctor.
- Physicians see 12 to 18 patients per day.
- Same-day appointments are routine.
productivity and quality.

“We want to take care of patients in a manner that’s driven by the patient’s desires, by quality, evidence, compassion,” Dr. Filer said. However, “payments have been lagging behind the value we give.” The pressure is on to see several patients each hour in the office, but “ethically, we know there are patients we can’t do that with.”

In response to such concerns, interest is on the rise among AAFP members in the direct-care model, which moves away from “fee-for-service” into a system in which physicians collect a retainer for a period of time, and deliver comprehensive primary-care services in return, Dr. Filer said.

Unlike direct care, the IMP model doesn’t fiddle with the way patients pay for care. Instead, it aims to cut overhead. The IMP model has solid outposts in the Northeast, where Drs. Moore and Wasson both started out, and in the Northwest, where Pamela Wible, MD, of Eugene, Ore., practices. Dr. Wible is possibly the best known proponent of the ideal medical practices model right now.

“It’s the human rights movement for doctors,” she said.

**Giving Patients What They Want**

Before she opened her own IMP 10 years ago, Dr. Wible held nine “town hall meetings” with potential patients and collected 100 pages of testimony, she says, to find out what they thought about what an “ideal” doctor’s office should be like. It all boiled down to this, Dr. Wible said: “They want real health care from a doctor who cares, at an affordable price, in their neighborhood.”

John Brady, MD, president of the board of Ideal Medical Practices, agreed. “It doesn’t get spoken of very often, but essential qualities for physicians are a sense of autonomy, a sense of purpose, a sense of mastery, the ability to work always to be better. In a small practice, you can do that. When you are employed, when you give up your autonomy to avoid the mundane stuff,” the productivity demands can be daunting, said Dr. Brady, a solo family practitioner in Newport News, Va. “Over about 20 patients a day, you start losing empathy; that’s my gut feeling. You’ll be worn out emotionally.”

An IMP offers “a wonderful way to practice medicine,” said Dr. Brady. His group, Ideal Medical Practices, is a nonprofit umbrella organization that works to demonstrate the efficacy of the IMP model, assist practitioners and improve quality.

It’s good for patients, too, he said. According to a recent study, practices with one or two physicians had 33% fewer preventable hospital admissions than larger practices, especially large hospital-owned practices, Dr. Brady noted.

**The Pendulum Swings Back**

Sakina Bajowala, MD, owner and sole physician at the Kaneland Allergy and Asthma Center in North Aurora, Ill., learned about IMPs from a urologist-heavy online practice management group, and thinks it could work for at least some other specialists like her. “People told me I was completely nuts when I was starting out,” she says about her debut in a solo IMP four years ago.

“It’s true, the pendulum is swinging in the other direction,” Dr. Bajowala said. “But when everything is under the control of large hospital systems, and [other people have] a lot of control over how doctors work, and they realize what that’s like, it’s going to swing back hard.” Meanwhile, “if there is a choice between being a number and being a person, I’m going to choose being a person every time.”

Dr. Bajowala, an allergist, worked in a large practice for three years at the beginning of her career. She had five or six support staff, but still often wound up handling things herself, she said, because she wanted her practice to be a particular way. “I realized I didn’t need a ton of people to do it for me all day long. That’s what led me to think
of this model,” she said.

She had no staff at all for the first 18 months in her new practice, and she is proud of the fact that at Kaneland Allergy and Asthma, “I am truly the one person who knows how to do absolutely everything. I can change the toner, take out the garbage and check the mail.”

About 18 months into running her new practice without a staff, she found “personal satisfaction” going down. “I couldn’t handle my clinical responsibilities and the front office, too.” She has a physician’s assistant now, and three additional part-time staffers.

Dr. Lindeman agreed strongly that some staff is critical. While it often makes sense to start out with a staff-free office, buying virtual reception and other services as needed, he is convinced that, long-term, “the people who are successful all have staff.”

Hands-on Personalities Best Suited

Dr. Lindeman and Dr. Bajowala have some things in common. First, they want to have that “family doctor” experience, even in the 21st century. They both love technology and they have friendly “hands-on” personalities. Both say they’ll roll up their sleeves and do just about anything, if the need arises and they have the time.

Dr. Lindeman took a course on how to use his practice’s new billing software right along with his staff. “They told me I was the only doctor who had ever taken the billing course,” he said.

Before opening his own practice, Dr. Lindeman was the medical director at a family practice residency, which had “lots of doctors” and about 30 staff people. In that job, he said, he “mostly learned what not to do. My biggest goal for my own practice was simplicity. I wanted it to be calm.”

Dr. Lindeman shares his office with Lois Miller, MD, who works roughly half-time. They provide each other coverage for vacations and other absences. He is in the office about nine hours a day Monday through Friday, typically sees 15 patients a day (his patient panel is about 1,800), and earns more than the median income for a family practitioner, he said. His patients all have his cell phone number, but he said, “I never get called unless somebody really needs me.” Same-day appointments are routine for sick patients, and everyone who has an appointment is seen, no matter how

Physicians Most Likely to Succeed

The Common thread doctors share who thrive in the Ideal Medical Practices model is “a sense of entrepreneurialism and problem solving,” said John Brady, MD, board president of the nonprofit Ideal Medical Practices umbrella group. Two Chicago-area IMPs agree. They enjoy those aspects of their practices, and they say the IMP model probably isn’t for everyone.

Sakina Bajowala, MD, whose allergy practice is in North Aurora, Ill., said, “The IMP was for me, really, because it satisfied my need to stay on top of quality control. I have to have my finger on the pulse of everything. If I had to wash my hands [of the day-to-day operations] and hope the practice was running well, I would be ill at ease.”

“At the end of the day, IMP doctors are not above doing anything that needs to be done, even opening up the office or mopping the floors. It’s not like a practice where a doctor is saying, ‘That’s not my job.’”

Lawrence Lindeman, MD, who practices in Chicago said, “Practice management is really important. A lot of doctors don’t want to get into the nitty-gritty of practice management.”

However, he said, “It’s important to look at everything from the patient’s point of view.”

“If the patient isn’t comfortable with something, we don’t do it. We don’t do tests—well, strep tests, yes, things that make sense. But we only have something if it’s to the patients’ benefit. If I had something around,” like an EKG machine, for example, “and I was making money, I would want to do [the tests]. So we don’t have them.”
long it takes.

Dr. Lindeman is proudest of “our clinical outcomes.” The practice is a Level 3 Certified Medical Home, affiliated with Advocate Illinois Masonic Medical Center, where Dr. Lindeman said he is not only among the top performers, but also gets high marks in patient-satisfaction surveys. “We spend a lot of time with our patients,” he said.

Lean and Efficient Staff

Embracing technology has been key in succeeding with the ideal medical model, Dr. Lindeman said. The practice belongs to several large insurance plans, and files for patients, but sends out virtually no bills, simply charging balances owed to patients’ credit cards kept on file. (Someone will call a patient if a big charge is about to hit, though, he said.) The practice encourages patients to book appointments online, which saves “tons of money,” he said, and steers them hard to the patient portal for lab results and other communications—though about 3% don’t use the patient portal at all, Dr. Lindeman said. “We’re like a regular doctor’s office, but we try to be very efficient,” he said.

The three staff nurses, including office manager Leticia Sandoval, who has been with Dr. Lindeman since the office opened, take blood, administer vaccines, and handle insurance and billing matters at the front desk. “We all know how to do pretty much everything,” Sandoval said.

“We don’t have many people, but they’re really good,” Dr. Lindeman said.

The office keeps track of chronically ill patients, and sends out emails and makes follow-up calls to diabetics overdue for a visit. Once a week, the staff meets to brainstorm ideas on how to improve efficiency. The practice tries a lot of things. Some work, some don’t, like the free pedometers the practice handed out once in hopes of getting diabetics to exercise more. “Not a single one used it,” Dr. Lindeman said.

Dr. Bajowala sees 15 patients on a really busy day, more typically 10 or 11. Technically, she works part-time, two full days, two half-days, plus every other Saturday. Dr. Bajowala spends an hour on each initial appointment, and schedules half an hour for each follow-up. Her patients, too, have her cell phone number.

“Allergy is a cognitive specialty. You have to be a bit of a detective. I spend most of my time taking a high-quality history, listening to the patient, teasing out the relevant information to see what is causing the problem. It is a specialty that does benefit from more time spent with the patient,” she said.

Getting More Face Time with Patients

Dr. Bajowala has a patient panel of 1,600, though she notes, “many of those got what they needed on the first visit.” The primacy of the doctor-patient relationship, the keystone of the IMP model, helps in a specialty like hers, where “a cure on the first visit” is not uncommon. “People are pleasantly surprised to find a practice where they feel listened to. You get a lot of word of mouth [referrals].” She said she loves being “the allergist for my subdivision, my kids’ classmates, and doctors down the hall.”

Dr. Bajowala tries to do all her paperwork while she is in the room with a patient. “I explain to them I will be typing on my laptop. I’m very upfront. I tell them it’s to increase efficiency and make it easier for them to access their records.” She keeps her EMR on her phone.

“When patients call, I don’t have to wonder who they are,” she said.

“I take from the IMP model what makes it so good, spending time with the patient, being accessible, addressing more than a single concern” during a visit, she said. “When I am able to demonstrate to my patients that I have taken an interest in who they are, they trust me more and they are more likely to take my recommendations, and that leads to higher quality care,” she said.

Delia O’Hara is a Chicago-based freelancer who frequently writes about health care and science topics. She was previously a longtime features reporter for the Chicago Sun-Times.
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It’s no secret that the landmark Patient Protection and Affordable Care Act (ACA) created by the Obama administration became a partisan issue with Democrats all in favor and Republicans all in opposition. Although the law was passed, Republicans still want to do away with a number of ACA provisions this year such as the 2.3% medical-device tax; the employer and individual mandates; the 30-hour workweek standard for requiring employers to offer coverage; the Medicare Independent Payment Advisory Board; and the risk-corridor program designed to protect insurers from losses in the new individual-insurance markets. But the most immediate threat to the ACA comes from King v. Burwell, a case now before the U.S. Supreme Court, which is expected to issue a ruling by June.

The case questions whether the federal government can legally provide health care subsidies in the 34 states, including Illinois, which opted out of creating their own health care exchanges. If the challenge is successful, premium tax credits for lower-income Americans in the states using the federal insurance exchange would be abolished. More than 7 million Americans could lose subsidies worth roughly $36 billion, according to the Urban Institute, a non-partisan public policy research and analysis group. Clearly, such a decision would have a significant financial impact on insurers, physicians and, of course, patients themselves.

Expecting Turmoil
One immediate effect that most experts agree on is the confusion and disruption in health care delivery that would occur if the plaintiffs are successful. They look back to fall 2013 when insurance companies canceled coverage for millions of Americans, either because the old policies weren’t up to Obamacare’s standards or because the insurers decided the old policies no longer made them a profit. The cancellations surprised most Americans, especially since President Barack Obama had promised that with the new health care system people could keep their old insurance plans if they liked them. The media was rife with stories of angry and scared citizens who couldn’t believe the health care system could fail them so badly.

An even more widespread disruption of services would occur if the federal health care subsidies were cancelled, since many more people would be affected. Patients who use the healthcare.gov marketplace would see their premiums go up. Calculations from the Kaiser Foundation suggest that premiums would rise $268 each month on average—a prohibitive sum considering that Americans using the subsidies are in lower-income brackets. Physicians worry that with that type of rise in premiums, patients—even those with serious medical conditions—may discontinue life-saving treatments.

Physicians also worry that if patients no longer have subsidies and stop paying their premiums, then insurance companies will look to them for reimbursement of procedures they performed on patients after they defaulted. The catch for physicians is that if a patient does not pay his or her health insurance premiums in full, insurers must give them a 90-day grace period. During the first month, the patient continues to have coverage, and the insurer must pay claims for physician services. During the second and third months of the grace period, the insurer may pay, hold, deny, or later recoup claims payments for services during that time.

If the patient pays his or her premiums in full before the end of the 90-day grace period, the patient retains coverage, and the insurer is responsible for paying the pended claims. But if the Court rules in favor of the plaintiffs in King v. Burwell, many patients would likely default on their premiums, leaving physicians without reimbursement for the costs of procedures performed during the grace period. The situation would be especially harmful to physicians, such as cardiologists, who perform costly procedures.

The Beginnings
So how did we get into this mess? It all started with a 64-year-old Vietnam veteran named David King who simply did not want to buy health insurance. A resident of Virginia—a state that, like Illinois, also opted out of opening its own exchange—King works as a limo driver and makes $39,000 a year, according to a post on the Supreme Court blog. Based on his income and using the healthcare.gov marketplace, King would pay $275 a month for health insurance that actually costs $648 a month, according to the Supreme Court
blog. If subsidies didn't exist, King would be exempt from the ACA requirement to purchase health insurance or pay a penalty, which is exactly what he wants to do.

As a result, King and three other Virginia residents—Douglas Hurst, Brenda Levy and Rose Luck—filed a lawsuit titled King v. Sebelius in a federal district court in Virginia in September 2013. At the time, Kathleen Sebelius was the United States Secretary of Health and Human Services (HHS). The lawsuit challenged the government’s interpretation of the ACA as allowing subsidies for any qualifying individual who purchases health insurance on an exchange.

According to the plaintiffs, if a state establishes a health insurance exchange, then they would be required to purchase health insurance or pay a penalty. But, if the state does not establish an exchange, then the ACA does not impose those requirements. A three-judge panel in the Virginia federal district court ruled unanimously against the plaintiffs. In its decision, the court said the language of ACA is ambiguous and could be interpreted a number of ways. Circuit Judge Roger Gregory wrote that the tax credits are essential to fulfilling the primary goals of ACA and Senior Circuit Judge Andre Davis wrote that the purpose of ACA is to provide affordable health insurance options. Just because the Virginia residents who brought the case did not want to buy health insurance, he said, does not mean the court will deny affordable coverage to millions of Americans.

In July 2014, following the district court decision, the plaintiffs petitioned the U.S. Supreme Court. In November of that year, after much back and forth, the justices agreed to hear the case that is now called King v. Burwell, with Burwell being Sylvia Mathews Burwell, the current Secretary of HHS. Until the High Court’s decision is handed down, there will be no change to ACA premium subsidies or coverage obtained from any of the ACA exchanges.

State Rights v. Federal Rights
At root, the arguments have their beginning in the consistent tug-of-war between state rights and federal rights. Section 36B of the Internal Revenue Code, which was enacted as part of the ACA, authorizes federal tax credit subsidies for health insurance coverage that is purchased through an “Exchange established by the State under section 1311” of the ACA. But in 2012, in an act known as the IRS Rule, the IRS extended subsidies to all Exchanges—not only those established by states but also those run by the federal government. The plaintiffs claim that these extensions contradict the statutory text restricting subsidies to exchanges “established by the State.” The plaintiffs also argue that, “under the Constitution’s core federalism constraints, Congress cannot compel sovereign states to create Exchanges.”

As the ACA was originally being written, lawmakers proposed hefty incentives to ensure that each state would set up its own exchange. Accordingly, they did not appropriate in the ACA any specific funds for HHS to build exchanges. And the ACA’s proponents emphasized that “all health insurance exchanges... are run by states,” to rebut charges that the Act was a federal “takeover” of health care.

But much to the surprise of lawmakers, most states did not create their own exchanges.

So under the IRS Rule, subsidies became available in all states, no matter whether the state had its own Exchange or relied on the Federal government Exchange. States that did not set up their own Exchange then formed so-called “partnership exchanges” with the Federal government, which allowed states to make key decisions such as tailoring qualified health plan choices to suit its demographics. Partnership exchanges also allowed states such as Illinois that planned to transition to a State-based Exchange in later years to take on management functions as they were ready.

Partnership Exchanges, however, triggered the ACA’s individual mandate tax penalty for many who would otherwise be exempt—individuals such as David King. That penalty does not, however, apply to those who cannot afford coverage—people for whom the annual cost of the least expensive coverage with a subsidy exceeds 8% of his or her projected household income. David King falls just below that percentage.

And the Verdict Is...
After the oral arguments heard in the Supreme Court beginning on March 4, many analysts such as those at Politico and the Huffington Post predict the decision will favor the Obama administration and thus the federal subsidies. These analysts expect that the four liberal justices Ruth Bader Ginsburg, Stephen Breyer, Sonia Sotomayor and Elena Kagan battered the plaintiffs’ attorney, Michael Carvin, and will almost certainly side with the government and vote to uphold the subsidies. They also widely agree that Justices Antonin Scalia, Samuel Alito, and Clarence Thomas will likely side with the plaintiffs. Currently, though, experts are unclear on where Chief Justice John Roberts and Justice Anthony Kennedy stand.

If the Supreme Court rules for the plaintiffs, access to health insurance will be divided into two sections—states with subsidies and those without. States without Exchanges could see sharp increases in uninsured residents. Physicians could be held financially responsible for services rendered to patients who suddenly forfeit their insurance. And patients could go without badly needed medical treatment.

There is not much certain in health care policies these days except for the uncertainty.
In the Spotlight: CMS Poster Competition Winners

Papers judged in three categories

ENTHUSIASTIC residents, fellows and students proudly showcased their work before physician judges at the Chicago Medical Society’s Abstract Research Poster Symposium on March 13-14. Held in conjunction with the 68th Annual Midwest Clinical Conference, the competition invited young members from Chicago’s seven teaching institutions to present original abstracts in one of three categories. Throughout the two-day educational MCC, entrants were also on hand to discuss their submissions with both the judges and MCC attendees. The following section presents the top-ranking abstracts in basic science, clinical medicine, and health policy/medical education. We begin with the resident and fellow competition.

CATEGORY: BEST OVERALL
Resident/Fellow Competition #1

Curbing COPD Readmissions: Finding the Target Population While They Are Still in Their Beds
By Tina Shah, MD, MPH; Samira Qadir, MHA; Michael Miller; Edward Kim; Steven R. White, MD; and Valerie G. Press, MD, MPH.
University of Chicago Medicine, Department of Pulmonary and Critical Care, Center for Quality, and the Department of Hospital Medicine

Background: Chronic Obstructive Pulmonary Disease (COPD) is the third leading cause of readmissions and is now included in the Medicare Hospital Readmissions Reduction Program (HRRP). Little data exists to support the effectiveness of interventions to reduce readmission risk in the first 30 days after discharge for an acute exacerbation of COPD (AECOPD). Our institution developed a program targeted to all patients admitted with AECOPD. Our objective was to reduce all-cause 30-day readmissions. We present the development of the intervention and preliminary feasibility and outcomes data based on our iterative approach.

Methods: We piloted program elements in two phases through a Plan-Study-Do-Act (PDSA) quality improvement (QI) model. The study population included all admitted adult patients. Phase 1 aims were to: 1) develop a screening algorithm that rapidly identified AECOPD admissions before discharge; 2) pilot inhaler teaching using a teach-to-goal technique by respiratory care specialists (RCS); and 3) test a pulmonary consult provider (PCP) checklist. Phase 2 included: 1) determining the sensitivity and positive predictive value (PPV) for the screening algorithm in real-time; 2) completing quality assurance for inhaler education; and 3) piloting a nurse practitioner (NP)-led COPD consultation. Readmission within 30 days was obtained by chart review and by follow-up patient contact.

Results: Phase 1 ran from February-July 2014. Of the 839 screened patients, 226 were identified as likely AECOPD. Sixty-five patients (28.8%) were seen by the PCP and 80 (35.4%) by RCS (algorithm sensitivity=67.8%, PPV=38.9%). Phase 1 demonstrated the need for additional personnel outside of the fellow-attending consult service to complete inpatient consults and regular RCS quality checks. Phase 2 occurred from August-October 2014. In this period, 103 of 562 screened patients were identified as likely AECOPD. A single NP had the capacity to treat all program patients both in-hospital (55) and in one-week follow-up post-discharge visits (25); RCS saw 37 inpatients. The algorithm successfully identified 90.2% of patients ultimately identified as having AECOPD with a PPV of 53.4%. Of 242 AECOPD admissions over both pilot periods, the readmission rate was 21.1% (51). Index patients tended to be black (88.0%) and female (56.2%) with a median age of 65.

Conclusion: Our PDSA-based QI project demonstrates a novel, highly sensitive screening algorithm that identifies AECOPD admissions under the readmissions penalty before discharge. We additionally demonstrate the feasibility of an inter-disciplinary program to reduce COPD readmissions, a first step toward helping hospitals avoid financial penalties and improve patient-centered care.

CATEGORY: HEALTH POLICY
Resident/Fellow Competition #2

A Resident’s Perspective of the ACGME
By Deepa Sheth, MD, and Mandy Velligan, BA.
University of Chicago Medicine. Accreditation Council for Graduate Medical Education (ACGME)

Background: The need for residents to be knowledgeable about the ACGME and its role in graduate medical training is becoming increasingly important. New requirements, accreditation systems and terminology are making their impact on programs and now on residents. The objectives below aim to:

“The need for residents to be knowledgeable about the ACGME and its role in graduate medical training is becoming increasingly important.”
• Determine residents’ knowledge base of the various pillars of the ACGME.
• Educate residents on what the ACGME is and what it does.
• Increase global awareness of the ACGME and its continuous role throughout a resident’s training.
• Assess whether future presentations of similar topics would be of value.

Methods: A 12-question survey was sent to the radiology residents at the University of Chicago Medicine. The survey was composed of six basic ACGME-related topics, including: milestones; duty hours; case log requirements; core competencies; scholarly activities; and evaluations. A post-survey email was sent to the residents to cover the information queried on the survey and ask whether future presentations would be of value.

Results: A majority of residents (61%) responded to the survey.
• 50% were aware of three of the six core competencies of the ACGME.
• 85% knew what the role of the Clinical Competency Committee (CCC) was. However, only 25% of respondents knew what CCC stood for.
• 25% correctly identified the required minimum case log for chest x-rays (CXR).
• 95% of respondents were aware of the duty hour limitations of 80 hours per week, averaged over a four-week time period.
• 15% knew that faculty performance should be evaluated by residents once every year.
• 50% were aware that a minimum of 12 months of training is required prior to independent in-house on-call responsibilities.
• 85% knew that a written plan must be discussed with and signed by residents when they experience difficulties or receive unfavorable evaluations.

Discussion/Conclusion: The lack of knowledge about the ACGME and the various requirements was evident among the residents. There was a variable distribution of resident knowledge about the core competencies and duty hour requirements. Only a minority of residents correctly identified evaluation and case log requirements.

Such data can provide insight into residents’ knowledge of the ACGME and the organization’s increasing role in residents’ education. Continued resident feedback can lead to biannual updates on relevant ACGME-related requirements, and be delivered at the program or institutional level.
**CATEGORY: CLINICAL MEDICINE**

**Resident/Fellow Competition #3**

**Concurrent Molecular Alterations in Non-small Cell Lung Cancer**

*By Randy F. Sweis, MD, and Ravi Salgia, MD.*

*Department of Medicine, Section of Hematology/Oncology, University of Chicago Medicine*

**Background:** Detection and targeting of genetic alterations in lung cancer have transformed our approach to therapy over the past decade. Somatic gene mutations or rearrangements in specific “driver genes” result in oncogenic transformation and tumor growth. Clinical guidelines now incorporate molecular testing for alterations in epidermal growth factor receptor (EGFR) and anaplastic large-cell lymphoma kinase (ALK). Inhibitors of both kinases have demonstrated clinical activity and are FDA-approved. Historically, EGFR and ALK alterations have been viewed as independent, mutually exclusive events. However, recently identified cases suggest otherwise. We aim to identify cases of lung cancer with concurrent EGFR mutation and ALK rearrangement, and to describe their clinical characteristics.

**Methods:** Patients at the University of Chicago with non-small cell lung cancer (NSCLC) with multiple molecular alterations were retrospectively analyzed from 2011 to 2013. An additional literature review was conducted of reported cases with dual alterations. Clinical, molecular, and outcome characteristics were compiled and analyzed.

**Results:** Four cases of NSCLC with alterations in both EGFR and ALK were identified. A total of 20 cases have been reported. Ages ranged from 37 to 77 years. Nine patients never smoked. Mutations found in EGFR included exon 19 deletion, exon 23 polymorphism, L858R, L861Q, A767_V769dupASV, L718P, and L862R. Detected ALK alterations included variants 1, 2, 3b, and increased gene copy number. Disease control rates in patients treated with EGFR inhibitors and ALK inhibitors were 46% (6/13) and 71% (5/7), respectively.

**Conclusion:** NSCLC may be driven by concurrent molecular alterations. EGFR and ALK-targeted therapies appear to have modest activity in patients with tumors possessing both alterations. This series highlights the importance of comprehensive molecular profiling of newly diagnosed lung cancer. Dual-altered NSCLC patients may have distinct clinical characteristics warranting further study. Combination targeted therapy or novel multi-targeted tyrosine kinase inhibitors may prove beneficial in this group of patients.

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**CATEGORY—BEST OVERALL**

**Student Competition #1**

**Implications of a Peroxisome Proliferator-activated Receptor Alpha (PPARα) Ligand Clofibrate in Breast Cancer**

*By Karthic Chandran and Neelam Sharma-Walia.*

H. M. Bligh Cancer Research Laboratories, Department of Microbiology and Immunology, Chicago Medical School, Rosalind Franklin University of Medicine and Science.

**Background:** Inflammatory breast cancer (IBC) is a rare, very aggressive disease involving invasive ductal carcinomas, and is frequently hormone-receptor-negative. IBC has not been extensively explored at the molecular level. The development of new treatments and more accurate prognoses for women diagnosed with this disease require an understanding of how inflammatory breast cancer begins and progresses.

**Methods:** Primary human mammary epithelial cells (HMEC) (Cell Applications, San Diego, CA) were cultured in HMEC medium (Cell Applications). Primary inflammatory breast cancer cells, SUM149PT, and highly invasive Breast Cancer cells, SUM1315MO2 were obtained from Asterand, Detroit, MI. Gene expression profiling was done by quantitative real time-PCR. Sections from breast tissue samples of healthy subjects and patients were obtained from Biochain Institute, Inc. Immunohistochemistry was performed using primary antibodies against human PPARα with no cross-reactivity with PPARβ or PPARγ (anti-mouse PPARα from Millipore, Temecula, CA) using standard protocol. Cell cycle analysis was done by propidium iodide staining followed by flow cytometry using LSRII (BD Biosciences). Results were analyzed using ModFit Lt V3 software.

**Results:** In this study, we detected high expression of PPARα in human SUM149PT and SUM1315MO2 breast cancer cell lines, and in tissue sections of human breast cancer, compared to their normal counterparts. Among the lipid lowering drugs such as clofibrate, fenofibrate, and WY14643, breast cancer cells SUM149PT and SUM1315MO2 showed greater chemosensitivity to clofibrate. Treatment, which was performed with 20mM clofibrate for 24 hours and 48 hours, induced PPARα DNA binding activity. A remarkable reduction occurred in the expression levels of arachidonic acid pathway effector proteins such as cyclooxygenase-2 (COX-2) and 5-lipoxygenase (5-LO). Notably, clofibrate treatment reduced the circulating levels of the endogenous PPARα ligands prostaglandin E2 (PGE2) and leukotriene B4 (LTB4) in the conditioned medium obtained from SUM149PT and SUM1315MO2 cells. In addition, clofibrate treatment reduced the proliferative potential of both breast cancer cell lines tested, most likely due to the down-regulation of NF-kB and ERK1/2 activation, as measured by the nuclear translocation and protein levels of p-NF-kB and p-ERK1/2. Treatment with clofibrate also reduced cell cycle proteins cyclin D1, cyclin A, cyclin E, and induced P21 levels. In addition, we observed the down-regulated expression of lipogenic pathway
genes such as SPTLC1 (serine palmitoyltransferase), SREBP-1c (sterol receptor element binding protein-1c), HMG-CoA synthase, and Acyl-CoA oxidase, and the induced expression of fatty acid oxidation (FAO) enzymes CPT-1a (carnitine palmitoyltransferase-1a) and SREBP-2 (sterol receptor element binding protein). Clofibrate treatment of SUM149PT and SUM1315MO2 cells did not reduce the level of FASN (fatty acid synthase) but it did effectively reduce the phosphorylated form of FASN. We observed high expression of coactivator proteins SRC-1 (steroid receptor co-activator-1) and histone acetylase CBP-300 (p300 kDa/CREB binding protein) in the nuclear complexes obtained from clofibrate-treated SUM149PT and SUM1315MO2 cells.

**Conclusion:** These findings collectively suggest that stimulating PPARα with the safe, well-tolerated, and clinically approved drug clofibrate may provide a safer and more effective strategy to target the inflammatory, signaling and lipogenic pathways in aggressive IBC.

**CATEGORY: BASIC SCIENCE**

**Student Competition #2**

**Repeated Stress Shifts the Balance between Appetitive and Anxiogenic Stimuli**

*By Suraj Jaisinghani and Amiel Rosenkranz. Chicago Medical School, Rosalind Franklin University of Medicine and Science.*

**Background:** Repeated stress can trigger episodes of depression, along with symptoms of anhedonia and anxiety. Though often modeled separately, anxiogenic factors potently modulate hedonic, or appetitive, behavior. While repeated stress can increase anxiety and decrease appetitive behavior, it is not clear whether repeated stress can influence interaction between anxiogenic factors and appetitive behavior. The purpose of this study was to test whether repeated stress increases the effect of anxiety on appetitive behavior.

**Methods and Materials:** Adult male Sprague Dawley rats were trained to lever-press for sucrose pellet reward, an appetitive behavior. After performance criteria were reached for this behavior, rats were exposed to daily social defeat stress or control handling, once a day for five consecutive days. After two days or two weeks, rats were tested in behavioral assays for social withdrawal and anxiety to confirm the effectiveness of the daily social defeat model of stress. These data were compared with control and stress groups using a one-way ANOVA (analysis of variance). After an additional 24 hours, rats were tested for appetitive lever pressing (fixed ratio four schedule) under dim light or in the presence of anxiogenic bright light. These measures were compared with control and stress groups across age using a two-way ANOVA. Statistical significance was set at p<0.05.

**Results:** Repeated social defeat stress reduced exploration in the open field (main effect of stress p=0.006, F(1, 40) = 8.5) and decreased social interaction (main effect of stress p=0.0004, F(1, 40)=14.9), consistent with other models of stress. Repeated social defeat had minimal effect on baseline lever pressing for reward. However, stress-exposed rats were more sensitive to the anxiogenic light, as repeated stress substantially enhanced the effect of anxiogenic bright light on lever pressing. This effect was greater two days after the last stress exposure, and began to diminish within two weeks (stress times age interaction p=0.04, F (1, 40) = 4.4).

**Conclusions:** Previous studies demonstrate that social stress impairs a range of behaviors. However, little is known about the effects of stress on the balance between appetitive and anxiety behavior. These data demonstrate that the anxiogenic and anhedonic features induced by repeated stress can be separately measured, and that the impact of anxiogenic stimuli can be greatly enhanced after repeated stress, even in the face of appetitive drive. The data also demonstrate that apparent anhedonic-like effects of repeated stress can be due to increased sensitivity to anxiogenic stimuli, and may reflect an imbalance between anxiety and appetitive behavior.

**Clinical Relevance:** Repeated stress can trigger symptoms of anxiety and anhedonia in patients. However, the clinical presentation of these symptoms is quite variable. In order to understand variability these symptoms’ expression, factors that modify the symptoms need to be understood. A first step towards this understanding is to understand how the symptoms interact with each other. Repeated stress in rodents has been used to model the effects of stress in psychiatric disorders, and to model symptoms of anxiety and anhedonia. This study demonstrates that stress enhances the ability of anxiogenic conditions to suppress hedonic behavior. This may parallel interactions in depressed patients whereby anxiogenic states might induce anhedonia-like behavior.

“**These data demonstrate that the anxiogenic and anhedonic features induced by repeated stress can be separately measured.”**

**CATEGORY: HEALTH POLICY**

**Student Competition #3**

**The Effect of Psychiatric Patient Boarding Times in the Emergency Department Following Closure of a Public Psychiatric Hospital**

*By Ryan Misek, DO; Ashley DeBarba, DO; Samantha Margaritis, BS, and April Brill. Chicago College of Osteopathic Medicine, Midwestern University, Emergency Medicine Residency Program.*

**Objective:** Recently, a 75-bed state-operated inpatient psychiatric hospital closed near our hospital system. We analyzed the effect of closing this public mental health facility on psychiatric...
Methods: We performed a retrospective multicenter cohort study of all patients assessed to require inpatient psychiatric hospitalization at two community EDs from July 1, 2010, through May 10, 2013. All patients requiring inpatient psychiatric hospitalization were included. Exclusion criteria consisted of patients under age 18; patients over age 65; patients requiring medical stabilization prior to transfer; pregnant patients; and patients discharged from the ED prior to transfer to a psychiatric facility. A total of 1,108 patients qualified; the time of arrival, time of disposition and time of transfer were collected along with insurance data and accepting facility type. Using SPSS software, a two-sample t-test with correction for unequal variance analyzed boarding times before and after the psychiatric hospital closure on July 1, 2012.

Results: We found a statistically significant difference in the boarding time for patients transferred to a private psychiatric facility following closure of the public psychiatric hospital ($t= -3.086$, $P=0.002$, $df= 666.134$). There was no significant difference between patient boarding time before and after closure when transferred to either a public or private psychiatric hospital ($t= -1.33$, $p= .894$). The mean number of minutes before and after the closure was 752.46 and 758.36, respectively. Subgroup analysis identified a statistically significant increase in boarding time of patients with private medical insurance ($t= -2.530$, $P=0.012$, $df= 251.429$) and Medicaid/Medicare ($t= -2.087$, $P=0.037$, $df= 470$) following closure. There was a statistically significant difference in boarding time before transfer to public versus private psychiatric hospitals both before ($t=17.27$, $P=0.000$, $df=661$) and after ($t=13.795$, $P=0.000$, $df=440$) the hospital closure.

Conclusion: Although there was no statistically significant difference in overall psychiatric patient boarding in the ED following closure of a public mental health hospital, we did find that patients who were transferred to private psychiatric facilities experienced longer ED boarding times following the closure.

We also identified a statistically significant correlation of increased boarding time in both Medicaid/Medicare and privately insured patient groups following closure of the state-funded hospital. This study highlights the significant impact that the closure of a single inpatient psychiatric facility can have on nearby emergency departments. We hope to bring attention to the need for increased psychiatric services during a time when there is a nationwide trend toward the reduction of available inpatient psychiatric beds.

The top student abstract in the clinical medicine category found that the prevalence of diabetic retinopathy and procedures varied by insurance status, suggesting that screening and treatment disparities may exist in this population.

**Determining the Diagnosis and Treatment Patterns of Diabetic Retinopathy Patients in Chicago Based on Insurance Status**

By Michael Mbagwu; Paul Bryar; Kathryn Jackson; Charlesnika Evans; Theresa Walunas; Abel Kho, MD; Dustin French.

Northwestern University Feinberg School of Medicine.

**Background:** Diabetes is the leading cause of blindness among adults in the United States age 40 and older. Diabetes and diabetic complication rates have been shown to be higher in medically underserved populations. Gaining insight into diagnosis and ophthalmic care of minority, low-income, and uninsured patients will provide a further basis to effectively prevent, detect, and treat diabetic eye disease. We hypothesize that there will be variation in the frequency of diagnosis and treatment of diabetic retinopathy in patients based on their insurance status (Medicaid/financial means tested/uninsured vs. Medicare/privately insured).

**Methods:** The HealthLNK database was used to determine the prevalence of diabetic retinopathy and procedures varied by insurance status, suggesting that screening and treatment disparities may exist in this population.
Diabetes is the leading cause of blindness among adults in the United States age 40 and older.

**Results:** Of the 1,933,082 patients in the HealthLNK database, 171,427 were identified as diabetic (representing a total prevalence of 8.9%); 12,014 patients had diabetic retinopathy (7.0% of diabetics); and 2,143 patients had CPT codes related to diabetic retinopathy treatment (17.8% of all retinopathy patients). There were differences in the prevalence of both diabetic retinopathy in diabetics (5.7% vs. 9.0%, p<0.01) and subsequent treatment (15.4% vs. 20.2%, p<0.01) when comparing Medicaid/financial means tested/uninsured vs. Medicare/privately insured patients.

**Conclusions:** The prevalence of diabetic retinopathy and procedures varied by insurance status, suggesting that screening and treatment disparities may exist in this population. Future work will need to be done to elucidate the significance and reasons for these differences. This work also provides rationale for targeted screening and treatment strategies. The study demonstrates the effectiveness of using large multi-center EMR data such as HealthLNK to identify health care disparities and to design solutions to bridge this gap.

**A Hearty Thank You to All Competition Entrants**

The Chicago Medical Society and its judges wish to thank all residents, students and fellows who entered this year’s competition. Contestants representing the region’s seven teaching institutions impressed the judges with the range and depth of their work, and certainly did not make it easy for them to select the top submissions in each of the categories of basic science, clinical medicine, and health policy/medical education. CMS eagerly anticipates next year’s poster symposium, showcasing the work of Chicago’s brightest young members.

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**List of ICD-9 Codes to Identify**

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<thead>
<tr>
<th>ICD-9 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>491.21</td>
<td>Obstructive chronic bronchitis; with acute exacerbation</td>
</tr>
<tr>
<td>491.22</td>
<td>Obstructive chronic bronchitis; with acute bronchitis</td>
</tr>
<tr>
<td>491.8</td>
<td>Other chronic bronchitis</td>
</tr>
<tr>
<td>491.9</td>
<td>Unspecified chronic bronchitis</td>
</tr>
<tr>
<td>492.8</td>
<td>Other emphysema</td>
</tr>
<tr>
<td>493.20</td>
<td>Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, unspecified</td>
</tr>
<tr>
<td>493.21</td>
<td>Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with status asthmaticus</td>
</tr>
<tr>
<td>493.22</td>
<td>Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with (acute) exacerbation</td>
</tr>
<tr>
<td>496</td>
<td>Chronic: nonspecific lung disease, obstructive lung disease</td>
</tr>
<tr>
<td>518.81*</td>
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</tr>
<tr>
<td>518.82*</td>
<td>Other disease of the lung; acute respiratory failure; other pulmonary insufficiency, acute respiratory distress</td>
</tr>
<tr>
<td>518.84*</td>
<td>Other disease of the lung; acute respiratory failure; acute and chronic respiratory failure</td>
</tr>
<tr>
<td>799.1*</td>
<td>Other ill-defined and unknown causes or morbidity and mortality; respiratory arrest, cardiorespiratory failure</td>
</tr>
</tbody>
</table>

*Principal diagnosis when combined with a secondary diagnosis of AECOPD (491.21, 491.22, 493.21, or 493.22)
The Chicago Medical Society and State Senate President John Cullerton have launched a public health initiative to educate legislators and the public on the importance of bystander CPR via Project SMILE (Saving More Illinois Lives through Education). Project SMILE disseminates information about cardiopulmonary resuscitation, with the goal of teaching bystanders how to give CPR to adult cardiac arrest victims outside the hospital, before paramedics arrive. The technique is easy to learn and saves lives.

To help kick off this initiative, Senator Cullerton joined CMS President Kenneth G. Busch, MD, at the CMS Building on April 10, to engage in a hands-only CPR and AED workshop for legislators and their staff. Overseeing the workshop was CMS Trustee Vemuri Murthy, MD. “Any CPR is better than no CPR,” Dr. Murthy emphasized, pointing out to attendees that in addition to saving lives, immediate CPR can also minimize brain damage.

Dr. Murthy founded Project SMILE in 2010 as a community public health initiative by CMS in collaboration with the Illinois State Medical Society, based on information from the American Heart Association (AHA). Tina and Dennis McCauley, SMILE volunteers and owners of Learn for Life CPR in Bensenville, participated in the workshop. Before the hands-on session, which used CPR manikins and automated external defibrillators (AEDs), Dr. Murthy made some observations on the importance of CPR. “In the United States, sudden cardiac arrest is a leading cause of death, yet most Americans feel helpless to act during a cardiac emergency. Only about 40% of sudden cardiac arrest victims get the needed help on the spot before the emergency team arrives.”

Dr. Murthy said that hands-only CPR is more appealing to many people than conventional CPR where both chest compressions and ventilations (either mouth-to-mouth or with a breathing device) are advocated. “It’s 100 compressions per minute in the center of the chest to the beat of the Bee Gees’ disco classic, ‘Stayin’ Alive.’”

Dr. Murthy commended State Sen. John Mulroe, chair of the Senate Public Health Committee, for his championing of HB 3724, which added CPR and AED training to health education programs in high schools, and was signed into law last June. Dr. Murthy also pointed out that resuscitation science clearly indicates that hands-only CPR is as effective as conventional CPR in cases of adult cardiac arrest.

Attending the workshop were: State Treasurer Michael Frerichs; Cook County Board Commissioner John Fritchey and staff Bridget Kilmer; State Rep. Ann Williams and Colleen Smith, chief of staff (COS); State Sen. John Mulroe; Eric Carlson, COS for State Rep. Sara Feigenholtz; Molly Chirico and Moira Dolehide, staff for Senator Cullerton; Hon. Consul General of Nepal; Marvin A. Brustin; Vincent Bufalino, MD, senior VP, cardiovascular services, Advocate Healthcare; and Mark E. Peysakhovich, director of government relations, Illinois, AHA.

For more information, contact: Haydee Nascimento at 312-670-2550; hnascimento@cmsdocs.org.
Welcome to the Chicago Medical Society!

Representing over 17,000 physicians, the Chicago Medical Society 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. When you join, 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 reimbursement practices, restrictions on physician autonomy and the erosion of valuable legislation that protects physicians’ practices. CMS and ISMS can help enhance your practice, improve your bottom line, and protect your autonomy as a physician.

As a member of CMS and ISMS you have access to the wealth of resources both organizations offer as well as access to the extensive expertise of their staff. CMS and ISMS offer you the opportunity to learn about trends in the practice of medicine through committee participation, policy development, educational seminars, and publications. Also, membership provides networking opportunities, membership services, and a strong voice in state and national policy-making bodies. This page focuses on the benefits of legislative advocacy.

Legislative Advocacy
CMS’ strong legislative programs build coalitions of engaged physicians and establish productive relationships with lawmakers and other decision makers locally and statewide. We work continuously to positively shape public policy on behalf of physicians and patients. We collaborate with ISMS, and its influential Governmental Affairs Division, to prevent harmful legislation from becoming law, and to implement pro-medicine legislative proposals at the county, state, and federal level. Our scope is ambitious and comprehensive, benefiting physicians globally and on a day-to-day basis, with tangible results and savings. Our policy and legislative components include:

Shaping Legislation
CMS provides a launching pad for physician and patient protection initiatives; your active participation is key to our success in Cook County, Springfield, and Washington, DC. Against a rapidly changing health care landscape, lawmakers are making rapid-fire decisions about funding, reimbursement, medical liability, ACOs, and public health, among other areas. Physicians have the unique perspective and insight to advise elected officials, explaining how specific legislation will positively or adversely affect the medical profession, patients and day-to-day practice. Working together, our organizations introduce and influence legislation at the county, state, and federal level. Who better than our team of experts to guide elected officials and key decision makers?

Relationships with Legislators
CMS leaders engage lawmakers on a regular basis. Each year we travel to Washington, DC, where we meet with approximately one-third of the Illinois Congressional Delegation. We also relay your concerns in Chicago and Springfield, proposing solutions on health care delivery, Medicare and Medicaid, medical liability, and looming workforce issues. This past year we engaged the following legislators: U.S. Sens. Richard Durbin and Mark Kirk; U.S. House Reps. Adam Kinzinger; Mike Quigley; Danny K. Davis; Jan Schakowsky; Bill Foster; and Tom Price, to name a few.

Mentorships for Lawmakers
The CMS Mini-internship program matches you for a day with an elected official while you make daily rounds, perform surgery, or care for patients in the clinic or hospital. This shows legislators firsthand the complexities and hassles you encounter each day. Many legislators have said they come away with a new appreciation and respect for the practice of medicine.

Not only do they witness the impact of legislation on physicians and health care delivery, but our members also acquaint themselves with the responsibilities of legislators, and learn how to communicate their needs to them. The program also informs lawmakers and civic leaders that CMS is a valuable source of information and guidance on health policy issues, which they should use in their deliberations.

For details on the CMS Legislative Mini-internship Program, please contact Haydee Nascimento at 312-670-2550; or hnascimento@cmsdocs.org.

Key Contacts Program
CMS makes it easy for members to commit themselves to the advocacy process. Through our Key Contacts program, CMS encourages and trains volunteers to form meaningful connections with their lawmaker or someone running for elected office. The program is flexible, accommodating physicians’ busy schedules.

Specific duties of a Key Contact include periodically communicating CMS’ views on specific legislation or other advocacy activities, as well as CMS events and goals, to legislators. Volunteers also may interact with legislative staff and report on their efforts to the CMS districts and leadership. The information exchange keeps volunteers up to date on issues within their communities.

Members who personally know a legislator are encouraged to build on their acquaintance with the lawmaker. To learn more about this worthwhile program, please call 312-670-2550.

Grassroots Advocacy Center
The CMS website informs members of new and pending legislation, encouraging them to engage with their congressional representatives. The site provides contact information, links, sample letters, and guidance on communicating effectively with legislators.

Governing Council
We recognize the necessity of a strong representative Society that engages all Cook County physicians. In recent years, CMS expanded its grassroots Governing Council, giving new seats to specialty societies and hospital medical staff organizations. This expansion gave our “affiliated” groups a voice, creating a platform for all 17,000 physicians in the county region. We encourage all members to actively shape Society policies and objectives through resolutions and to communicate with our leaders in this democratic forum.

Authoring Resolutions
The ISMS House meets once a year to set objectives on key issues. The resolutions members submit to the CMS Governing Council directly shape these objectives. ISMS also works directly with the Illinois General Assembly to introduce and influence legislation promoting and protecting medical practices and physicians.
Calendar of Events

MAY

1 ICD-10 CM: Preparing for a Successful Implementation Intended for all physicians, practice managers, physician executive staff, and medical office staff. A successful transition to ICD-10 CM by Oct. 1, 2015, will require careful planning. Numerous provider and health plan databases and applications will be affected—including applications where diagnosis or procedure codes are captured, stored, analyzed or reported. Participants will learn to describe the key plan elements required for a successful transition; make recommendations for each of the four implementation phases; discuss the code structure, format and basic conventions of ICD-10-CM diagnosis coding; and understand its impact. Speaker: Nelly Leon-Chisen, RHIA, director, coding and classification, American Hospital Association, Chicago. Registration/breakfast: 8:30-9:00 a.m.; presentation: 9:00 a.m.–12:30 p.m. Chicago Medical Society, 33 W. Grand Ave., Chicago. Up to 3.5 CME credits; $59 per person for CMS members; $159 for non-members or staff. Register online at: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

10 Stop the Clot Chicago 5K Run/Walk The National Blood Clot Alliance along with race director Christina Martin are hosting this event to educate the Chicago area about the dangers of blood clotting disorders. 9:00 a.m., Montrose Ave. Beach, 4400 N. Lake Shore Dr. For more information, please call 641-715-3900, ext. 593533, or visit www.stoptheclotchicago.com.

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

13 CMS Executive Committee Meeting Meets online 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. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

20 Resident Paper Competition This event is hosted by the Chicago Gynecological Society. 6:00 Registration; 7:00 Dinner and Lecture; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. Cost: one dinner credit for CGS members; $75 for non-members. To register and pay, go to www.chicagogyn.org/schedule. For more information or questions, call 312-670-2550.

21 High Volume Fat Grafting This event is hosted by the Illinois Society of Plastic Surgeons. 6:30 Cocktails and Registration; 7:00 p.m. Dinner and Lecture; Speaker: Louis P. Bucky, MD; Willis Tower Metropolitan Club, Michigan Room on 66th Floor, 233 S. Wacker Dr., Chicago. Members may attend at no cost. To RSVP, please call 312-670-2550.

30 Midwestern Association of Plastic Surgeons 54th Annual Scientific Meeting 7:00–6:00 p.m.; Northwestern Memorial Hospital, 251 E Huron, Chicago. To register, go to https://maps2015.eventbrite.com.

JUNE

3 ICD-10 CM: Preparing for a Successful Implementation See description for the May 1 event. Speaker: Nelly Leon-Chisen, RHIA, director, coding and classification, American Hospital Association, Chicago. Registration/breakfast: 8:30-9:00 a.m.; presentation: 9:00 a.m.–12:30 p.m. Hilton Chicago-Oak Lawn, 9333 S. Cicero Ave., Oak Lawn. Up to 3.5 CME credits; $59 per person for CMS members; $159 for non-members or staff. Register online at: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.

10 Senior Resident Paper Competition This event is hosted by the Illinois Society of Plastic Surgeons. 7:30 Cocktails and Registration; 8:00 p.m. Dinner and Presentations; Columbia Yacht Club, Upper Deck, 111 N. Lake Shore Drive, Chicago. Members may attend at no cost. To RSVP, please call 312-670-2550 or contact Andrea at aalletto@cmsdocs.org.

6-10 AMA House of Delegates The legislative and policymaking body of the AMA transacts all business not otherwise specifically provided for in its Constitution and Bylaws, electing general officers except as otherwise provided in the Bylaws. CMS actively participates in the American Medical Association’s policymaking meetings, advocating for both members and their patients. Resolutions adopted at the CMS governing Council frequently travel to the Illinois State Medical Society, where they are implemented, before ultimately reaching the AMA. CMS delegates to the AMA may submit a resolution directly to the AMA House for consideration and support. Physicians are encouraged to exercise this membership privilege, ensuring their voice is heard at the highest levels of organized medicine and beyond. The Hyatt Regency Hotel, Chicago. For information, please go to www.ama-assn.org.

10-12 Physician Legal Issues Conference 2015 (Sponsored by the Chicago Medical Society and American Bar Association’s Health Law Section.) Designed for all physicians and health care attorneys, this 2.5 day CME program will give participants a medical-legal update of changes and trends in the health care delivery system; review the impact on the practice of medicine; and offer strategies to meet these challenges. Core topics are as follows: Medicare in crisis; Stark Law and Anti-kickback Statute; negotiating managed care contracts; HIPAA for physician offices; the state of payment innovation; clinical integration payment trends; payer and provider initiatives; medical liability trends; public health service community pharmacies; update on Medicare program integrity efforts; anatomy of an investigation, vendor relationships; maintaining a successful independent practice, physician shortages and use of NPs and other allied health workers; ethics and conflicts in representing multiple entities and partners; physician and lawyer wellness; and telemedicine. There will also be a diversity reception. Wednesday, June 10 (1:00-4:30 p.m.); Thursday, June 11 (8 a.m.-7:00 p.m.); and Friday, June 12 (8 a.m.-2:30 p.m.). The Palmer House Hilton, 17 E. Monroe St., Chicago; approximately 15 CME credits. To RSVP, please visit: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or call 312-670-2550, ext. 338.
Personnel Wanted

Anesthesiologist, board-eligible or board-certified needed, part-time for Family Planning Surgical Centers in Chicago, Northwest suburbs and West suburban Chicago, Ill., area. Early morning to mid-afternoon hours one to four days a week available. Please send resumes to administration@officegci.com and/or vg1028@aol.com and by fax to 847-398-4585.

Ob-gyn physician wanted to perform surgeries, D & C, laparoscopic tubal sterilization, hysteroscopy and other gynecological procedures part-time (25-30 hrs.) in Family Planning Surgical Centers in Chicago, Northwest suburbs and West suburban Chicagoland area. Must be within 50 miles of Chicagoland area. Please fax CV to 847-398-4585 or administration@officegci.com and/or vg1028@aol.com.

Office/Building for Sale/Rent/Lease

For sale. Medical practice with building including office and three apartments at 6151 W. Belmont Ave., Chicago. Asking price: $348,000. Call 773-909-0890.

For sale: Freestanding multi-specialty surgery center in Wood Dale, Ill., with ample parking. State-licensed ASC with one larger and one smaller operating room, 3,800-4,000 sq. ft. Asking $4.75 million, not including real estate. Serious inquiries only. Email Administration@officegci.com and vg1028@aol.com or fax: 847-398-4585.

For sale: Medical office/urgent care facility; 1650 Maple Ave., Lisle; 1,500-4,000 sq. ft. available. Single story, 20-30 car parking lot. Asking $799,000. Email kimberleeo@officegci.com and/or fax: 847-398-4585.

For sale: Plastic surgery/pain management medical office; 736 N. York Rd., Hinsdale. Building area (approx.) 3,200 sq. ft. Large operating room and recovery room. Single story, freestanding building, ample parking. Asking $859,000. Email administration@officegci.com or vg1028@aol.com. Fax: 847-398-4585 with serious inquiries.

Business Services

Physicians’ Attorney—experienced and affordable physicians’ legal services including practice purchases; sales and formations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning; and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0060; or 847-212-5620 (mobile); 2700 Patriot Blvd., Suite 250, Glenview, IL 60026-8021; shj@sjesser.com; www.sjesser.com.

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District 5
Mary L. Kelly, MD
Bettina W. Killion, MD

District 6
David A. Ebert, MD
Ajay Nehra, MD
As Medical director of the Communicable Disease Program for the Chicago Department of Public Health (CDPH), Stephanie Black, MD, MSc, has had a guiding hand in helping Chicago’s health care facilities deal with emerging issues. Her office made outreach efforts to guide the medical community during the recent Enterovirus D-68 outbreak; during the Ebola scare, she helped set up designated treatment centers, and worked closely with Chicago's Ebola Resource Network chief medical officers and hospital epidemiologists. And she's “on call” if any infectious disease outbreaks, spate of food poisonings, or pandemics, befall our city.

“My job is to identify the source of infectious diseases, find those who are infected or at risk of infection, communicate concepts about the illness and to halt the spread of infectious diseases” Dr. Black says. She emphasizes that her department exists to serve as a resource to the medical community, and to respond when clinicians identify clusters of illness or diseases that are reportable to the state health department and the Centers for Disease Control. “We work as a team to investigate infectious disease cases or clusters and often work in conjunction with other local health departments, the state, and the CDC,” she says.

For Dr. Black, working in public health was something she seemed destined for. She grew up in Bethesda, Maryland, where her cardiologist father, Robert Goldstein, MD, worked for the National Institutes of Health, and her late mother, Sue, was a psychiatric social worker. She recalls times with her parents that stimulated her love of health care. Like the time when she was a teenager, and her father brought her to the hospital, and told her to feel for a patient's pulse. “It’s not regular,” she told her dad. “You’re right!” he beamed since she recognized a key finding that would establish a diagnosis of atrial fibrillation. She felt good about her “diagnosis.” In 1988, when she was a sophomore in college, her father was invited to speak at a teaching hospital in Zambia in Southern Africa during the first few years of the AIDS epidemic. Dr. Black and her mother joined him. Dr. Black recalls her mother as “being like Princess Diana,” shaking hands with AIDS patients—before it was OK to touch AIDS patients. “My mother encouraged me to become a doctor.” And that’s just what Dr. Black did, earning her medical degree from Temple University Medical School. Dr. Black went on to work in infectious disease at Rush University Medical Center, where she had a grant to develop disaster preparedness material for physicians. She found the work fascinating, and when she saw what the CDPH was doing in these areas, she jumped at the chance to join, becoming medical director of the Communicable Disease Program in 2008.

Today, Dr. Black is working to increase the CDPH’s interaction with health care providers from all the city’s health care facilities, and is developing plans to work more closely with long-term health care facilities on infection control.

On a personal note, Dr. Black is married to Adam Black, MD, an emergency medicine physician at Presence Saints Mary and Elizabeth Medical Center. They have two sons, Aiden, 12, and Aaron 8. “I think Aiden might end up becoming a physician,” Dr. Black says. “Every night he asks us all about our work that day, and he has an app where he can create pandemics. But my youngest, Aaron, says he wants to drive the Blue Line L train when he grows up, or become an artist.”
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