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John Jay Shannon, MD, CEO of the Cook County Health & Hospitals System, has long worked for the common good. Starting with an early desire to find solutions to the problem of asthma, Dr. Shannon—an internist with specialist certifications in pulmonary and critical care medicine—has broadened his interest to include reducing health care disparities in Cook County. By Cheryl England
A Victorious Session

As the driving force behind landmark policies, Chicago Medical Society representatives to the Illinois State Medical Society House of Delegates tackle many diverse and red-hot issues facing physicians in Cook County. This year alone, CMS brought nearly two dozen measures to our medical legislative body, which met April 17-19, to forge a consensus on over 50 member-authored proposals. Between deliberations, CMS Caucus members strategize, testify before reference committees, and generally shape the course of advocacy in the State of Illinois.

The highlight, of course, is seeing our resolutions pass, thus creating a foundation for new laws to protect physicians and their practices. Major CMS measures this year dealt with universal topics like maintenance of certification, payment guidelines, medical necessity, and more. Still others laid the groundwork for public health initiatives on behalf of patients.

On the practice-related front, the House overwhelmingly passed “The Provider Shield Act of Georgia,” a resolution from CMS President-elect Kathy M. Tynus, MD. The measure seeks Illinois legislation to prevent the linking of payment policies with standard of care in medical malpractice lawsuits. The legislation is modeled on a law signed into effect in Georgia in 2013. “Physician Certification and Licensure” urges ISMS to pursue a state law forbidding employers and insurers from requiring physicians to participate in time-limited MOC. For details on this resolution, see page 8.

Several initiatives will be carried forward to the American Medical Association and, from there, to the halls of Congress. “Food Allergy Notification by Restaurants,” introduced by CMS Past President Howard Axe, MD, proposes state law modeled on the Food Allergy Awareness Act in Massachusetts. The measure also calls for the AMA to introduce federal legislation modeled on the law. For details on this resolution, see page 14.

You’ll find coverage of this year’s bountiful crop of CMS resolutions throughout the magazine.

CMS is privileged to have more delegates than any other county medical society in the state. As a result, our voice is particularly strong when it comes to advocating for legislative issues of importance to physicians and their patients. Our participation in ISMS gives physicians of all specialties a strong united voice. The forward march of resolutions on a trajectory that begins at CMS is proof that every single CMS member has the power to shape the direction of health care legislation.

As we celebrate our victories, your CMS leaders encourage you to think about the many issues you would like to address next year. Together, we can make this happen.

Kenneth G. Busch, MD
President, Chicago Medical Society
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Finding Your Inner Medical Student

We need to be reminded why we went into medicine and how fortunate we are to be doctors By Sameer Vohra, MD, JD

LAST MONTH, I attended a lecture on the current landscape of the health care marketplace. Sitting in the back of a crowded classroom, I listened to a director of a high-powered health care consulting firm open his talk by asking the audience to associate one word with doctors. The audience, mostly business, policy, and social service personnel, started with the words smart and rich. Then, someone yelled out unhappy. Murmurs followed with two other individuals also stating, “Yes, very unhappy.” The speaker moved on, but as I listened to him discuss the many recent health care mergers and acquisitions in Chicago, I could not stop thinking about that introductory exchange. Was the secret out? Does everyone know that doctors are unhappy? Medical students understand this concept profoundly, which is why they are so excited. They want to be us. We should want the same thing.

A week later, I found myself addressing medical students at the University of Illinois at Chicago. I was invited to speak about advocacy during residency and provide the students with a model of patient and community engagement. The students in attendance were so engaged. They asked wonderful questions, participated enthusiastically in discussions, and were eager to implement the lessons I had conveyed. Everyone in the room could feel the excitement. These medical students were so passionate about becoming doctors and about the impact they were going to make on people’s lives. Despite the long hours and strenuous study, these students were profoundly happy.

“Our time, education, and struggle allow us the unique privilege of healing the sick. Medical students understand this concept profoundly, which is why they are so excited. They want to be us. We should want the same thing.”

I left that room so energized. I was excited to see my patients and continue to make a difference. But, I could not shake that lecture from last month. Was I as enthusiastic about medicine as a medical student? I think I was. If so, what happened? How did it happen so quickly? Would my current excitement wear off the moment I entered the hospital? I was very afraid it would.

The truth is many physicians are unhappy and dissatisfied with their career today. We have all heard a colleague say, “If I had to do it all over again, I would not be a doctor,” or similarly, “I will never let my children become physicians.” Even if you do not agree, most physicians completely understand. Our profession has challenges, and many just don’t want to be doctors anymore. The Medscape Physician Compensation Report 2014 shows that only 58% of physicians would choose medicine as a career if they could do it all over again. Only 47% would choose the same specialty, and a miniscule 26% would choose the same practice setting. Even the most satisfied specialty, dermatology, had an overall satisfaction percentage of only 65%. The data is clear, and the secret is definitely out. Physicians are not satisfied with their profession.

This general feeling of discontent is as prevalent in young physicians as it is in our older colleagues. Our friends of similar age and intellect have high-powered positions with status or income that we may not share. Instead, we enter a bureaucracy where we have limited control and ownership over our lives. This arrangement combined with decreasing salary, long hours, and disgruntled patients leave us feeling lost. The hope and optimism that filled us as medical students have been overwhelmed by challenges and constraints.

A Special Profession

But there is hope. In the weeks following my lecture, I have become increasingly satisfied with my job. The challenges remain, but I rediscovered why I wanted to be a doctor in the first place. Just like those enthusiastic medical students, I wanted to make a positive impact on people’s lives. I wanted to make my patients healthy so they could live their lives to the fullest. I cannot say for certain that this excitement will continue in the weeks or months to come. However, I am going to hold on to my inner medical student, and will continually remind myself how lucky I am to be a doctor.

I think all of us, regardless of our years of experience, need these interactions with medical students. We need to be reminded why we went into medicine in the first place and how fortunate we are to be doctors. Our time, education, and struggle allow us the unique privilege of healing the sick. Medical students understand this concept profoundly, which is why they are so excited. They want to be us. We should want the same thing. When we do, others will continue to realize how special our profession really is.

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.
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Physicians and practice managers often ask why they have to consider compliance with the Stark Law when it comes to their internal physician compensation system. The short answer is that a practice has to meet the statutory definition of a “group practice” under the Stark Law to satisfy certain exceptions to the Stark Law self-referral prohibition.

The Stark Law prohibits physicians from referring Medicare beneficiaries to health care providers, including their own group practice, for certain services if their financial relationship with the provider does not fall within an exception to the Stark Law. A group practice is also prohibited from billing the Medicare program and any other payers for any services provided pursuant to a physician referral prohibited by the Stark Law.

One of the most commonly used exceptions to the Stark Law is the “in-office ancillary services exception.” This exception allows physicians to refer Medicare patients to their practices for certain diagnostic services and for the practice to bill Medicare for these services through their practice. One of the requirements of this exception is that a physician’s practice must meet the statutory definition of a group practice under the Stark Law.

The group practice definition in the Stark Law prohibits physicians from being compensated in a manner that directly takes into account the volume or value of the physician’s referrals for services that are not personally performed by the physician. For example, a physician who orders a nuclear scan or CT from his or her practice cannot be allocated directly the revenues from the technical portion of these tests. However, physicians can be allocated the revenues from the professional interpretation of these tests.

The next question often asked by physicians and practice managers is whether any physicians or group practices have been prosecuted or entered into settlements with the government for having an internal compensation arrangement that was not in compliance with the group practice definition under the Stark Law.

In short, yes. For example, in August 2014, a New York cardiology group paid $1.3 million to settle allegations that it violated the False Claims Act by compensating its physicians in violation of the Stark Law. Specifically, the government alleged that the cardiology group paid compensation to its partner physicians over a one-year period based on a formula that took into account the volume or value of that physician’s referrals for nuclear scans and CT scans provided through the group. The government also alleged that the group adopted this compensation formula with knowledge that doing so could violate the Stark Law.

The Stark Law also contains specific rules for allowing physicians to be paid productivity bonuses and profit shares without violating the prohibition against compensation based directly upon a physician’s referrals. For example, a physician may be paid a portion of the revenues received by their group based upon services ordered by that physician, which are subject to the Stark Law. In regard to profit shares, the revenues can be from the entire group or any subgroup of at least five physicians.

In summary, there are several types of physician compensation affected by the Stark Law. And, based on the case in New York last year, the internal compensation practices of physician groups are not beyond the reach of the Stark Law.

The information in this article is intended for informational purposes only, and should not be construed as legal advice. Clay J. Countryman, JD, is a partner with Breazeale, Sachse & Wilson, LLP, in Baton Rouge, Louisiana. You can reach him at Clay.Countryman@bswllp.com.

History of the Stark Law

The Stark Law is named after U.S. Rep. Pete Stark, who sponsored the initial bill in 1989. The federal physician self-referral law, normally known as the “Stark Law,” generally prohibits healthcare professionals from referring their Medicare and Medicaid patients to facilities in which they or their immediate family members have an ownership or investment interest. The idea behind the Stark Law is that, if physicians are permitted to make such “self-referrals,” they will make more referrals than are medically necessary, resulting in over-use of the system and an unwarranted draining of the taxpayer dollars.

The Stark Law contains a number of exceptions, including exceptions for space and equipment leases and physician recruitment, as long as certain requirements are met. The Stark Law is related to, but not the same as the federal Anti-Kickback Statute.
Starting Meaningful Use Now

It’s not too late if you know what to do  By Janet Baxter, MBA, RHIA, and Abel Kho, MD

In May 2013, the Centers for Medicare and Medicaid (CMS) announced that more than half of all eligible health care providers had been paid under the Medicare and Medicaid EHR Incentive Programs. More than half a million providers have received payments and almost $30 billion has been paid out to meaningful users through February of this year. Penalties to Medicare Part B billings have started for those who are not enrolled.

The good news is that you can avoid future penalties and earn incentive payments if you use an electronic health record system in a meaningful way. Any eligible physician can start now. Certified electronic health record technology (CEHRT) is required. Hospital-based providers are not eligible, but there is a program for hospitals, too. Eligible providers who see Medicare or Medicaid patients can receive incentive payments, while other participants can avoid Medicare penalties but are not eligible for incentives.

Why Participate?
All EPs who are not meaningful users today will have a penalty applied to any Medicare physician fee schedule (PFS) billings for covered professional services starting in 2015. Even if you are not eligible to start the Medicaid incentive program but are using CEHRT, you should attest to avoid the penalty. The penalty starts at 1% and increases each year to become 5% of Medicare Part B billings in 2020.

EPs who are eligible for incentives paid through Medicaid can start the program through 2016. This requires that you bill more than 30% (20% for pediatricians) of your patient encounters for Medicaid services starting in 2014 CEHRT, register on the CMS website and start meeting the Stage 1 measures.

What to Do Now
Start by implementing a 2014 CEHRT. The cost for these systems runs from zero dollars to hundreds of thousands. If you have already started using 2014 CEHRT, register on the CMS website and start meeting the Stage 1 measures.

If more than 30% of your encounters are for Medicaid participants, register for the electronic Medicaid Incentive Payment Program (eMIPP) with Illinois HFS. If you have committed to a certified system and are eligible for the Medicaid program, you can attest to AIU (Adopt, Implement, Upgrade) and get the first payment of $21,250 for each eligible provider. The next step is to attest to meeting the Stage 1 measures in 2016.

What Is a Meaningful User?
To prove you are using the EHR in a meaningful way, you will attest that you have met or have exceeded a set of specific measures, such as how often you use the system to enter orders, e-prescribe and provide a summary of visits.

Some core measures are met by simply attesting “yes” that you have met the measure. These measures include completing a security risk assessment and turning on certain features of the EHR such as warnings for possible drug interactions or allergies to prescribed medications. Other measures require you to meet certain thresholds for the number of times you use the system correctly.

Thresholds reflect the documentation of patient information such as current medications, allergies, problems, vital signs, smoking status and demographics. You will also report the number of orders entered by the provider (CPOE), the amount of e-prescribing, and the quantity of after-visit summaries presented to your patients. The newest requirement is to provide electronic access to more than 50% of patients seen.

You will also need to attest that you are submitting electronic data to I-Care for immunizations administered. You can then choose four of the following: implementing a drug formulary; having lab results entered as structured data, such as with a lab interface; sending patients appropriate reminders; providing patient education; and recognizing inbound or outbound transitions of care by documenting medication reconciliation or providing a summary of the patient’s care to the next provider.

To become a meaningful user, you will also report certain clinical quality measures, either with your meaningful use attestation or through Physician Quality Reporting System (PQRS). There is no threshold required on these measures.

How Long Does the Program Last?
To avoid penalties on any Medicare Part B reimbursements, you’ll need to attest each year until the federal CMS says you can stop. The Medicaid EHR Incentive Program payments will end after you have earned six payments, for a total of $63,750, or when you reach the year 2021, whichever comes first. You cannot start the Medicaid Incentive program after 2016.

The Chicago Health IT Regional Extension Center and Illinois’ Meaningful Use Help Desk offer help. Call 855 MU HELP1.

Janet Baxter, MBA, RHIA, is meaningful use program manager at Alliance of Chicago. Dr. Kho is an internist and co-executive director of the Chicago Health IT Regional Extension Center (CHITREC).
The Chicago Medical Society is actively engaged in advocacy to protect physicians from unnecessary regulatory and financial burdens. Here is a summary of CMS initiatives debated by the Illinois State Medical Society House of Delegates on April 17-19.

**Physician Certification and Licensure**

**Author:** Makis Limperis, MD  
**Status:** Adopted

This CMS measure directs ISMS to seek Illinois legislation that would prohibit any and all entities from requiring physicians to participate in prescribed corporate programs, including maintenance of certification or expiration of time-limited MOC, and from discriminating against physicians economically through various fee schedules. The measure applies to hospitals, employers, all insurers and third-party payers (Medicare and Medicaid), the Illinois Department of Financial and Professional Regulation, and others. In addition, the resolution directs the American Medical Association (AMA) to introduce corresponding national legislation.

Before bringing this initiative to ISMS, CMS reaffirmed its advocacy for lifelong continuing medical education, and active opposition to discrimination against physicians who choose not to engage in corporate re-certification programs labeled as “voluntary” by the specialty medical boards.

The American Board of Medical Specialties (ABMS) changed the concept of lifetime, into “time-limited,” further implementing yearly participation enrollment against active physician opposition. ABMS continues to press legislation coupling insurance payments to active enrollment in time-limited board certification and the associated maintenance of certification program nationally.

[The Federation of State Medical Boards’ proposed Interstate Medical Licensure Compact]
creates a license for physicians who want to practice in more than one state. The Compact would override state medical board licensure, and add a costly new bureaucratic layer for practicing physicians. The Compact requires at least seven states to participate before the legislation can be enacted, enabling functionality and the creation of an interstate commission. Also, the Compact defines a physician as someone who "holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists."

Provider Shield Act of Georgia

Author: Kathy M. Tynus, MD
Status: Adopted

This CMS measure won unanimous support from the ISMS House. CMS seeks Illinois legislation to prevent the linking of payment policies with standard of care. The measure comes in response to provisions in the Affordable Care Act (ACA) that expose doctors to potential medical liability if they fail to comply with payment policies.

Illinois legislation modeled after the Provider Shield Act of Georgia is critical to ensuring that payer policies and criteria under federal law are not used to establish a legal basis for negligence or breach of standard of care in medical malpractice or product liability lawsuits. The Georgia law protects physician from various liabilities for breach of federal statutes, regulations, programs, policies or any other provisions that might apply.

Signed into effect in May 2013, the law amends Chapter 1 of Title 51 of the Official Code of Georgia Annotated. The model legislation was drafted by the AMA’s Advocacy Resource Center.

Medical Necessity

Author: Jonathan C. Gamze, MD
Status: Adopted as Amended

The House approved this CMS effort to amend Illinois’ Insurance Code. The Code should be consistent with CMS and ISMS policies that clearly stipulate that only treating physicians may determine medical necessity while insurance providers determine medical benefits.

ISMS will therefore support or cause to be introduced legislation amending the Illinois Insurance Code to align with these policies, so that medical necessity decisions are the domain of treating physicians. Illinois law currently permits insurance companies to deny benefits claiming that a procedure is not medically necessary, when the denial is actually based on concealed cost criteria unknown to the patient and physician. Thus, insurers could no longer deny care under the guise of medical necessity.

The measure also clarifies the distinction between medical necessity and medical benefits. Greater transparency allows patients and physicians to know exactly which services are reimbursed. Disputes over medical necessity have led to controversial litigation, including lawsuits against physicians. Virtually all Illinois physicians and patients stand to benefit from reform of the Code.

Medicaid Primary Care Pay

Author: Chicago Medical Society Advocacy Committee
Status: Adopted as Amended

Pursuant to the Affordable Care Act, primary care providers got a much-needed pay increase, allowing them to keep their doors open to Medicaid physicians. Your Chicago Medical Society is working to keep it that way. The three-year bump came to an end on Dec. 31, 2014, with potentially tragic consequences for patients. That’s why this initiative urges lawmakers to maintain higher pay for Medicaid primary care providers in Illinois.

Although some state legislatures have agreed to maintain the higher amount, Illinois is not among those states. ISMS therefore will support or cause to be introduced legislation in the General Assembly to ensure the higher rate for primary care providers is not reduced below the original Illinois incentive payment schedule.

Momentum for this CMS-launched measure comes from physician members who warn that pay cuts threaten gains in patient access, with particularly detrimental effect on children who recently enrolled in the program. The influx of patients into Medicaid coupled with a shortfall of participating physicians all point to critical access issues without legislative action.

Support for Physician-Owned Labs to be Exempted from Anti-Markup Legislation

Author: Maura Quinlan, MD, and Amy Derick, MD
Status: Adopted

This CMS resolution would broaden the exemption currently in place that prohibits physician-owned laboratories from marking up the anatomic pathology services they order or provide. (Public Act 098-1127). Illinois law does exempt facilities licensed under the Hospital Licensing Act, public health clinics, and nonprofit health clinics. Both the Illinois Dermatological Society and the Illinois Section of the American Congress of Obstetrician and Gynecologists support broadening the exemption.

Public Act 098-1127 was an initiative of the Illinois Society of Pathology. As originally introduced, the bill amended the Medical Practice Act to prohibit any clinical laboratory or other physician from charging, billing or otherwise soliciting payment for anatomic pathology services unless the services were rendered personally by the clinical laboratory or physician, or under the clinical laboratory’s or physician’s direct supervision.
The legislation was the subject of great controversy within the physician community when it was introduced in 2013. Dermatologists, obstetricians, gynecologists and gastroenterologists opposed the bill. A subsequent bill, Senate Bill 1630, amended the Act to prohibit the markup of anatomic pathology services. It requires that a physician who orders, but does not supervise or perform, an anatomic pathology service to disclose in a bill to the patient the name and address of the physician or laboratory that provides the pathology service and the amount paid or to be paid for each pathology service. The amendment does not prohibit a referring physician from charging a specimen acquisition or processing charge under certain circumstances.

Senate Bill 1630, as amended, passed both houses despite some medical specialties remaining opposed.

FOID Mental Health Reporting

**Author:** Christine P. Bishof, MD  
**Status:** Adopted

This CMS measure seeks better definition of the new state reporting requirements. The Illinois Department of Human Services (IDHS) issued emergency rules mandating that physicians, licensed psychologists and qualified examiners report patients who they believe pose a clear and present danger to themselves or others to the IDHS Firearm Owner Identification (FOID) Mental Health Reporting System. The current legislation leaves many physicians unsure of their responsibilities when it comes to identifying patients who pose “a clear and present danger to themselves or others.” For those whose expertise is not in mental health, or who have insufficient contact with a patient to make a determination, the existing requirements create an undue burden. Physicians could potentially find themselves forced to make determinations for which they may feel underqualified or lack sufficient information.

The House overwhelming approved the CMS resolution. ISMS will therefore introduce legislation defining the state reporting requirements for all physicians and others with the appropriate training and experience to identify patients who pose a clear and present danger to themselves or to others.

**Conflict of Interest Disclosure**

**Author:** Jerrold B. Leikin, MD  
**Status:** Referred for Study

Generating mixed testimony, this complex issue is important to physicians but additional information is needed. ISMS will therefore study this measure from the CMS, which addresses punitive disclosure policies as part of the credentialing process. CMS seeks legislation to ensure that medical schools and hospitals are indeed complying with the law or not overextending their reach for punitive purposes.

Under the CMS policy, conflict of interest disclosures should only target medical staff or faculty who have a specified leadership position within a medical center or hold positions of...
Virtual Credit Card Payments

**Status:** Adopted

CMS physicians testified in favor of educating physicians on how these cards work. Virtual credit cards are a new and seemingly innocuous method by which insurers are paying physician practice claims for covered services, but they pose hidden dangers for unsuspecting offices. Physician practices and those who administer the cards are likely to lack full information about the high transaction costs of accepting such payments compared to alternatives. Third-party payers who pay using such virtual credit cards typically receive rebates (think “cash back bonus or air miles”) from the credit card issuer for the use of this mechanism for payment that is based on a percentage of the cost of the claim being paid. Payments are being, in effect, further discounted to the benefit of the third party payer and the credit card company in a misleading manner.

ISMS will educate members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via an automated clearinghouse.

ISMS will also advocate for transparency in the form of disclosure that accompanies payments or notices of payments from third party payers, including but not limited to the total amount of any transaction fees and the portion that is rebated to the payer or agents of transaction.

And finally, ISMS will submit a resolution to the AMA to adopt these same policies.

Three Day Stay Rule

**Status:** Adopted

The CMS gave its resounding support for this measure. Medicare's inpatient hospital stay requirement poses financial obstacles for many patients in need of skilled nursing home rehab care. Eliminating the three-day stay rule is the goal of the new policy. ISMS will bring a similar resolution to the AMA to change the eligibility requirement.

The Centers for Medicare and Medicaid Services' existing three-day stay rule mandates that a Medicare patient must be admitted to the hospital as an inpatient for three days to be eligible for Medicare payment coverage for rehabilitation in a skilled nursing facility. However, in many instances hospitals retain patients in their facility under an “observation” classification rather than as an admitted inpatient. This practice may reduce or eliminate a patient's skilled nursing or rehabilitation funding assistance by Medicare.

CMS opposes the three-day prerequisite for Medicare coverage and believes that other appropriate criteria would allow for timely and appropriate skilled nursing facility placement of Medicare patients.

CMS President-elect Kathy M. Tynus, MD, (far right) won overwhelming support for her resolution to prevent the linking of payment policies with standard of care under the Affordable Care Act.
AME DAY for ICD-10 is Oct. 1, 2015. And now is the time to get ready in order to nail down a solid win—after all, it's an important game! Here are the steps you need to take.

**Draft Your Team:** Create an ICD-10 team within your practice. Be sure to choose a physician, a clinical staff member, a biller, and a captain to lead your team.

**Huddle Up:** Develop a game plan by assigning various tasks to team members and create a timeline for completion. Key tasks include:

- Create a list of your practice's frequently used ICD-9 codes. Most practices will be able to run a utilization report in their practice management system.
- Contact your software vendor. Ask your EMR and PM vendors what they are doing to prepare your practice for the transition. Inquire about any webinars and/or training programs they are offering. This is a great way to get training specific to your software applications.
- Reach out to specialty specific member organizations. Many medical specialty organizations such as the ACOG, the AAFP, and the AAOS are offering specialty specific ICD-10 education programs. This is a great opportunity for physicians and staff to receive training that is focused on their specialty. Do not miss this opportunity.

**Budget:** Anticipate a significant increase in claim denials, processing errors, and payment delays. Put off any non-essential major purchases and secure a line of credit if your practice cannot withstand a 90-day delay in reimbursement.

**Kick Off:** Put your game plan into action and be sure to tackle the following:

- Select and schedule training for all providers, billers, and any staff members who use diagnosis and procedure codes (clinical staff who produce medication or procedure orders, charge posters, pre-cert team members).
- Obtain requirements from electronic medical record (EMR) and practice management (PM) vendors regarding enhancements, updates, and customization needed to insure your applications are ready. Create a timeline to implement the requirements.
- Create an ICD-9 to ICD-10 crosswalk if your software vendor does not provide this. Create a file on your shared drive to allow access for all employees. Be sure to update this file regularly as codes are added and/or changed.
- Reach out to insurance carriers and note the following:
  - Will they allow early testing and if so, when?
  - On what date they will begin allowing ICD-10 claims?
  - How long will they allow ICD-9 codes on a claim in the event of implementation issues?
  - What payer specific conversion issues/requirements should the practice be aware of?

**Score:** You can't win if you don't score. Rack up points by completing the following:

- All providers and selected staff complete a training program.
- Software applications are updated and tested.
- Quick references are available for coding crosswalk.
- Printed materials such as super bills, outpatient charge cards, etc., are updated to include ICD-10 codes.
- Providers begin adding ICD-10 codes to visits, along with ICD-9 codes, prior to the deadline simply to become familiar and comfortable with the transition.
- Test if claims that include ICD-10 codes are transmitted to your clearinghouse without error. Some payers will also be accepting test claims prior to the Oct. 1, 2015, start date.
- The practice has a plan in place for possible reimbursement delays.

**Celebrate Your Victory:** Your strategy, determination, and hard work will be rewarded with a seamless transition to ICD-10. There will be blocks and bruises along the way but the strongest team always prevails.

It is important to note that there are still a considerable number of practices that are not using an EMR system. These practices will most likely have an extremely difficult time with the ICD-10 transition and are at the greatest risk of suffering significant financial setbacks. If your practice does not currently use an EMR, we highly recommend that you consider implementing one very soon since it is highly unlikely that the ICD-10 mandate will be delayed again.

Gina Zinanni is a senior health care consultant with PBC Advisors, LLC, in Oak Brook. PBC Advisors provides business and management consulting and accounting services to physician practices and hospital systems. For more information, visit their website at www.pbcgroup.com.

Winning the Battle Against ICD-10

What you should be doing now to avoid defeat!

By Gina Zinanni
Communication saves lives.
Just ask Dr. Singh.

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

DocbookMD is a free benefit of your CMS membership.
Learn more about the app at docbookmd.com.
Protecting Public Health

CMS resolutions work for the common good

The following Chicago Medical Society initiatives came before the Illinois State Medical Society House of Delegates on April 17-19. Here is a summary of new patient protections.

Medical Marijuana Dispensing Facilities

**Author:** Jerrold B. Leikin, MD  
**Status:** Adopted as Amended

A CMS member teamed with colleagues at the Kane County Medical Society to address gaps in the marijuana dispensing facility requirements. After mostly positive testimony, the House voted to support or cause to be introduced legislation that amends the Compassionate Use of Medical Cannabis Pilot Program Act to be consistent with the changes. As such, dispensing entities will disseminate a detailed explanation of cannabis’ adverse effects and risks to each individual at the time of dispensing.

Patient education materials will include:

- Updated information about the purported effectiveness of various forms and methods of medical cannabis administration.
- Updated information about the purported effectiveness of strains of medical cannabis on specific conditions.
- Current educational information issued by IDPH about the health risks associated with the use or abuse of cannabis.
- Whether possession of cannabis is illegal under federal law.
- Information about possible adverse effects.
- Prohibition on smoking medical cannabis in public places.
- Offer any other appropriate patient education or support materials (68 Ill. Adm. Code 1290.425).

Receipt of this patient educational information will be individually documented by the dispensing organization; the written information be standardized and approved by the IDPH.

Food Allergy Notification by Restaurants

**Author:** Howard Axe, MD  
**Status:** Adopted as Amended

Protecting people with allergies and educating food service handlers is the goal of this initiative. The CMS seeks strong protections in Chicago and Cook County. Specifically, CMS supports state law modeled on Massachusetts’ Food Allergy Awareness Act. The law requires education of food service handlers and customers about the health risks of allergies.

Per the CMS resolution, ISMS will support or cause to be introduced legislation modeled on the Massachusetts Food Allergy Awareness Act, to make restaurants and food service establishments safer for those with allergies, by educating food service handlers and customers about the health risks of allergies. The resolution calls for the AMA to introduce federal legislation modeled on the Massachusetts law.

Medicare Coverage of Pneumococcal-13 Vaccine

**Author:** Howard Axe, MD  
**Status:** Adopted as Amended

This CMS resolution requests an update in Medicare’s payment policies to reflect ACIP’s latest recommendation. The ACIP calls for administering the Pneumococcal Conjugate Vaccine PCV-13 (Prevnar) in a series with Pneumococcal Polysaccharide Vaccine PPSV-23 (Pneumovax). All Medicare enrollees should receive the vaccines without out-of-pocket costs.

CMS’ new global policy also says that CDC/ACIP-recommended vaccines should be covered automatically for all Medicare enrollees with no out-of-pocket cost. The latest ACIP recommendations were issued in September 2014.

In adopting the measure, ISMS voted to request action by the American Medical Association (AMA) to update current Medicare payment policies on pneumococcal immunization.

Headphone Public Awareness

**Author:** Kamala A. Ghaey, MD, MPH  
**Status:** Adopted as Amended

Leading a local campaign, the CMS will develop specific safety guidelines and recommendations for headphone use outdoors and for product manufacturers. This includes a public awareness initiative on the danger of wearing earbuds in both ears while biking, jogging, rollerblading, skateboarding or walking.

Under the CMS measure, ISMS will work with the General Assembly to develop a statewide public awareness campaign to educate citizens of Illinois about the dangers of using earbuds in both ears during outdoor activities requiring auditory attention (including but not limited to biking, jogging, rollerblading, skateboarding or walking) and while driving. ISMS will also introduce legislation requiring warning labels to be printed on packaging of smart phone and similar devices indicating the dangers of using earbuds in both ears.

Aircraft Restraints on Small Children

**Author:** Ajay Chauhan, MD  
**Status:** Adopted as Amended
The goal of this CMS initiative is to adequately protect small children while they are traveling by air. Because existing rules are somewhat inconsistent, a practical approach is needed to educate the flying public on child safety on commercial airliners. ISMS therefore will support and encourage public education and legislation promoting the use of age- and weight-appropriate child safety restraints on airplanes.

Meanwhile, new CMS policy stipulates that all children under age two and small children under 40 pounds be restrained in aircraft-approved child safety seats. CMS also calls for study into ways to educate parents, guardians and caregivers on how to use child safety seats during air flight and travel.

The directive urges the AMA to renew its efforts to: (1) encourage the use of appropriate restraint systems for all children on all commercial airline flights; and (2) work with the Federal Aviation Administration to establish criteria for appropriate child restraint systems.

**Increasing the Smoking Age**

**Author:** Howard Axe, MD  
**Status:** Adopted as Amended

New CMS policy increases the legal age of sale of tobacco products in Cook County from 18 to 21 years. Under an accompanying directive, CMS will advance legislation in the Chicago City Council to raise the age, by collaborating with City’s Committee on Health and Environmental Protection, and other interested aldermen. The CMS measure calls for a statewide law, and for implementation by the AMA. Under the resolutions adopted by the House of Delegates, ISMS will work for statewide legislation and request the AMA to seek a national law.

**Measles Vaccination**

**Status:** Referred for Study

CMS members testified on behalf several resolutions pertaining to the measles resurgence.

One proposal says ISMS should collaborate with other organizations to educate physicians, patients, and parents about the importance of proper immunization. Taking things a step farther, ISMS would advocate with the Illinois Department of Public Health and the Illinois Education Association, to ensure that no child begins school or returns to school without a first-time immunization or up-to-date immunization. The final plan component involves working with the IDPH and state association representing licensed daycare operators, with the goal of assuring that all children attending these facilities receive immunization against measles.

Delegates also considered a resolution that takes a page from the state of Nevada, where children must have valid and current proof of immunization to attend daycare and preschool. The state actively reviews the immunization status of children. If they are found not in compliance, children are removed from these institutions.

A more controversial proposal before the House sought policy opposing unsubstantiated religious exemptions to state-mandated vaccinations. The author asked ISMS to support or introduce state legislation requiring requests for religious exemption to vaccine mandates to include written documentation from a religious leader supporting the request on religious grounds. This exemption request would be reviewed by a medical provider.

Finally, a proposal says that ISMS should establish policy opposing philosophical exemptions to state vaccination requirements. The resolution argues that states with philosophical vaccination exemptions rather than medical contraindication or religious objections, have the highest number of vaccination preventable illnesses in the country. Illinois does not allow for philosophical vaccination exception, and some families claim religious exemption from vaccination under false pretenses.
**Multistate Listeria Outbreak**

An overview of this virulent foodborne pathogen  

By Vishnu V. Chundi, MD

LISTERIA MONOCYTOGENES is the bacterium that caused the recent multistate outbreak associated with consumption of ice cream produced by Blue Bell Creameries. This is just one in a long list of outbreaks associated with this bacterium. Currently there are ten cases in four states (Kansas, Texas, Oklahoma, and Arizona). The current multistate outbreak has been ongoing for several years. Listeria causes over 2,500 illnesses a year in the U.S. with an overall mortality of ~ 17%. Outbreaks have been associated with vegetables like cabbage, fruit such as melons, meats such as cold cuts, milk products such as ice cream, and prepared foods including hummus. The bacteria grows well in salt and in colder conditions, thus allowing propagation even in cured meats and during refrigeration. There are many types of listeria but Listeria monocytogenes and, rarely, Listeria ivanovii, are pathogenic to humans. Healthy animals harbor the bacteria in their intestinal tracts. Vegetables may become contaminated through soil or manure. Unpasteurized milk products are a primary source of infections. Foods contaminated with Listeria look, smell and taste normal.

Individuals at high risk include pregnant women, who have a 20 times greater risk than healthy adults. Patients with decreased cell-mediated immunity due to hematological malignancy, solid organ or bone marrow transplantation, end-stage renal disease, diabetes, radiation therapy, or treatment with immunosuppressing medications such as steroids, anti-rejection medications, or cancer chemotherapy, are at greater risk. In fact, AIDS patients have about 300 times greater risk than those individuals with normal immune status. Neonates may become infected by their mothers.

Symptoms of infection vary from mild gastroenteritis to muscle aches and fever to diarrhea. More severe cases may present with meningitis, bacteremia and sepsis. Pregnant woman may present with fever, diarrhea, miscarriage, stillbirth, or premature delivery. Neonates may present with sepsis. Diagnosis requires a high index of suspicion. Performing a culture of the blood, cerebrospinal fluid, meconium of newborns and vaginal secretions of pregnant women will confirm infection. Ampicillin is the antibiotic of choice. Listeria is naturally resistant to cephalosporins.

Listeria outbreaks are a consequence of industrialization, of meat, milk and food production. Refrigeration and cold enhancement used in the distribution of food products are a major source of potential infections despite modern techniques. Prevention of listeriosis includes thoroughly cooking food, washing raw vegetables with clean water before eating, keeping uncooked meats separate from produce and other ready-to-eat items and avoiding consumption of unpasteurized milk.

The FDA has enacted mandatory measures for food production facilities and this has resulted in decreased contamination of meat products. Milk products, however, have not had a similar decline in infections. Physicians should be aware of the risk factors, common presenting symptoms, and signs of this deadly yet treatable infection.

Dr. Chundi is head of infection control at Westlake Hospital and at West Suburban Medical Center.

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**Hep C Screening Bill Advances**

Contact your representative today to urge a “No” vote

SENATE BILL 661, which mandates primary care physicians to offer Hepatitis C screening to adults born between 1945 and 1965, has passed in the Illinois State Senate and is now under consideration in the State House of Representatives. The Illinois State Medical Society and the Chicago Medical Society oppose the bill. The proposed legislation is based on guidelines from the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force. ISMS and CMS believe in the appropriateness of Hepatitis C screening guidelines; more than 36,000 cases of Hepatitis C have been reported to the Illinois Department of Public Health in the last five years. These individuals would not have been identified without the screening ordered by physicians.

Yet ISMS and CMS remain extremely concerned that the bill sets a dangerous precedent by mandating the practice of medicine. Clinical guidelines frequently change as new technology, pharmaceuticals and treatments are discovered and implemented—changes that the legislature will never be able to keep pace with.

A vote can happen any day. Please contact your representatives to urge them to vote “No” on SB 661.
Join us for a memorable golf scramble with members of the ABA and the Chicago Medical Society. Located on the 150-acres estate of Oak Brook Hills Resort, Willow Crest Golf Club offers premier course condition combined with a spectacular, natural setting for an unforgettable golf experience. The course is specifically designed for players of all abilities.

**Saturday, June 13, 2015**

**Ticketed Event:** $175 includes 18 holes, golf cart, lunch and reception.

Transportation optional—Additional $70 Fee. Payment may be made at the conference.

Lunch- 11:00am-12:00noon | Golf – 12:00noon-5:00pm | Reception- 5:00-7:00pm

Sign up today at: [http://ambar.org/PLIgolf](http://ambar.org/PLIgolf)
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HAKESPEARE wrote “[a] rose by any other name would smell as sweet.”

And the Seventh Circuit Court of Appeals in its recent U.S. v. Patel decision could have stated: “A referral by any other name (certification for care) would smell as illegal.”

A decision and settlement announced by the U.S. Department of Justice (DOJ) in March highlight some of the less common ways a provider may violate the federal Anti-Kickback Statute (AKS).

Patel Case Facts

An internist with a large Medicare population, Dr. Patel ordered home care for many patients. When he determined a patient needed home health, his staff gave the patient 10 to 20 home health company brochures and let the patient independently choose one. Dr. Patel’s assistant would then fax the selected provider the patient’s name, information, and prescription for home health care signed by Dr. Patel.

Grand Home Health Care approached Dr. Patel with the cash-for-certification proposal after losing market share. When a patient selected Grand as his provider, Grand would create a treatment plan for the patient and fill out Medicare Certification Form 485 for Dr. Patel’s signature, which is required for reimbursement. Grand met regularly with Dr. Patel to pay him $400 cash for each signed certification and $300 for each recertification. There was no written contract or formal payment record.

No one disputed the medical need for the home health services or argued that Dr. Patel influenced or directed patients’ initial choice of Grand. Only a minority of his patients used Grand.

The government began investigating Grand for health fraud, and Grand agreed to cooperate by recording telephone calls and meetings with physicians taking part in the scheme, including Dr. Patel. He was charged criminally for AKS violations, and in addition to $31,900 in monetary fines and 200 hours of community service, he is facing eight months in prison.

The Court held that Dr. Patel’s certification or recertification of the need for care after a patient picked an agency is an illegal “referral” under the AKS when coupled with cash payments from the home care agency. Thus, the AKS can apply beyond the traditional scenario of a “referral” when Dr. X sends a patient to Provider Y, and can apply when Dr. X acts as a “gatekeeper” to care and payment.

“Referral” Broadly Defined

This case hinged entirely on the definition of “referral.” The AKS provides that anyone who knowingly and willfully receives or pays anything of value “in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program” can be held accountable for a felony. However, the AKS does not define “referral.”

Dr. Patel argued that “refer” means the physician personally recommends a provider, and conversely, there is no “referral” when a patient independently chooses a provider, as was the case here.

The Court arrived at a broader definition, holding that, even if a patient selected Grand initially, Dr. Patel “referred” the patient to Grand when he certified/recertified, via Form 485, that the patient needed care; that Grand would provide the care; and that Grand could be reimbursed by Medicare for services. While Dr. Patel did not direct patients initially to Grand, the Court believed he acted as a “gatekeeper,” which is enough to constitute a referral. Without Dr. Patel’s signed certification/recertification, the patient could not get Medicare-reimbursed care from Grand.

Basing its holding on the main purpose of the AKS, the Court listed the following dangers of fraud at the certification/recertification stages: increased cost of care, if a physician refuses to certify a patient to a patient-chosen provider unless the provider pays a kickback; and contravention of patient choice, since payments for each recertification incentivize a physician to authorize more unnecessary care and to ensure the patient continues using the same provider. The Court was also influenced by the Stark physician self-referral regulations, which treat certifications as “referrals.”

Dr. Patel argued the Court’s holding would criminalize such activities as a hospital paying a physician to give a speech if some of his patients are later treated by that hospital. The Court disagreed, noting two points. First, a payment must be “in return” for a referral to trigger the AKS; payments made solely as compensation for legitimate services (such as giving a speech) are not illegal. Second, to be a “referral,” the physician must “do something” that either directs a patient to a particular provider or allows the patient to receive care from that provider. And even if the doctor in Dr. Patel’s hypothetical had steered his patients to the hospital, the doctor could not be prosecuted because he was not paid “in return for” referrals.

While some have called this a broad and unfounded “extension” of the AKS, can anyone argue there was no AKS violation here? Penalizing this cash-for-certification scheme seems well within the spirit of the AKS even if the conduct was not within the narrow traditional view of what constitutes a referral.
Incriminating Facts
- Grand approached Dr. Patel and offered to pay for “referrals,” after which Dr. Patel started signing certifications and receiving cash payments.
- Grand paid in cash, with no written contract or formal payment record.
- In addition to $400/$300 per certification/recertification, Grand paid Dr. Patel $1,000 cash and $8,000 in loan forgiveness.
- Dr. Patel provided no identifiable service to Grand other than signing certifications/recertifications.
- At least once, Dr. Patel refused to sign the certifications/recertifications because Grand did not have the cash.
- Dr. Patel was not a passive bystander; he received cash only after he signed the forms, thus allowing Grand to be paid.

So, if Dr. Patel was not paid for referrals, what was he paid for?

Recommendations as Violations
While most AKS violations involve the direct quid pro quo of payment for referrals, a recent settlement for $1 million is a potent reminder of another aspect of the AKS. Along with payment, Dr. Charles Denham agreed to a four-year voluntary exclusion from federal health care programs for alleged violation of the prohibition on accepting remuneration in return for recommending the purchase of an item.

Two consulting firms owned or controlled by Dr. Denham entered into contracts worth $11.6 million with CareFusion, the maker of Chloraprep, a product used to prevent surgical-site infection. Dr. Denham, a patient safety expert, served on the National Quality Forum (NQF) and as co-chair of its Safe Practices Committee, but did not disclose these relationships to NQF. The DOJ alleged that Dr. Denham received payment in exchange for influencing NQF’s Safe Practices recommendation on surgical-site infection prevention.

There was no statement to indicate the government viewed these payments as fair value for services provided. NQF recommendations can have wide-ranging implications, with costs for health care payers and government health programs. In the settlement, the DOJ noted: “Kickback schemes undermine the integrity of medical decisions, subvert the health marketplace and waste taxpayer dollars.”

Lessons Learned
These two cases highlight areas to consider before entering into arrangements:

- **No Cash or Other Remuneration.** The Patel case is limited to certification/recertification. This leaves room to argue that other actions by physicians with less direct connection to the patient are not “referrals” under the AKS, such as physicians giving patients a list of area health care suppliers. The Denham settlement should caution physicians against trading on their professional positions.
- **Get into a Safe Harbor.** Rather than splitting hairs, play it “safe” by structuring all arrangements involving payment to fit within the AKS safe harbor for personal service and management contracts. Generally, this will require a signed written agreement for identified and bona-fide services at fair market rates.
- **Never Pay for Nothing.** Payments to a physician in a position to “recommend,” when there are no real or substantial services being provided, are never a good idea.
- **Watch out for Stark.** Dr. Patel’s signing of certifications/recertifications is likely a referral for Stark Law purposes. Under Stark, “referral” includes the “certifying or recertifying of the need for” a service. Since cash payments to Dr. Patel were undocumented and for no discernible service, the payments would not meet a Stark exception.
- **Jail is Possible.** Grand paid Dr. Patel only $28,500 over six years, yet he was charged criminally under the AKS, and in addition to monetary fines, faces eight months in prison.

Lisa A. Lyons, JD, is of counsel with the Health Law Group at Quarles & Brady, based in its Milwaukee office. She may be reached at lisa.lyons@quarles.com. Alyce C. Katayama, JD, is a partner in the firm’s Health Law Group. She may be reached at Alyce.Katayama@quarles.com.

“Rather than splitting hairs, play it “safe” by structuring all arrangements involving payment to fit within the AKS safe harbor for personal service and management contracts.”

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**THE CHICAGO Medical Society and the American Bar Association have established a formal relationship to address medical-legal issues affecting CMS members and their practices. This legal section is sponsored by the Health Law Section of the American Bar Association.**

For CMS members this means that you get monthly articles from legal experts who specialize in health law. The articles will focus on subjects of current interest to the medical profession as well as new laws and regulations as they are implemented. The authors will vary every month in order to bring you the best information possible from the attorney who specializes in the subject matter.

If you have a particular question or would like more information on a subject, please send us your suggestions. You can send an email to Elizabeth at esidney@cmsdocs.org.
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When Time is Muscle

Major cardiac centers re-set the clock on STEMIs, cutting door-to-balloon time

By Howard Wolinsky
Four Times a day on average, 1,500 times a year, someone in the Chicago area experiences the most deadly heart attack, a STEMI, short for ST-elevation myocardial infarction, after its signature electrocardiogram tracing.

A STEMI occurs when plaque blocks one of the main coronary arteries, interrupting the blood supply to the heart. STEMIs in the large coronary artery branches (the left anterior descending) used to be known as “widow-makers” because of their deadly impact. Mortality from STEMI in the United States is between 4% and 11%, noted Atman Shah, MD, director of the coronary care unit and co-director of the cardiac catheterization laboratory at University of Chicago Medicine. Death rates are higher in the elderly and among women and African Americans, he said. In comparison, mortality from STEMIs in the Netherlands, a world leader, is 5% to all patient groups.

Cardiology has moved away from the term widow-maker, Dr. Shah noted. “Widow-maker is too dramatic. Plus, the very term seems to exclude women from having the disease,” he said.

Symptoms vary widely. Interventional cardiologist Mark Ricciardi, MD, director of cardiac catheterization and interventional cardiology at the Bluhm Cardiovascular Institute at Northwestern Memorial Hospital, said, “With a heart attack, if there is a typical patient, the patient will have symptoms that are consistent with myocardial ischemia or low blood flow to the heart muscle. And typically, when the blood flow to the heart muscle is compromised, the vast majority of patients will have some sensation of either chest tightness or chest discomfort. It can be central on the left side of the chest.”

In some patients, the sensation will radiate to the back or to the left shoulder, left neck or left jaw.” Sometimes a patient will just complain of a toothache or jaw pain without any of the chest symptoms. That’s what makes it a little difficult to diagnose. Even when people have symptoms that are in their minds’ potentially cardiac in nature—and sometimes they’ll discount it.”

“Pain” vs. Chest Fullness
He said that in training students, residents and fellows, he discourages use of the word “pain” because patients often dismiss it. Any kind of discomfort in the chest, especially a squeezing discomfort, tightness, radiation and associated symptoms—nausea, sweat, or a feeling of doom—should be considered. Those are symptoms that can’t be ignored,” he said.

Interventional cardiologist Sandeep Nathan, MD, co-director of the cardiac catheterization laboratory at the University of Chicago, said there’s a lot of publicity about chest pain, but many patients don’t experience STEMIs that way. “If
you talk to patients who have had a diagnosed, confirmed STEMI, less than 50% will endorse typical symptoms. They will say that they had some ill feeling, chest pressure, chest heaviness, chest discomfort, flu-like sensation, extreme fatigue, shortness of breath, cold sweats, nausea, passing out, burning sensation, choking sensation. All of these descriptive terms skirt the key word “pain.”

“And when you directly confront somebody who’s having a STEMI asking, ‘How is your chest pain?’ many of them will correct you and say, ‘Like I told them in the emergency room Doc, this is not pain. I’m not having pain. But I just feel like there is fullness in my chest.’”

The Centers for Disease Control and Prevention (CDC) conducted a survey in 2005 that found less than one third of respondents knew the five major signs of a heart attack, which include: pain in the neck, jaw, or back; feeling weak or lightheaded; chest pain or discomfort; pain in the arms or shoulders; and shortness of breath. Many patients don’t realize they ought to be calling paramedics rather than waiting for symptoms to resolve on their own.

Interventional cardiologist Fred Leya, MD, medical director of the cardiac catheterization laboratories at Loyola Medicine in Maywood, notes the vast improvements in cardiac care since the 1980s.

Interventional cardiologist Gary Schaer, MD, director of cardiology research at Rush University Medical Center, says that Rush has increased the number of on-call staff to handle STEMI patients.

with percutaneous coronary intervention (PCI), the odds also increase for massive heart muscle damage and death.

PCI became the standard of care for STEMIs. The goal, promoted by the American Heart Association in 2006, was revascularization within 90 minutes. Dr. Ricciardi said the 90-minute goal had its origins in retrospective studies. “Cardiologists follow the mantra that time is muscle. If your artery is occluded, that muscle is not getting blood supply. The longer you wait before you open that artery, the worse the chances for survival,” he said.

Failing to Account for Delays in Treatment

But not all programs were created equal and patients faced risks along the road from the onset of symptoms to ambulance transport to hospital entry and ultimately, to the catheter lab. “The trouble was that some of the programs responded late. It was more than 90 minutes,” Dr. Leya said. There were plenty of obstacles to prompt treatment of STEMIs.

Dr. Leya said patients often don’t recognize what is going on, thinking they are having a digestive problem, for example, and delay calling 911. Until recently, ambulances here weren’t equipped with the 12-lead ECGs with the algorithms paramedics need to flag a STEMI on the fly. Following protocols shaped by medical politics and logistics, paramedics took the patient to the nearest hospital rather than the one best equipped to handle STEMIs. And then there could be delays during a stop in the emergency department, and finally, in fielding a cath lab team in a timely fashion.

Dr. Leya said, “90 minutes works if you assume the patient immediately responded to the chest pain; that the patient understood that this was a heart
attack and the patient didn’t delay care by staying at home and thinking that’s my stomach or something else, but this actually was a heart attack. Normally, the heart starts dying inside of the chamber. Within one to two hours, essentially, the entire length and width of the myocardium can be destroyed. “Ninety minutes, although an important standard, is simply too long for the dying heart.”

Dr. Nathan said epidemiological data suggests reducing door-to-balloon time (D2B)—the time from the patient’s arrival in the emergency department until the time when a catheter guide wire opens the plaque—is important to reducing mortality. He agreed with Dr. Leya: the wild card in all of this is door-to-recognition-of-symptom-to-balloon time. The cardiac teams can’t control patient recognition but they can control many factors affecting how quickly they can respond to these patients. Major cardiac centers in the Chicago area and others around the country set out to reduce door-to-balloon time.

Harlan Krumholz, MD, a cardiologist and an outcomes researcher at Yale University School of Medicine, and colleagues, noted in Circulation that in 2002 only one-third of patients received primary PCI within 90 minutes and one-third received the procedure more than two hours after reaching the hospital. “These lackluster times led to a national response,” he said. The American Heart Association, the American College of Cardiology, the Centers for Medicare and Medicaid Services (CMS), and other groups began to pressure hospitals to improve door-to-balloon time.

Racing to Cut Response Time
Dr. Krumholz reported from federal CMS data that the percentage of STEMI patients who received revascularization within 90 minutes improved from 44.2% in 2005. D2B time declined from a median of 96 minutes in the year ending Dec. 31, 2005, to a median of 64 minutes in the three quarters ending Sept. 30, 2010.

The experts agree that quicker time to the cath lab is the goal. But there is debate over the best way to manage delivery of this care, whether from 24/7 in-house response teams or calling teams into receiving hospitals.

Loyola’s Heart Attack Rapid Response Team is among the few available at U.S. hospitals to have interventional attending physicians on call in-house 24 hours a day. “As soon as we are notified that a patient is coming to Loyola with a heart attack, we literally go and meet them in the emergency room and take the patient directly to the cath lab, bypassing most of the emergency room care,” said Dr. Leya.

The Loyola team delivers 300 emergency angioplasties a year, about 50 in STEMI patients. Dr. Leya said Loyola’s median door-to-balloon time is 43 minutes, placing it among the upper 10% of hospitals in the U.S. National Cardiovascular Data Registry report that of the 1,500 hospitals voluntarily submitting data, the median door-to-balloon time was 60 minutes.

Dr. Leya said Loyola had found it was not possible to reach a 90-minute threshold with attending doctors living 20 or 30 miles away from the medical center. He said the key was to treat night-time and weekend staffing like daytime staffing. That meant staffing the cath lab 24 hours a day.

When Loyola switched to that approach in 2009, its door-to-needle time was cut in half, going to 44 minutes from 90 minutes, he said. But 24-hour staffing of a cath lab is an expensive proposition. Loyola did not disclose the cost of operating its program.

The more common approach is to require cath lab staff to live within 30 minutes’ driving time to the hospital. Dr. Nathan said his team members are required to live within 30 minutes of the medical center. “It takes me 22 minutes to get to the hospital,” he noted. He said when his iPhone app “pings” he immediately starts driving in.

Interventional cardiologist Gary Schaer, MD, director of cardiology research at Rush University Medical Center, said major improvements in delivering care to STEMI patients have been implemented at his hospital. “If you look back 10 years ago at Rush and many other academic medical centers, it was not uncommon to have a delay getting the patient with a STEMI to the catheterization lab to open the blocked artery, particularly on nights and weekends when the cath lab staff and cardiologists were not in the hospital. Over the past 10 years, we have completely re-engineered the logistics of STEMI care at Rush and have reduced the ER door-to-angioplasty treatment time to 30-60 minutes in the vast majority of patients.

“90 minutes works if you assume the patient immediately responded to the chest pain; that the patient understood that this was a heart attack and the patient didn’t delay care by staying at home and thinking ‘that’s my stomach or something else,’ but this actually was a heart attack.”

“To optimize care for the 30-50 STEMI patients we see each year at Rush, we increased the number of staff on-call to ensure that STEMI patients can be treated as rapidly as possible. Our success has also been facilitated by the design of our new hospital and emergency department that makes transfer of patients to the cath lab much more rapid and efficient.

Dr. Ricciardi said the Northwestern team has made incremental improvements over the years and now has a D2B time of 50 minutes. “We look at this data constantly, certainly every quarter, but we actually look internally every month. We see it go
NATO Left Heart in Chicago

**The Eyes** of the world were on Chicago in May 2012, as heads of state gathered for a summit of the North Atlantic Treaty Organization to discuss the Arab Spring, the Libyan Civil War, the global financial crisis and other issues of the day. Thousands of demonstrators hit the streets to voice their concerns and to try to disrupt the meeting. And thanks to the summit, something else momentous happened that directly impacted the health of Chicagoans.

The City of Chicago officially launched an upgrade of the Chicago Fire Department’s (CFD) emergency medical response vehicles. To protect delegates attending the summit, the federal government gave around $500,000 to the CFD to upgrade its emergency vehicles to 12-lead electrocardiograms, defibrillators and other gear designed to identify patients at the greatest risk of dying from a heart attack (also known as myocardial infarction). The computerized EKGs can determine if a patient is undergoing a potentially deadly ST-elevated myocardial infarction (STEMI). Under the protocol, paramedics contact the nearest qualified cardiac catheterization lab offering artery-opening angioplasty with stents as soon as possible to reduce the morbidity and mortality rates.

Art Miller, RN/EMT-P, director of Illinois Mission: Lifeline, the American Heart Association’s initiative to establish and support regional systems of care focused on STEMI and sudden cardiac arrest resuscitation, said the move to update Chicago’s Emergency Medical Services EKG equipment was perfectly timed to coincide with a collaborative effort among the City’s EMS medical directors, its hospitals, the CFD, and the American Heart Association to develop an advanced STEMI protocol to take full advantage of the new equipment. Everyone involved with the STEMI protocol development process was thrilled to see the stars align on the eve of the NATO summit, he said.

Gary Schaer, MD, chairman of the STEMI Advisory Committee to the Chicago EMS Medical Directors Consortium, noted that the AHA and the City had been working on advancing the protocol development process and securing the necessary funds for the equipment upgrade for years. The interventional cardiologist at Rush University Medical Center said the NATO summit provided Mayor Rahm Emanuel with the leverage he needed to obtain federal funding for the upgrade, while the advances on protocol development ensured that those upgrades could immediately be put to use.

The CFD launched the STEMI system five days before the NATO summit. That morning, a 52-year-old man was diagnosed with a severe heart attack in the ambulance. The crew bypassed a hospital to deliver the patient to West Suburban Medical Center, the closest STEMI-ready facility. Cardiologists met the patient at the door from which the man was brought to the cardiac catheterization laboratory and his artery reopened.

Interventional cardiologist Mark Ricciardi, MD, director of cardiac catheterization and interventional cardiology at Bluhm Cardiovascular Institute at Northwestern Memorial Hospital, said paramedics can transmit data from their vehicle to the receiving hospital. “They can transmit it to the main desktop computer in triage in your ED. You can transmit it to the cardiologist on call. You can transmit it to every cardiologist in the hospital,” he said. The data can trigger a smartphone app to direct attending physicians and staff to the catheter lab.

Within Chicago, there are 16 STEMI receiving centers, qualified based, among other criteria, on having teams on call that can perform angioplasty and have a track record of opening arteries within 90 minutes 70% of the time, said Dr. Schaer. The AHA aims to help establish similar STEMI systems of care throughout the state.

Money is just one obstacle to creating a STEMI system. Medical politics and economics are another. Some hospitals initially are reluctant to accept ambulances that bypass their facilities to deliver patients to other centers with 24-hour cath lab capabilities.

Of the 11 Emergency Medical System Regions in Illinois, only two have Mission: Lifeline Regional Systems of Care in place: Chicago and the western suburbs from Oak Park to Naperville (Region 8). Miller stressed: “We’re anticipating more regional participation in the near future. But it doesn’t mean that the care isn’t out there.”

For example, he said, Region 10, from the North Shore to the Wisconsin border, has STEMI protocols in place and does a great job caring for STEMI patients. However, he said, EMS medical directors and cardiologists have not agreed on a data collection tool yet. Miller said data collection is key: “You can’t improve what you don’t measure.”

He said creating a STEMI system “requires ongoing dialogue. It’s a slow process. It takes a little time. The data in Regions 8 and 11 have clearly shown that establishing a system of care is beneficial for all the stakeholders, including dispatchers, prehospital personnel, emergency departments, cardiology and most importantly of course, the patients.”
handles about 100 emergent angioplasties annually, all STEMIs. Shah noted: “We know that a door-to-balloon time of less than 90 minutes saves lives compared to a door-to-balloon time of 90-120 minutes. We do not have any data that 44 minutes versus 50 minutes has any benefit. We are not really sure if 60 minutes has significant benefit to 90 minutes. The data isn’t there yet.”

**Educating Patients About Symptoms**

Dr. Ricciardi said door-to-balloon time is a hospital metric that hospitals need to continue to improve, but he feels patient education is the key to lowering mortality. “Heart damage occurs within minutes of the artery being occluded. Certainly within 20-30 minutes, you can demonstrate that there is damage to the heart muscle. But the reality is we can’t treat everybody in 20-30 minutes from the time that symptoms occurred. There is nothing magical as to whether you happen to be at the hospital room door or not,” he said.

Beyond traditional education efforts to promote prevention of heart disease through healthier diets and exercise, the medical community needs to educate the public to be more sensitive to the symptoms of STEMIs, to call 911 as soon as possible, and not to expect the symptoms to resolve on their own said Dr. Ricciardi. “The real metric is the time from the onset of symptoms to the time to treatment. And, of course, we’re not talking about prevention here. Once the symptoms become manifest, that’s when the clock really starts. And then the community effort has to be ‘hey, if you have symptoms of myocardial infarction, you get in. You get care as soon as possible. And once you arrive, once you have your first medical contact, there’s another clock that gets set,’” Dr. Ricciardi said.

Treating STEMI patients is challenging, but gratifying to interventional cardiologists and their colleagues. Dr. Ricciardi said, “It’s incredibly rewarding to take care of patients like this because we see and achieve immediate results that benefits patients. It’s dramatic and exciting and energizing. A lot of people really enjoy taking care of patients who are in dire straits and turning them around. But there is all the other stuff we do that has incredible impact but is maybe is a little less sexy, but we do it to improve survival. That’s the name of the game.”

Howard Wolinsky is an instructor at Northwestern University’s Medill School of Journalism. He is the former medical and technology reporter for the Chicago Sun-Times and a former staff writer for American Medical News.
Physician Legal Issues Conference
Docs and lawyers join to cope with ACA challenges

THE CHICAGO Medical Society and the Health Law Section of the American Bar Association are collaborating once again to present the popular annual Physician Legal Issues Conference June 10-12 at the Palmer House Hilton. CMS members will receive a discounted registration fee.

This year’s conference offers CME and CLE activity and is targeted towards all physicians and health care attorneys. The conference will explore the myriad issues around the Affordable Care Act (ACA). Physicians, payers and patients have now had five years to struggle with and address the changes that have accompanied the ACA’s enactment in 2010. As a result of the ACA, physicians have been forced to adapt with strategies that have sometimes been successful and sometimes not. Physicians have witnessed the erosion of private practice and now compete with large health care systems and payers. Conference topics include:

- Medicine in Crises: Response and Standards of Care in Disasters and Pandemics
- The Federal Stark Law and Anti-kickback Statute: Keeping Up with Recent Trends
- Negotiating Managed Care Contracts
- The State of Payment Innovation
- Leveraging Professional Liability Companies in a Competitive Market
- Navigating the Perilous Waters of the False Claims Act from Medical Necessity to the Anti-Kickbacks Statute and Beyond
- Vendor Relationships: What a Physician Needs to Know
- The Physician Shortage Crisis and the Use of Allied Health Care Providers
- Legal Ethics in the Representations of Physicians, Groups and Their Businesses
- Recognizing and Dealing with Impairments that can Affect a Physician’s Ability to Practice
- Telemedicine Compliance—Maximizing Patient Care and ROI while Minimizing Government Risks

Among the nationally recognized speakers are: Shantanu Agrawal, MD, deputy administrator and director, Centers for Medicare and Medicaid Services, Center for Program Integrity, Washington, DC; Daniel H. Angres, MD, Positive Sobriety Institute, Chicago; Kevin R. Barry, JD, deputy chief, Administrative and Civil Remedies Branch, Counsel to the Office of the Inspector General, Washington, DC; Humayun Chaudry, MD, president & CEO, Federation of State Medical Boards, Washington, DC; Clay J. Countryman, JD, Breazeale, Sachs & Wilson, LLP, Baton Rouge, LA; Bill Crounse, MD, senior director, Worldwide Health, Microsoft, Redmond, WA; Matthew Penn, JD, Centers for Disease Control and Prevention, Atlanta, GA; Russell G. Robertson, MD, U. S. Department of Health and Human Services.

To register and for more information, go to www.cmsdocs.org or call the Chicago Medical Society at 312-670-2550 and ask for the Education Department.

Global Desired Learning Outcomes

AT THE CONCLUSION of this conference CME and CLE participants should be able to:

- Identify emerging trends in innovative payment models that promote clinical integration and encourage the development of collaborative relationships between payers and providers.
- Determine at least two key contractual provisions in agreements between providers and managed care payers for effective negotiation.
- Implement new strategies that assist independent provider practices stay successful and thrive in the current industry climate.
- Review the fundamentals of the Stark Law, Federal Anti-Kickback Statute and HIPAA/HITECH compliance issues affecting today’s physician, including lessons from recent government enforcement.
- Explain the legal and clinical issues that arise from using nurse practitioners and other allied health professionals to fill staffing gaps due to physician shortages.
- Examine how government enforcement agencies develop and conduct investigations of health care entities and discuss recent government program integrity efforts and priorities.
- Recognize at least two best practices and two pitfalls for relationships between providers and their vendors.
- Explain recent developments in telemedicine and its impact on the provision of health care services.
- Grasp the challenges faced by the medical community and its ability to respond and meet standards of care during times of disasters and pandemics.
- Identify and address the ethical dilemmas that arise when attorneys represent multiple entities and partners.
- Identify impairments that can affect a physician’s ability to practice medicine, as well as ways to intervene, and understand their potential legal implications.
Our Power is in Our Relationships
Uniting us as a voice for better health care
By Scott A. Cooper, MD

The Illinois State Medical Society’s annual meeting and House of Delegates was held April 17-19 in Oak Brook. Physicians, residents and medical students gathered to discuss hot topics, catch up with friends and strategize on building a stronger medical voice in Illinois.

At this meeting, I had the honor of introducing myself as ISMS’ new president. In my inaugural address, I emphasized my strong belief in the power of our relationships—their power to benefit us individually in our own communities and practices, and to unite us as a voice for sound medical policy on the local, state, and national levels.

No one knows more than physicians about the ins and outs of patient care and the systems in which we provide care. No one is more qualified than we are to influence these systems, both from the inside as participants and caregivers, and from the outside through advocacy and concerted action.

We do this through the power of relationships. When we gather as members of ISMS and set the course for the future of the organization’s policy and action, we know that our resolve to accomplish our goals is only as strong as the relationships that bind us together.

Our goals are diverse in scope and ambitious in scale. At our April meeting, ISMS delegates considered more than 50 resolutions, many of which will form the foundation for the bills we pursue in the Illinois General Assembly. Topics discussed range from credentialing issues and maintenance of certification to immunization exemptions and a wide variety of other public health issues. Our lunchtime CME program on Ebola, “Lessons from the Frontlines,” reminded us why we became physicians in the first place, and will soon be available for on-demand viewing through the ISMS Education Center (www.isms.org/CME).

We also focused a segment of our meeting on issues of leadership development and member engagement. ISMS is seeking to foster greater engagement and participation from our members. One approach to strengthening the relationships between ISMS leaders and Illinois doctors is through more frequent updates at medical staff events and other physician meetings. If you are interested in having me or another ISMS representative speak at a medical staff, group or specialty meeting, please contact Ms. Lori O’Connor at LoriOconnor@isms.org or 312-853-1678 to request a speaker.

Throughout the year, I hope you’ll stay informed and active through ISMS publications, calls to action, and other resources. More importantly, I hope you’ll take the lead in nurturing the relationships between your colleagues and encouraging them to join with us. ISMS is the only organization that speaks for all Illinois physicians, and when an elected official or a news reporter wants to know where physicians stand, they know that ISMS is the only call they need to make.

Thank you for your membership, and I look forward to serving you over the next year.

Dr. Cooper is the president of the Illinois State Medical Society.

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Whatever your health care practice, or even if you are a young professional entering the field, you need ongoing education to gain valuable insight and strategies. These CME and CLE webinars are held in conjunction with the American Bar Association. So, they are also invaluable for health care attorneys, whether new to the legal field or longtime practitioners. Offered exclusively by The Chicago Medical Society. Your resource for high-quality education.

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For more information or to register please visit: http://cmsdocs.inreachce.com

For registration questions and online assistance, call the customer support line 877-880-1335. For other questions, contact the Chicago Medical Society’s Education Department 312-670-2550 ext. 338, or email: emedrano@cmsdocs.org or fax to: 312-670-3646.
Calendar of Events

MAY

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 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.

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 and pay go to https://maps2015.eventbrite.com.

JUNE

3 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 and coordination of resources. Numerous provider and health plan databases and applications will be affected—including applications where diagnosis or procedure codes are captured, stored, analyzed or reported. In this session, participants will learn to describe the key plan elements required for a successful transition; make recommendations for each of the four implementation phases (planning, impact analysis, implementation, and post-implementation); 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. Hilton Chicago-Oak Lawn, 9333 S. Cicero Ave., Oak Lawn. Up to 3.5 CME credits; $59 per person for CMS members; $119 for non-members or staff. Register online at: www.cmsdocs.org or contact Haydee at aalletto@cmsdocs.org.

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 meeting takes place in Chicago at the Hyatt Regency Hotel. For information, please go to www.ama-assn.org.

10-12 Physician Legal Issues Conference 2015 (Sponsored by the Chicago Medical Society and the 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 physicians; 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 Haydee at aalletto@cmsdocs.org.

17 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.

22 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.

22 CMS Annual Dinner/Governing Council Meeting The Society’s governing body meets four times a year to conduct business on behalf of the Society. The policymaking Council considers all matters brought by officers, trustees, committee members, councilors, or other CMS members. Following the Council meeting, CMS will welcome the 2015-2016 leadership team and president awards to outstanding members. 7:00-9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

26 Chicago Neurological Society 2015 Symposium. 8:00 a.m.-2:30 p.m. Gleacher Center 450 N. Cityfront Plaza Dr., Chicago. For more information, contact Andrea 312-670-2550, ext. 325, or aalletto@cmsdocs.org.
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 kimberlee@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.

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For the Good of the Public

Pulmonologist and critical care specialist has a special interest in health care disparities

By Cheryl England

T’S A GOOD thing for Cook County that John Jay Shannon, MD, CEO of the Cook County Health & Hospitals System (CCHHS), decided early on that lab work wasn’t for him. “I was working in a lab trying to give mice asthma,” he says. “But I didn’t like the mice and the mice didn’t like me.”

An Illinois native, Dr. Shannon was appointed CEO of CCHHS in June 2014. He was immediately charged with executing the system’s CountyCare Medicaid program that his predecessor had initiated. “I’m up to my hips in that right now,” he says. “With luck and filling out my leadership team, I hope to find time to teach residents and see patients.”

An internist with specialty certifications in pulmonary and critical care medicine, Dr. Shannon has spent most of his professional career at John H. Stroger, Jr. Hospital. He first joined the medical staff in 1990 when Stroger was called Cook County Hospital and served in several roles, including director of the adult asthma clinic—the busiest asthma clinic with the highest risk patients in Chicago. While in that position, he was a co-principal investigator on an NIH grant to study asthma disparities in the Chicago area. “That grant allowed me to incorporate my clinical training with a growing understanding of the complexity of health care systems,” he says. “It spurred me to think more about public health and care disparities across ethnic and income lines.”

Simultaneously, from 1999–2007, Dr. Shannon also served as associate chairman for the department of respiratory and intensive care medicine and as chief of the divisions of pulmonary and critical care medicine at Cook County Hospital. “But then out of the blue, I got a call from a physician I admired and had trained under at the Parkland Health and Hospital System in Dallas,” he says. “The physician wanted me to be chief medical officer and join them in addressing health care disparities.”

Dr. Shannon jumped at the chance to expand his expertise beyond clinical work and teaching. He and his wife, Robin, a clinical instructor in population health at the UIC College of Nursing, and their three children moved to Dallas in 2007 for a five-year stint. By the time he left Parkland, Dr. Shannon held a joint position as the executive vice president for medical affairs and as chief medical officer at Parkland. “The experience was like a whole separate graduate education for me,” he says. “I learned how to put together people, leadership and funding to reach important objectives.”

In 2012, Dr. Shannon returned to Chicago for personal and professional reasons not knowing where he would end up. “At the time, there were a lot of mergers, alignments and acquisitions happening in Chicago,” he says. “I had no idea I would end up at “home”—CCHHS.”

Initially, Dr. Shannon returned as chief of clinical integration at CCHHS. In March of 2014 he was appointed interim CEO and in June the board unanimously named him CEO. “This has been a great challenge and opportunity to expand access in the ACA environment,” he says. “We have the opportunity to provide even better health care for vulnerable populations. The day of universal health care will be a wake up call for all public health systems. We must be a system of choice rather than one of last resort.”

Dr. Shannon’s Career Highlights

WHEN YOU’VE had a career as full of success as has Dr. Shannon, narrowing down highlights can be difficult. But when asked what he considers his greatest accomplishment, teaching and public service top the list of this 1986 graduate of Rush Medical College. Dr. Shannon has consistently won awards for excellence in teaching at Stroger, with ten awards in 14 years. In 2007, Dr. Shannon received the prestigious Physician Service Award from the American Lung Association of Metropolitan Chicago and just recently, he received a 2015 Leadership Award from Becker’s Healthcare.
“As physicians, we have so many unknowns coming our way…

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