Fighting Anti-vaccine Fever
Physicians Get New Help in the Battle to Vaccinate Children

Understanding New Overtime Rules
Getting Tough on Opioid Marketing
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Senior Vice President of System Integration at Rush University Medical Center, David Ansell, MD, MPH, spreads the gospel of healthcare as a human right while also writing about his searing experiences at Cook County Hospital.
A N INCREDIBLE journey comes to an end. Looking back on my year in office leading the Chicago Medical Society, I’m amazed by how much we’ve accomplished, and how far we still have to go. I’ve met with aldermen, Chicago’s Health Commissioner, state representatives, the Illinois Attorney General, legislators, insurance executives, medical staff presidents, and so many of you, my friends and colleagues. Having access and influence is an awesome, yet daunting, responsibility. My service has been a privilege for which I am grateful and humbled.

Writing this column every month has given me the opportunity to air my views on many important topics: electronic health records, gun violence research, maintenance of certification, prescription drug prices, millennials’ political activism, narrowing insurance networks, the opioid epidemic and the single payer model. These messages also are now broadcast via Facebook and Twitter, ensuring that we reach a wider audience.

This year, CMS held highly successful summits on health policy and medical research with Congressmen Mike Quigley and Danny Davis. These summits allowed local medical experts to inform and educate our federal representatives on important funding needs.

We’ve also held multiple meetings with insurers, AMA and ISMS legal experts, leadership from local medical societies and other stakeholders on the issue of narrow networks, which resulted in HR 5652, now pending in Springfield. If this legislation passes, it would be the most comprehensive law in the country mandating minimum requirements for insurance networks.

I am grateful for all the support that my colleagues have given me. I’m certainly standing on the shoulders of giants who have guided me along the way: Drs. Ken Busch, Bob Panton, Howard Axe (“you need some fire in your belly!”), Tom Anderson, Bill McDade, Peter Orris, Dick Geline, Shastri Swaminathan, Peter Eupierre, M. LeRoy Sprang, and Raj Lal, to name but a few. I’ve also benefited from having smart, talented and devoted officers to help guide me: Drs. Adrienne Fregia, Clarence Brown, Vemuri Murthy, Tina Shah and Dimitri Azar are the “Dream Team” executive committee who helped me navigate some tough decisions to keep CMS moving forward.

Finally, there is not enough that can be said about the hard work, talent and incredible access that our Executive Director, Ted Kanellakes, brings to CMS. It’s hard to imagine CMS functioning without him. Add the talented team of Liz Sidney, Scott Warner, Patrick Derse and Haydee Nascimento and you have a highly polished team of professionals working to support the goals and needs of Chicago-area physicians and their patients.

We’ve come a long way but we still have many challenges to face. The opioid epidemic continues unabated, gun violence is tearing apart the fabric of our society, our insurance system seems poised to collapse and our political system remains paralyzed by ideological stalemate. We may not be able to solve these problems, but we are at the table, making sure our voices are heard. I look forward to seeing our next president, Dr. Clarence Brown, bring his intelligence, poise and common-sense to these and many other problems.

Kathy M. Tynus, MD
President, Chicago Medical Society
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.

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Learn more about the app at docbookmd.com.
OIG: Billing Must Match Services

Practices risk significant financial liability when it comes to submitting claims without adequate documentation By Clay J. Countryman, Esq.

Several recent settlements by the Office of Inspector General (OIG) and the Department of Justice underscore the importance of practices regularly reviewing the documentation of their physicians and other billing providers. In the health care industry, you may hear an old expression that if there is no documentation of services, then it is as if services were not provided. The Social Security Act specifically prohibits payment for services by the Medicare program unless the provider maintains medical records including sufficient documentation to substantiate the nature and necessity of the services rendered.

The Centers for Medicare and Medicaid Services provides guidance for proper billing and documentation. The CMS Claims Processing Manuals generally provide that any coding deficiencies, including those for insufficient or improper documentation, lead to a classification of services billed as not medically necessary. In cases where there is a lack of proper documentation, physician practices also face the risk that the federal CMS will consider that a physician has upcoded claims if there is a lack of corresponding medical records. In addition, a lack of sufficient documentation may provide the basis for a False Claims Act violation if a provider knowingly or recklessly bills federal payers for services that are not supported by adequate documentation.

Settlements in the News

The following highlights “real” examples so to speak of financial liability for physicians and other billing providers who fail to maintain adequate or sufficient documentation to support claims submitted to third-party payers:

- In June 2016, St. Vincent Medical Group, Inc., paid $523,135 to settle allegations of violating the Civil Monetary Penalties Law based on submitting claims to federal health care programs for E&M services where the services where upcoded and where the supporting documentation did not support any billable services.
- Also in June 2016, CNY Women’s Healthcare, PC, paid $123,122 to settle allegations that it violated the Civil Monetary Penalties Law based on submitting claims to federal health care programs for services provided by a physician that lacked sufficient documentation.
- In February 2016, Decatur County Memorial Hospital agreed to pay $3,757,615 to settle allegations that it violated the Civil Monetary Penalties Law because the hospital submitted claims for home health care where the underlying patient files in part had: (1) missing or incomplete documentation; (2) certifications and orders unsigned or undated by physicians; and (2) documentation indicating that the requisite physician face-to-face encounter was not timely performed, or the absence of any face-to-face encounter documentation.
- In February 2016, Cedars-Sinai Medical Center agreed to pay $872,925 for allegedly violating the Civil Monetary Penalties Law based on claims submitted to federal health care programs for outpatient and inpatient professional services on behalf of a physician that were not provided as claimed or for which there was insufficient documentation to support the level of professional services claimed.
- Also in December 2015, Westview Hospital Physicians paid $61,755 for allegedly violating the Civil Monetary Penalties Law based on submitting claims for E&M services allegedly performed by a physician, where the medical record documentation for the services failed to support the level of services billed and lacked physician credentials and signatures.
- In June 2015, Triangle Spine and Back Care Center of Raleigh North Carolina paid $21,166 for allegedly violating the Civil Monetary Penalties Law based on claims for services performed by a former physician that contained inaccurate CPT codes and inadequate documentation.

Although detailed information is not available from the OIG, an underlying message to physician practices is that not keeping or not maintaining sufficient documentation to support claims to Medicare and other payers can lead to significant financial liability. As a compliance measure, physician practices should consider conducting regular audits of documentation by physician providers as part of their ongoing compliance program.

Clay J. Countryman, Esq., is a partner with Breazeale, Sachse & Wilson, LLP, in Baton Rouge, Louisiana. He may be reached at: Clay.Countryman@bswllp.com.
State Shuttles Land of Lincoln Health

ACA policyholders feel pinch

**THE STATE’S** shutdown of its Affordable Care Act-approved Land of Lincoln Health has sent thousands of Illinoisans scrambling for new coverage. The company will cease operations by Oct. 1. Many of the nearly 50,000 policyholders who had signed up with this state-sanctioned insurer had counted on the coverage to manage chronic illnesses or other long-term treatment. Under a recently convened “special enrollment” period, they will now have until Oct. 1 to find another plan on the Illinois exchange to cover the last three months of the year.

These customers, who had heeded federal law and bought their insurance last year through the state’s health insurance exchange, will most likely have to pay higher premiums for that coverage, along with paying all deductibles and out-of-pocket costs again. In addition, the new policies will most likely include more limited networks of hospitals and doctors. Land of Lincoln had offered coverage through a significant network of providers including the University of Chicago Medicine and Northwestern Memorial Hospital. But now, many of those patients could be required to pay higher rates to remain with hospitals or physicians.

And there’s not much else these patients can do. The Illinois Department of Insurance (IDOI) doesn’t have the power to force insurers to allow policyholders to shift to new plans without recalculating deductibles and other out-of-pocket payments. Nor does the state have the funds to reimburse insurers for their losses. In the meantime IDOI Acting Director Anne Melissa Dowling has said she is looking at the possibility of finding financial or other means for Land of Lincoln policyholders who are facing these extra costs.

In a written statement addressing healthcare providers, Dowling said it is important that Land of Lincoln insureds continue to receive healthcare services without interruption from Land of Lincoln providers. “Providers will be paid for services delivered to Land of Lincoln insureds under their provider agreements,” she stated. “Claims for services should be submitted as usual for payment. Providers should not refuse service to insureds.”

Dowling also offered the following information to Land of Lincoln policyholders:

- Current insurance coverage with Land of Lincoln will terminate Sept. 30, 2016.
- Through Sept. 30, policyholders may report their upcoming loss of coverage to the Federal Health Insurance Marketplace (1-800-318-2596) and enroll in a new plan for coverage starting on Oct. 1, 2016, and ending Dec. 31, 2016. Enrolling in a plan during this time will allow consumers to avoid a gap in coverage and any financial assistance they may be receiving.
- Alternatively, there will also be a special enrollment period from Oct. 1, 2016, through Nov. 29, 2016, to enroll in a new plan for coverage starting on the first day of the following month. Enrolling in a plan during this time may result in a gap in coverage and financial assistance.
- Policyholders who fail to enroll or obtain private health insurance coverage by Nov. 29 may not be able to enroll in coverage through the Federal Health Insurance Marketplace until the start of Open Enrollment starting Jan. 1, 2017.

Sources: Chicago Tribune, July 26 “Land of Lincoln Health and Obamacare”; Ill. Dept. of Insurance.

Illinois Obamacare Facing Hurdles

*IT’S NOT JUST* Land of Lincoln policyholders who will be facing sticker shock when trying to buy affordable new health insurance policies. On Aug. 1, federal officials revealed proposed Illinois insurance rates for 2017. As a Chicago Tribune editorial remarked, “Pass the smelling salts.” Insurers plan to increase rates as much as 45% for those who purchase plans on the Affordable Care Act marketplace when open enrollment begins Nov. 1. The reason for the price surge? “Many insurers have been losing money in the marketplace,” said Katherine Hempstead, a senior adviser at the Robert Wood Johnson Foundation, who was quoted in a Chicago Tribune article. Blue Cross Blue Shield of Illinois, for example, is proposing increases ranging from 23% to 45% in premiums for its individual healthcare plans. Aetna, the nation’s third-largest insurer, has called off its planned expansion in the Affordable Care Act’s insurance exchange. The insurer further suggested that it could abandon the market altogether. And UnitedHealthcare, the nation’s biggest health insurer, is departing the Illinois exchange next year, citing larger than expected losses on individual plans. But Cigna, one of the nation’s largest health insurance companies, is taking a different tact, and has announced plans to enter the ACA marketplace in the Chicagoland area for the first time. The company plans to sell health policies to individuals and families who buy their own coverage in the individual market. The plan would need to be approved by Illinois regulators.
IN MID-MAY, the U.S. Department of Labor (DOL) updated the federal overtime pay rule for the first time since it was initiated in 1938 as part of Franklin Roosevelt’s Fair Labor Standards Act. The update that will impact millions of workers including healthcare workers and medical researchers. The rule goes into effect on December 1 of this year and will extend overtime pay protections to an additional four million U.S. workers. Almost 200,000 of those workers reside in Illinois according to the DOL.

The biggest change, and the one that will most directly affect healthcare workers, is an increase in the salary threshold for overtime pay from $455 per week to $915 per week. This means that an employee making $47,476 per year or less is eligible for overtime pay of 1.5 times their normal pay when they work more than 40 hours per week. In addition, the salary level for highly compensated employees (HCE) was updated so that a full-time salaried white-collar employee would now have to be paid $134,004 per year instead of $100,000 per year in order to be automatically exempt from overtime pay. Bonuses, commissions and incentive pay can all be counted when calculating a HCE’s salary.

In the healthcare industry, the new overtime pay rule will most likely affect lower salaried jobs such as nurses, medical assistants and paramedics. Non-hospital health care service providers, which are considered small businesses, will also be highly affected by overtime charges. The DOL estimates that the healthcare sector will see an increase of $26.3 million in payroll, or 1.5% of average payroll. When including other expenses associated with these overtime changes, the increased cost to healthcare-related small businesses is expected to be more than $41 million in the first year and almost $47 million after ten years.

The Effect on Research
Currently, the new rule is making the biggest waves at research institutions such as laboratories and universities, where many are concerned with how the law will impact postdoctoral researchers. Because most postdocs work more than 40 hours, employers can either pay them overtime or increase their salaries.

The National Institutes for Health (NIH) provides National Research Service Awards (NRSA) with stipends for the first three years at $43,692, $45,444, and $47,268, all of which fall below the new overtime threshold. Even when postdocs are paid directly from investigators’ grants, most institutions use the NRSA levels as a guideline. While a raise in salary of, say, $4,000 to meet the threshold may not seem like a lot, the amount grows when you add in benefits and social security taxes.

Additional Requirements
The new rule also provides for automatic updates. Beginning Jan. 1, 2020, and every three years thereafter, the overtime threshold will be raised to the 40th percentile of full-time salaried workers in the lowest wage census region. The current estimate for the 2020 threshold is $51,168. The HCE threshold will also be updated every three years.

Exemptions are available for some employees. The rule spells out exemptions for executives, administrative staff, professionals, outside sales and computer employees. The professionals exemption includes physicians and lawyers, among others. For a full description of the exemptions, go to the Federal Register at www.federalregister.gov.

What Physicians Can Do
Physicians who own their own practices should determine which of their employees may be affected by the new overtime rules. It is important to note that these rules are only applicable to employees who are deemed to be white-collar workers. The rules for overtime pay for other worker classifications were not changed in these rules.

If eligible employees regularly work overtime, then physician practices need to decide how to handle the situation starting December 1. One option is to raise salaries to meet the threshold either by a direct bump or by implementing a bonus structure. This expense will need to be factored into the practice’s budget for 2017 and beyond, including the automatic updates.

Another option is to reallocate duties or eliminate extra work so that employees do not work overtime. If that is not completely possible, then a practice can, at least, try to minimize the number of overtime hours worked by employees. And, if there's simply no way to get around below-threshold employees working overtime, then be sure to budget for the additional pay to see how it affects your bottom line.

The new overtime rule will greatly increase the number of workers eligible for overtime pay. The health care field won’t be exempt—it will be highly impacted. With that in mind, the time to start planning is now.

Understanding New Federal Overtime Rules
Higher salary thresholds will have a large impact on physician practices

By Cheryl England
After a nationwide analysis of convictions and settlements over the past year, the Department of Health and Human Services Office of Inspector General is cautioning providers and home health agencies to avoid improper payment and other conduct. The OIG stresses that compensation arrangements may violate the Anti-Kickback Statute even if one purpose of the arrangement is compensating a physician for referrals to the home health agency. Both physicians and home health agencies must base payment on fair market value that is commercially reasonable in the absence of federal program referrals.

The OIG alert discusses cases in which the government alleged that home health agencies or providers violated the federal Anti-Kickback Statute by directly or indirectly paying physicians for referrals of Medicare patients to home health agency services or by directly or indirectly soliciting or receiving payments in return for these referrals.

Other violations—the healthcare fraud statute and False Claims Act—are addressed in the alert. Government allegations involving medically unnecessary services for patients not actually homebound, including false certification of home confinement, upcoding of patient visits and billing for care plan oversight when such care was not actually rendered were also the subject of the OIG alert.

The OIG reported that the physicians participating in these arrangement were not the primary care physicians. In fact, the primary care physicians for the particular patients were often not even aware that their patients were receiving home health services.

Home health agencies must ensure that Medicare patients receiving home health services are actually homebound. Both agencies and physicians should ensure home health services are reasonable and necessary.

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IN WHAT COULD serve as a model for other drug makers, Pfizer, the world’s second-largest drug company, has agreed to a written code of conduct in Chicago for the marketing of opioids. On July 6, Mayor Rahm Emanuel announced the breakthrough agreement with the pharmaceutical giant that will commit the company to strict standards for the marketing and promotion of prescription opioids, and ideally help curb the use of these addictive painkillers.

By way of background, in June 2014, the City of Chicago filed a lawsuit against five pharmaceutical manufacturers for misrepresenting the benefits of opioids and concealing the serious health risks associated with these drugs. In the lawsuit, the city claimed that in 2009, approximately 1,100 emergency room visits were due to opioid overdose or misuse. The city also contends it paid out more than $12 million in insurance claims for painkiller prescriptions between 2008 and 2015. And in 2015, Chicago had 84 fatal overdoses due to prescription opioid painkillers.

OxyContin Manufacturer Targeted

The lawsuit sought to end deceptive marketing so that patients and physicians are able to make informed decisions about when and how to use these highly addictive drugs. While the original lawsuit was dismissed last year, the city filed an amended complaint this past fall that gave 326 pages of specifics about Chicago’s costs related to painkiller abuse, and the drug companies’ marketing practices. Among the targets of Chicago’s lawsuit was Purdue Pharma, manufacturer of OxyContin, a painkiller that was touted to reduce the risk of addiction and abuse. Years earlier, Purdue pleaded guilty to criminal charges of making misleading statements to regulators, the public and physicians about the drug’s addictive qualities.

Pfizer, which was not named in the lawsuit, has cooperated with the city’s investigation and litigation, providing documents and other evidence relevant to the city’s claims against other manufacturers of opioids. According to Stephen Patton, Chicago’s corporation counsel, Pfizer is “a company that has agreed to embrace what we think are the common-sense proscriptions that we are seeking as part of our lawsuit.” Patton also says that Pfizer’s action sets it apart from companies that have been accused of fueling an epidemic of opioid misuse through aggressive marketing of their products.

Was Agreement a Breakthrough?

Patton maintains that some opioid manufacturers are still using deceptive tactics and are spreading their message more subtly, and often through third parties. However, the city’s recent agreement with Pfizer hopes to curtail such practices.

While the Mayor’s office hailed the agreement as a breakthrough, some industry experts are saying that Pfizer is already bound to these practices that are part of existing regulations and laws that currently govern drug marketing. Pfizer is currently working with Eli Lilly on the development of a possible safer alternative to opioids, an injectable painkiller that would be administered every eight weeks. Now in late-stage testing, the injectable

The Chicago/Pfizer Opioid Agreement

AS PART of its written code of conduct with the City of Chicago, Pfizer has committed to fairly and accurately disclose the risks of opioids in its promotional activities and external communications, including through its sales representatives who promote drugs directly to doctors. Under the four-year agreement, specifically, the company will:

- Disclose the risk of addiction to opioids, even when used as directed.
- Disclose that there are no adequate and well-controlled studies of the use of these products for longer than 12 weeks. (This is especially important since opioids are frequently prescribed for chronic pain conditions.)
- Not promote opioids for any off-label or unapproved uses.
- Include information on opioid addiction and abuse in connection with its promotional efforts and communications, whether under the Pfizer brand or not.
- Maintain and promote a non-marketing website.
- Upon request, and to the extent it is educating prescribers about opioids, fund continuing medical education programs aimed at increasing prescribers’ awareness of the risks of opioid addiction and abuse and helping prescribers identify signs of opioid addiction and abuse.

Sources: The Washington Post, July 5, 2016, Pfizer reaches agreement with Chicago to limit opioid marketing, by Lenny Bernstein; Statement from City of Chicago, Office of the Mayor, July 6, 2016, and Pharmalot.
drug would be used to treat chronic pain resulting from a range of conditions such as osteoarthritis and cancer. Pfizer is seeking regulatory approval for the injectable drug by 2018.

Currently, the Chicago Department of Public Health (CDPH), is relying on Pfizer to assist the city in educational efforts about opioids and the proper disposal of unused opioid prescriptions. “Opioids have caused a public health epidemic that has affected patients, their families and entire communities, and education is key to preventing other forms of abuse,” said CDPH Commissioner Julie Morita, MD. “We look forward to working with Pfizer to help keep residents of Chicago fully informed about the risks associated with the use of these painkillers.”

**From Opioid to Heroin**

Health officials further point out that many patients who receive a valid prescription for an opioid painkiller not only become addicted, but may also turn to heroin because it is cheaper and easier to access. A recent study found that heroin use among those who misuse or abuse opioid painkillers has increased, with many people reporting abuse or misuse of these drugs before starting heroin.

By dramatically increasing the market for opioids, drug companies have also created a supply of drugs that are diverted to people to whom they are not prescribed. In fact, more than three out of four people who misuse prescription painkillers use drugs prescribed to someone else.

Nationwide, nearly 165,000 people have died from overdoses of prescription narcotics since the year 2000, according to the Centers for Disease Control and Prevention. The CDC estimates that 2.1 million people are addicted to prescription painkillers. “We are waking up as a society to the fact that these are dangerous drugs,” CDC Director Tom Frieden, MD, said in an interview. “Starting a patient on opiates is a momentous decision, and it should only be done if the patient and the doctor have a full understanding of the substantial risks involved.”

**Combatting Opioids**

Obama signs opioid addiction bill into law

**PRESIDENT OBAMA** has signed into law a bill that aims at reducing heroin and prescription opiate deaths, and also pledges efforts to protect drug-dependent newborns and help their parents.

The bipartisan Comprehensive Addiction and Recovery Act was passed nearly unanimously by both the Senate and the House of Representatives and became law on July 22. Known informally as “Lali’s Law,” the legislation was inspired by the family of a young Lake County resident, Alex Laliberte who died of a heroin overdose in 2008. The legislation includes provisions to increase access to the life-saving antidote naloxone throughout the United States. The law approves $181 million in funding for states to battle opiate and heroin addiction, and puts new emphasis on courts to opt for treatment rather than incarceration. U.S. Rep. Robert Dold of Illinois, who sponsored the bill, said he hopes to increase funding in the near future.

The legislation also includes special consideration for babies born addicted to drugs. The new measure stipulates that the federal government and every state begin adhering to a 2003 law that mandated hospitals and social services to monitor, report and assist drug-dependent infants and their families. Until now, most states have largely disregarded the requirement. This has resulted in many unnecessary deaths among newborns discharged to families not in a position to care for them properly, according to a Reuters News Agency investigation last year.

**Non-punitive Approach**

Reuters found that one drug-dependent baby was born on average every 19 minutes in the United States. The news agency stated that most children born to addicted mothers, including many others who were taking prescribed methadone, were not being reported by hospitals as required by law. Furthermore, the non-reporting occurred because medical workers often feared inviting child protective services, as the existing law required. The new measure, however, seeks to rectify that with a non-punitive approach that includes “safe care plans” aimed at keeping newborns at home with their parents, who in turn will get more help.

Sources: Lake County News Sun, July 25, 2016, Jim Newton; Reuters, July 22, 2016, Wilson Duff.
THE ILLINOIS Department of Public Health (IDPH) is echoing the unprecedented recommendation from the Centers for Disease Control and Prevention (CDC) that pregnant women avoid travel to an area in Miami, Florida, because of the risk of Zika virus. This recommendation comes after the Florida Department of Health identified a one-square mile neighborhood just north of downtown Miami, which includes Wynwood, where the Zika virus is being spread by mosquitoes. So far more than 15 cases have been reported, marking the first time that Zika has been locally transmitted in the continental United States. The virus, which has been linked to birth defects, including microcephaly.

The CDC, which deployed an emergency response team to Miami, has issued guidelines for people who visited this area any time after June 15, 2016. “We know that Miami is a popular travel destination for Illinoisans and we urge all residents to follow updated CDC recommendations, given that it is now possible to contract Zika virus in the United States,” said IDPH Director Nirav D. Shah, MD, JD. “We want to make sure that people traveling to the Miami area have the facts so that they can protect themselves from being infected.”

Here are the recommendations for pregnant women and their partners:

• Pregnant women should not travel to the affected area.
• Pregnant women and their partners traveling to this area should follow steps to prevent mosquito bites.
• Anyone who traveled to this area and who has a pregnant sex partner should always use condoms or other barriers to prevent infection or not have sex during pregnancy.
• Pregnant women who frequently travel to this area should be tested in the first and second trimester of pregnancy.
• Pregnant women with possible Zika virus exposure and signs or symptoms of Zika virus should be tested for Zika virus.
• Pregnant women who traveled to this area or had unprotected sex with a partner who traveled to or lives in this area should talk to their healthcare provider and should be tested for Zika virus.
• Women with Zika should wait at least eight weeks and men with Zika should wait at least six months after symptoms began before they try to conceive.
• Men and women who traveled to this area or other areas where Zika is being transmitted should talk to their providers before they try to get pregnant.

Upon returning to Illinois, travelers should take precautions to prevent the spread of Zika virus, even if they don’t think they have it, Dr. Shah said. Travelers should watch for symptoms after returning home, call a healthcare provider immediately if they suspect Zika virus, use insect repellent for three weeks after travel, and use condoms during sex.

Illinois Still Safe
As for Zika being contracted directly by citizens in Illinois, so far that does not seem likely. According to Allison Arwady, MD, chief medical officer, Chicago Department of Public Health (CDPH), the species of mosquito that most easily carries the Zika virus (Aedes aegypti) is not native to Illinois. In order for a mosquito to transmit the virus, it must first bite someone who already has it.

Dr. Arwady says the CDC is studying the reported cases of sexually transmitted Zika, but these cases are rare. And while the Zika virus is a concern for pregnant women, Dr. Arwady says it should be of little worry for practically everyone else; 80% of those who contract the virus don’t even know they have it, and those who do become ill generally don’t suffer long-term consequences and rarely need hospitalization.

CDC Offers Funds
While President Obama requested Congress in February to approve about $1.9 billion in emergency funds to fight Zika at home and abroad, and pursue a vaccine, so far lawmakers have not passed funding legislation. In the meantime, the CDC reports it has provided more than $16 million to 35 states and five territories to help detect any cases of microcephaly, and other Zika-related conditions.
IN MYRIAD WAYS, the Chicago Medical Society works to fulfill its public health mission. Vetting candidates to serve on the Cook County Health and Hospitals Systems independent governing board is one of these essential duties. That’s why CMS is pleased that a physician candidate nominated by the Medical Society won appointment to the Board. Virginia Bishop, MD, MPH, assistant professor in preventative medicine – behavioral medicine at Northwestern Feinberg School of Medicine, joined four other board members who were formally approved by Cook County commissioners on July 13.

CMS’ other nominee to the board was Linda Rae Murray, MD, MPH, adjunct assistant professor at the University of Illinois at Chicago School of Public Health, and former chief medical officer at the Cook County Department of Public Health. Both nominees were chosen by CMS for their broad and deep leadership experience.

When vacancies come up, Board President Toni Preckwinkle relies on a 14-member nominating committee to screen and recommend candidates. CMS participates on the committee along with other key stakeholders. Charged with filling five vacancies this year, the committee convened on May 24 to begin the process. The vacancies were the result of three resignations and two expiring terms. Of the 15 individuals who advanced for Preckwinkle’s consideration, the board president and former alderman chose five, one of whom was a reappointment.

Volunteer board members oversee and manage the massive Cook County healthcare delivery system. Their decisions have a significant impact on the 1,000-member medical staff and the care of hundreds of thousands of patients who depend on the system each year.

The Medical Society has been part of the screening process since 2008, to ensure that Chicagoans have access to a strong public health system. The volunteer nominating committee includes experts in healthcare management, finance, and regulatory affairs as well as public policy, labor relations, clinical medicine and public health.

CMS Shapes County Health System
Nominee wins appointment to governing board
By Elizabeth Sidney

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Wireless communications, including Wi-Fi and other wireless technologies, have proven to be incredibly useful not just in the healthcare industry, but across virtually every industry. However, the benefits of wireless technologies have been accompanied by significant challenges and risks that sometimes are not fully appreciated by healthcare providers or device manufacturers.

By U.S. Food and Drug Administration (FDA) definition, “Radio frequency (RF) wireless medical devices perform at least one function that utilizes wireless RF communication to support healthcare delivery. Examples of functions that can utilize wireless include transferring patient data from the device to another source, device control and programming, and monitoring patients remotely.” Further, “Incorporation of wireless technology in medical devices can have many benefits including increasing patient mobility by eliminating wires that tether a patient to a medical bed, providing health care professionals the ability to remotely program devices, and providing the ability of physicians to remotely access and monitor patient data regardless of the location of the patient or physician (hospital, home, office, etc...).” These devices are ubiquitous in any hospital, long-term care facility or other healthcare entity. They are also increasingly becoming the center of patient healthcare engagement.

While the failure of a wireless connection in a personal laptop, cell phone or other wireless device due to network congestion or signal interruption may go entirely unnoticed by non-medical device users, interruption or interference in the wireless signals of many FDA-approved medical devices can pose risks to patient health and safety. Additionally, clinicians and other users are becoming dependent on these wireless medical devices, so disruptions to their operation can negatively impact clinical workflows and other business-critical applications. As a result, device manufacturers and healthcare providers should be aware of the risks inherent with those wireless interruptions or interferences and the management solutions available to them. Two of the most important of these risks are: 1) cybersecurity; and 2) the disruption or congestion of the wireless radio frequency spectrum.

Fortunately, regulatory agencies and other organizations are working to help medical device manufacturers and healthcare providers understand, acknowledge, and manage the challenges associated with wireless medical technologies. With regard to all types of medical devices, the FDA recently issued guidance addressing cybersecurity vulnerabilities. In January 2016, the FDA published guidance entitled, “Post-market Management of Cybersecurity in Medical Devices Draft Guidance,” which provides recommendations for mitigating risks associated with post-market cybersecurity vulnerabilities for marketed medical devices. The guidance “emphasizes that manufacturers should monitor, identify and address cybersecurity vulnerabilities and exploits as part of their post-market management of medical devices.”

The FDA also issued additional draft guidance entitled, “Design Considerations and Pre-market Submission Recommendations for Interoperable Medical Devices,” to identify considerations for improving the interoperability of medical devices through the stages of their development and design. The guidance demonstrates the FDA’s heightened focus on addressing the cyber risks associated with medical device vulnerabilities, although neither speak directly to the wireless spectrum risks.

The FDA has also addressed the risks of disruption or congestion of the wireless radio frequency spectrum, which is the focus of this article. In 2013, the FDA issued guidance on Radio Frequency Wireless Technology in Medical Devices to address “the increasing use of RF wireless medical devices, continuing innovation and advancements in wireless technology, and an increasingly crowded RF environment. RF wireless technology considerations should be taken into account to help provide for the safe and effective use of these medical devices.” The FDA encourages manufacturers and users of medical telemetry devices to use the Wireless Medical Telemetry Service (WMTS) spectrum established by the Federal Communications Commission (FCC) and subject to FCC service rules. This regulatory scheme provides
for a coordinated oversight function by both the FDA and FCC.

**Wireless Medical Telemetry Service**

WMTS is generally used to monitor a patient’s physiological parameters and other patient-related information (vital signs including pulse and respiration) using RF communication with the advantage of allowing patient movement without restricting patients to a bedside monitor with a hard-wired connection. These telemetry or patient monitoring devices send real-time transmissions of physiologic data, which includes alarms, upstream onto the network to a surveillance station.

“Interference occurs when a first transmission and at least a second transmission occurs at the same time, in the same frequency band, and are received by the same receiver. It is analogous to having two people talking to you at the same time. At the point the interference makes it impossible to understand the transmission, the term ‘harmful interference’ might be applied. A high rate of interference indicates that receivers have harmful interference at a high enough rate that data communications are delayed or fail.” Further, “There is only so much space for radio waves to coexist and not cause interference between devices. Management of this airspace in the healthcare environment is a requirement in order for medical devices to be used in a safe and effective manner.”

In a 2012 Science Advisory, the American Heart Association (Heart Association) articulated that network latency may pose significant risks to patients. Considering that “any telemetry system that relies on wireless transmission and a data network is potentially vulnerable to these delays, because transmission errors are inherent to wireless or network communications,” managers of wireless hospital telemetry systems must work to mitigate such delays while also being prepared for occurrences of delay and avoid over-reliance on these systems.

The Science Advisory describes a case in which such network delays apparently resulted in severe injury to a patient in cardiac arrest. More recently, a 2013 FDA Guidance on wireless technology in medical devices noted that “lost, corrupted, or time-delayed transmissions, and degradations in wireless transmissions including when caused by competing wireless signals or electromagnetic interference (EMI) to the medical device or its wireless transmissions” is an example of potentially problematic wireless-related hazards. The FDA also advised that “selection of RF wireless operating frequency and modulation should take into account other RF wireless technologies and users that might be expected to be in the vicinity of the wireless medical device system. These other wireless systems can pose risks that could result in medical device signal loss or delay that should be considered in the risk management process.” The FDA further noted that “an increasingly crowded RF environment could impact the performance of RF wireless medical devices, which makes risk management an important part of integrating RF wireless technology into medical systems.”

Today’s hospitals have computers, in-house telephones, infusion pumps, electrocardiogram carts, pulse oximeters, and some physiological monitoring systems along with devices operating for consumer use operating on the 2.4 GHz region. This is not part of the dedicated WMTS spectrum, and these wireless infrastructures can become overwhelmed with non-critical traffic which may interfere with valuable clinical information.

“...clinicians and other users are becoming dependent on these wireless medical devices, so disruptions to their operation can negatively impact clinical workflows and other business-critical applications.”

As noted above, the FCC has dedicated a particular spectrum, the WMTS, to licensed medical wireless technologies. This service provides for a more protected spectrum within certain wireless frequency bands including 608 to 614 MHz, 1395 to 1400 MHz and 1427 to 1432 MHz. These spectrum bands are narrow and provide limited bandwidth or capacity. The WMTS can be used within certain defined healthcare facilities and only by authorized healthcare providers.

Recently, the FCC engaged in rulemaking about allocation and auction of spectrum near the WMTS. In its Report and Order, issued August 2015, the FCC recognized the need to protect WMTS systems from potential interference with personal/portable devices. The FCC attempted to address the potential for interference by further regulation of the spectrum space near the WMTS and by limiting the power of the non-medical devices that might function in those spaces. The FCC also sought to create a three megahertz “guard band” around the WMTS. The FCC’s new rule also allows for fixed and personal/portable non-medical devices to operate within the WMTS with certain power and physical separation distances from healthcare facilities in order to avoid harmful interference.

Many parties submitted comments to the FCC in favor and in opposition to these new rules. The controversy centers around the adequacy of the protections the FCC has put in place, and the controversy has continued with a flurry of filings asking the FCC to reconsider. The common thread throughout all the filings is that interference within the WTMS is a serious patient safety concern.

**Industry Leadership by the AAMI**

While no one group or individual has the definitive solution to handling the continuous and evolving
challenges of wireless medical technology in healthcare, as an industry leader the Association for Advancement of Medical Instrumentation (AAMI) created a special group called the Wireless Strategy Task Force (WSTF) specifically to address these challenges. The WSTF has been active in the healthcare community and was instrumental in providing subject matter experts for the 2015 FCC and FDA Joint Workshop on Medical Technology Innovation and Wireless Test Beds.

“The common thread throughout all the FCC filings is that interference within the Wireless Medical Telemetry Service is a serious patient safety concern.”

The AAMI’s WSTF, which meets at least three times a year, initially emerged from a 2012 event called the Wireless Workshop. The Wireless Workshop produced a document entitled [ital.]Healthcare Technology in a Wireless World[ital.], which includes a list of the “Top 10 Mistakes in Implementing Wireless Technology in Healthcare.”

The document also identifies several high-priority issues to be addressed, including:

• Clarifying roles and responsibilities in the wireless arena (management of spectrum and devices operating on the spectrum).
• Managing the spectrum to improve safety and reliability.
• Designing wireless infrastructure for high reliability.
• Managing risk and preventing failure.

In 2014, the WSTF developed a document entitled FAQs for the Wireless Challenge in Healthcare, which provides answers to frequently asked questions about wireless issues in the healthcare environment. The AAMI has additional resources and updates on its website.

AAMI also has a standards developing committee, called the AAMI Wireless Working Group (SM/WG 06), which is working on a technical information report (TIR) for manufacturers to address wireless coexistence of medical devices. The TIR will address the need for a test method when multiple radio frequency wireless users are in the same frequency range as a medical device. The TIR will also address the need for incorporating risk management principles into the development of wireless medical devices. Although the material presented in any similar AAMI report may need further evaluation by experts, releasing the information is valuable because the industry has a pressing need for it.

Exponential Growth and Opportunity

Healthcare industry leaders and healthcare information technology (HIT) experts have seen wireless technology in healthcare become pervasive and ubiquitous. The adoption and deployment of wireless medical systems has outpaced the development of applicable standards and regulations. Wireless innovations grounded in wireless communication technologies and applications from food, pharmaceutical, and automated supply chain processes to new mobile health applications are seemingly born daily. Healthcare providers are using these communication technologies with devices for patient diagnosis, treatment, monitoring, or therapeutically within facilities and in patient homes.

In fact, consumer and medical home use is a rapidly growing segment of the medical device market. The technology is also being deployed in remote patient monitoring devices that are ever-expanding in the complexity and depth of data gathering and communication.

This rapid influx of wireless medical technology into the healthcare arena is resulting in an increasing demand for expertise in this area, both technically and legally. There is no common industry “playbook” for spectrum governance or management. Instead the limited number of wireless medical device experts rely on one another to find novel solutions to the myriad challenges they are encountering as wireless connectivity goes mainstream in the open market. The promise of digital health is dependent on the safe and effective use of wireless technology, particularly given the increasing use of wireless wearables and other components of the Internet of Things (IoT), which refers to the ability of every-day objects to connect to the Internet and to send and receive data.

Beyond increasing healthcare provider and HIT vigilance and compliance, solutions to wireless challenges are requiring the creation of industry and government wireless networking standards, the identification of proper implementation methods to ensure compatibility with existing infrastructure, coexistence with medical and non-medical devices, and industry-wide educational efforts. Recognizing these solutions is important; the industry now faces the challenge of vigorously engaging and expanding them.

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The upcoming fall school season will be the first major test of a new law that puts Illinois solidly among states tightening up on parental excuses not to have their children vaccinated. The 2015 measure, signed too late for last year’s school sign-up, toughened the Illinois religious exemption from the student vaccination requirement. It mandates a form that requires parents to state the religious basis for an exemption and to cite the specific vaccines to which they object, and to acknowledge unvaccinated children can be barred from school under certain circumstances. It also requires a healthcare provider to sign the form, affirming that the parent has been given information on the benefits of immunization and the health risks from preventable communicable diseases. The only other exception allowed in the law is for a certified medical reason.

“By requiring that parents have a conversation with their own physician, Illinois’ religious exemption law is now amongst the most robust in the country,” said Elmhurst pediatrician Eddie Pont, MD, who served as physician leader for the Illinois Chapter of the American Academy of Pediatrics in advocating for the law. “Studies have shown that these laws, even though they do not eliminate the exemption, are effective at encouraging parents to vaccinate.”

Measles Momentum

Statewide, religious exemptions granted for measles vaccinations, a common benchmark for missed immunizations, were nearly 15,000 at last count, according to Illinois State Board of Education figures. In 2009, that number stood at somewhat over 8,000.

Illinois physicians and others, concerned about the exemptions trend, had eyed tougher standards. Then they got a big out-of-state assist in making a tougher law a reality. It came from Disneyland.

A measles outbreak began there in late 2014 and spread to a number of other states, Mexico and Canada. California soon became the nation’s third, and by-far largest, state with the strictest vaccine exemption law. Parents can either prove a credible medical basis for an exemption or start home schooling.

Illinois very quickly joined California. “The impetus for this measure was the measles outbreak in California. Several legislators wanted to champion improving the religious exemption law. ICAAP was instrumental in this effort, providing technical advice as well as lobbying legislators directly,” said Dr. Pont.

Vaccine advocates see the Disneyland outbreak as a turning point nationally. “For parents, for politicians and for the media, that epidemic out at Disneyland made the diseases more real to them,” said Benard P. Dreyer, MD, president of the American Academy of Pediatrics. At press time, the AAP was preparing to formally release a national policy statement that addresses opting out of vaccinations. As is the case in California, “We believe that there should be no religious or personal exemptions.”

That is a view shared by other organizations including the American Medical Association and, locally, the Chicago Medical Society. In terms of the Illinois law, “It’s CMS’ belief that we should go further, and mandate these vaccines for all children attending schools in Illinois, similar to state law in California,” said outgoing CMS President and internist Kathy M. Tynus, MD.

Figures and Families

The Illinois law exemption form kicks in at entry to kindergarten, middle school and high school. However, the immunization discussion, and most of the shots, should take place long before then.

The overwhelming majority of parents don’t need convincing. At the other extreme, hard-core abstainers may seek out practices they have heard are sympathetic. If those parents don’t find out by word of mouth, the names can be found on anti-vaccine websites.

“Personal or philosophical reasons cannot be used as the basis for an exception under Illinois law. The belief must be religious, though it ‘need not be directed by the tenets of an established religious organization.’”

Still, parents ranging from the merely nervous to the adamantly antivaccine are a routine part of childhood primary-care practice life. The data on safety and effectiveness always has a place in the vaccine discussion, but experienced physicians find an effective communication strategy entails shifting from figures to families. “I think that trying to have a statistics-based discussion about the very low risk of any negative consequence of immunization is not helpful,” said Andy Bernstein, MD, member of a north suburban pediatrics group practice. He noted that parents can attach their fears to even a very slim possibility of danger and envision that bad outcome for their child.
Dr. Bernstein will talk about the science and improvement of vaccines, but the overarching context is the benefit to the child. “The first thing I teach residents in training who rotate through my office is that the biggest motivator of parents who don’t want to immunize their children is that they, like me, are interested only in doing what’s best for their children,” he said. “The fear that a lot of people have is that we’re immunizing kids with so many shots for so many diseases. What they don’t realize is that although it’s true, that we are protecting kids against more diseases now than ever before.”

He and his colleagues head off problems by running a practice that “has a reputation for being an office that believes in the benefits of immunizations. From our first meetings with potential patients, we’ll often be clear about intending to have a fully immunized practice.”

He can almost always successfully reassure even very anxious parents. However, he added, for parents who come to him “and say ‘we don’t think we want you to immunize, are you the right doctor for us?’ my swaying rate is probably closer to 50%.”

“From our first meetings with potential patients, we’ll often be clear about intending to have a fully immunized practice.”

Anita Chandra-Puri, MD, member of a Lincoln Park pediatrics group practice, also starts from a position of empathy and focuses on why parents are hesitant. An anti-vaccine message doesn’t necessarily have to come from afar. “Sometimes it can be because there is a family member who has been in their ear the whole time,” she said. A parent can have a hard time refuting that family member.”

Both Drs. Chandra-Puri and Bernstein are at practices that won’t continue to see unvaccinated patients, unless there is a legitimate medical reason. Where Dr. Chandra-Puri practices, physicians will talk with patients about the importance and safety of vaccines “for a few visits, to try and get them to understand our belief and our policy,” she said. “If truly by six months we feel like they are not going to be vaccinating their children, we suggest that they find a different practice because we feel like their thought processes and our thought processes don’t meet up.”

The practice reluctantly allows some limited leeway to “splitters”—parents concerned about too many shots at one time and who want to work them in over a few visits—but warns them that their belief in spacing out vaccines is not safe. Immunization visits are well planned and designed to maintain the dialogue with parents. It is “our way of trying to make sure that they don’t just come in and willy-nilly decide which vaccines they want to get. We explain to them very early that they are sort of playing a lottery in deciding which thing that they’re worried that their child will be exposed to,” she said. After conversations that help parents understand what is at stake in terms of the child’s well-being, “I find people who start out as splitters who then will quickly become schedule followers.”

Tying Vaccines to Home
Family physician Santina Wheat, MD, MPH, site medical director at a federally qualified health center in Humboldt Park, often lets her patients know she would never recommend something that she didn’t believe in fully for her own children.

Dr. Wheat, MD, MPH, site medical director at a federally qualified health center in Humboldt Park, also addresses vaccine concerns with a view to the family—her own. “I often share with my patients that I am a mother myself and fully vaccinate my children. I would never recommend something that I didn’t believe in fully for my own children.”

When the discussion turns to the welfare of others, it is still tied to home. “I don’t actually find that my families respond well to “What about everybody else in the class?” but if I can identify someone in their family that they might be putting at risk, then often I feel that it works a little bit better.”

The overwhelming scholarly research on vaccination has been focused on the safety and effectiveness of the vaccines themselves. But investigation has also turned to effectively communicating about them.

A paper published last year in the Proceedings of the National Academy of Sciences was greeted warmly in the lay press. Among the headlines was the Washington Post’s “There’s a surprisingly simple way to convince vaccine skeptics to reconsider.” Researchers tested two communication strategies, one showing that vaccines don’t increase the risk of autism and the other, providing information on the harm from illness as a result of not vaccinating. Of the two, the benefits argument was significantly

**ANTI-VACCINE FEVER**

Family physician Santina Wheat, MD, MPH, site medical director at a federally qualified health center in Humboldt Park, often lets her patients know she would never recommend something that she didn’t believe in fully for her own children.
ANTI-VACCINE FEVER

“...more persuasive. “We successfully countered people’s anti-vaccination attitudes by making them appreciate the consequences of failing to vaccinate their children,” wrote the authors of the paper.

However, Pediatrics, the American Academy of Pediatric’s official journal, the previous year presented a paper that tested four strategies, including themes that were overlapped in the later study, and found that, “none of the interventions increased parental intent to vaccinate a future child.” Among some parents there was actually a “backfire” effect, hardening attitudes against vaccines. To the extent that the two studies appear to agree, it is in the staying power of autism fears and the challenge to overcome them.

Language and the Law
As work is done to refine the most effective vaccination messaging, the anti-vaccine movement—the common catch-all name, although many in that community would say their positions are more nuanced—stands ready to offer its own tutorials on how to avoid the shots.

The ground rules laid out by the state limit the basis for an exemption, but also provide some latitude for those filling out the form. Personal or philosophical reasons cannot be used as the basis under Illinois law. The belief must be religious, though it “need not be directed by the tenets of an established religious organization,” according to the measure.

Most adherents to modern interpretations of major religions shouldn’t rely on those doctrines to justify an exemption. However, there is a dizzying variety of religion-based claims and interpretations to be found online. Parents looking for help can easily find anti-vaccine websites that offer sample language on what to write. Time will tell what wording will be acceptable to the local school officials who are responsible for determining if an exemption statement meets the requirements of the law.

The how of resisting vaccination on anti-vaccine sites is secondary to the why to resist, and anti-vaccine activists claim to have their own mountain of evidence to refute that of the scientific community. Vaccine advocates hope that curbing the ease of abstaining, combined with proof that outbreaks can occur and, now, a requirement that parents hear the scientific facts about vaccines, will be effective in slowing the momentum of the anti-vaccine movement.

“I am optimistic. I was in practice during the [celebrity and activist] “Jenny McCarthy” era; at the peak of her influence, I estimate I was calming parental vaccine anxiety in about one of every five rooms,” said Dr. Pont. “It’s much better now, and I believe we’ve turned a corner in terms of the public’s trust in vaccine safety and efficacy.”

However, physicians are also aware of the irony that the triumph of vaccines has made some parents unwilling to vaccinate. “Vaccines, in many ways, are victims of their own success. If you’ve never seen measles, you’re less likely to understand how important it is for your child to receive the measles vaccine,” said Dr. Pont. “This means that the physician community has to be constantly vigilant on the subject of vaccination.”

Benjamin Mindell is an award-winning writer and the former editor-in-chief of American Medical News. He lives in Chicago. ©
A S M O S T physicians know, effective medical practice requires more than simply following algorithms or rigidly adhering to guidelines. But how common is it for physicians to get the science right but the care plan wrong? Our foray into this question began in 2006 when we hired a team of actors to show up in office-based practices throughout the Chicago area with medical complaints for common ambulatory conditions, but also with clues that the usual approach to care would not be sufficient. All of the participating physicians agreed to the terms of the study which is that they would not know at the time of the visit that their patient was “fake,” but would find out shortly after they had entered their orders and written a note.

The scripts that we prepared for the actors were based on real cases. One, for instance, portrayed an elderly man who came to the doctor’s office complaining of weight loss. His pants were loose. He also gave several clues that he was homeless and not eating regularly. Before we hired an actor in his 70s to learn the script and start visiting doctors in our study, we showed it to a group of board-certified physicians and asked them how they would manage such a patient, after confirming he was food insecure and probably malnourished. Four out of four said they would focus on strategies for resolving his food insecurity, such as referring him to Meals on Wheels.

However, when we deployed the actor into the field as an “unannounced standardized patient,” meaning that he stayed in character during medical visits and followed the same script at every encounter, we discovered that most of the time physicians did not address the evidence that their patient’s weight loss was related to a particular life challenge (lack of access to food). Only a minority addressed his social situation. The few who picked up on the food insecurity and delved into the situation rarely ordered expensive tests. The rest ordered an extensive malignancy workup, including CT scans, colonoscopy, and other tests.

Naming the Problem
What do we call this sort of error? According to the National Academy of Medicine (formerly the Institute of Medicine) a medical error is defined as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Doing a big malignancy workup to address weight loss in a patient who is starving is clearly a “wrong plan to achieve an aim.” It’s a medical error. But what kind of medical error is it?

One characteristic of such an error is inattention to the patient’s life context. The same could be said for prescribing a medication a patient can’t afford when a cheaper alternative is available, or expecting her to self-administer insulin when her vision is too poor to read the bottle. We’ve termed these medical errors, and many like them as “contextual errors.”

One can think of the information physicians need to plan care for patients as either biomedical or contextual. Most often, to get the care plan right, they need both. A high potassium level, a history of heart disease, and findings on a CT scan are examples of biomedical information. They are all about what is going on inside the body. Conversely, an inability to pay for a medication, or to make an appointment after working the night shift are expressed outside the body. We refer to them as “contextual factors.” These contextual factors may be grouped into 12 broad categories, referred to as domains of context (see page 21).

Sometimes biomedical information also has contextual implications. For instance, signs and symptoms of depression constitute biomedical information, since depression has a biomedical substrate—the brain. At the same time, those symptoms may be an important part of the context for poor diabetes control. If we overlook that a patient has stopped taking his medicine because he is depressed and we simply prescribe a higher dosage we are missing the context. It’s true, the patient’s body does need more insulin, but prescribing more insulin isn’t going to solve that problem.

Hence, getting the science right but the care plan wrong occurs when physicians attend to biomedical information but overlook contextual information. In essence, such contextual errors occur when the physician is looking at the patient through a narrow angle lens and sees only the patient’s body, when the patient needs a wide angle lens through which one can also see her life situation.

Costly Avoidable Errors
We began our research on contextual errors by hiring actors to serve as unannounced standardized patients because they allowed us to hear and compare how doctors responded to contextual information our actors were trained to disclose at multiple visits. After conducting about 400 of these unannounced standardized patient visits, we added up the costs of all the unnecessary studies and therapies physicians ordered when they took a biomedical approach to a contextual problem and compared it to the cost of those who simply addressed the patient’s particular life challenge. We focused on common ambulatory presentations, and trained actors to portray them. Each actor visited about 50 different primary care internists portraying the same case.

Based on the cases our actors portrayed we found that contextual error rates and costs were high. Despite clues embedded in each case that the patient was facing a life (“contextual”) challenge that could be addressed with customized care planning, in more than half the encounters the physician exhibited a “biomedical bias,” meaning the physician presumed the patient had an unaddressed biomedical problem and overlooked evidence that the underlying problem was contextual. As a result the physician ordered tests and treatments that were not appropriate under the circumstances. The average costs of these contextual errors was $231 (see “Costly Avoidable Errors” on page 23).

One of the findings that surprised us was that those physicians who got the care plan right—who “contextualized care”—didn’t have longer visits. We had assumed that the challenge of contextualizing care—of finding out what is really going on in the lives of patients that accounts for non-adherence and other obstacles to better outcomes—was the lack of time during a typical primary care visit. After comparing audio recordings of doctors who missed the context with those who addressed
Contextualizing Care Domains of Context

<table>
<thead>
<tr>
<th>IN THEIR BOOK Listening for What Matters: Avoiding Contextual Errors in Health Care, Drs. Weiner and Schwartz listed 10 categories that physicians should consider when practicing contextualized care. These categories, recently expanded to 12, are as follows:</th>
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<tr>
<td><strong>Competing Responsibilities.</strong> An obligation or commitment patients have that impacts their ability to manage their health care.</td>
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<tr>
<td><strong>Social Support.</strong> A patient’s access to a supportive network of individual(s) able to assist if needed.</td>
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<tr>
<td><strong>Access to Care.</strong> The patient’s ability to receive care in a timely manner.</td>
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<td><strong>Financial Situation.</strong> The patient’s ability to afford care.</td>
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<tr>
<td><strong>Skills, Abilities and Knowledge.</strong> A patient’s intellectual understanding and physical ability to manage health care.</td>
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<tr>
<td><strong>Emotional State.</strong> The emotional condition of patients and its relationship with their ability to manage their health care.</td>
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<tr>
<td><strong>Cultural Perspective / Spiritual Beliefs.</strong> The customs or faith-based practices patients have that impact health care.</td>
</tr>
<tr>
<td><strong>Environment.</strong> The physical and social setting that encompasses a patient.</td>
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<tr>
<td><strong>Attitude Towards Illness.</strong> The feelings patients have toward their condition that impacts their ability to manage it.</td>
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<tr>
<td><strong>Relationship with Health Care Providers and System.</strong> Patients’ feelings and attitudes towards their providers and the health care system that impact their ability to manage their health care.</td>
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<tr>
<td><strong>Resources.</strong> The possessions and materials available to patients that can facilitate their ability to manage their care.</td>
</tr>
<tr>
<td><strong>Health Behavior.</strong> Actions and lifestyle choices that impact patients’ health care.</td>
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(for example, prescribing more medicine) rather than addressing the underlying challenge the patient was facing. These care plans, while looking appropriate if you didn’t know the context, were in fact contextual errors.

Next, we followed these two groups of patients for up to nine months to track the outcome of the original presenting contextual red flag. So, for instance, if the contextual red flag was a rising hemoglobin A1c, we tracked whether it came down or continued to rise or stay high. If the contextual red flag was that a patient was missing a lot of schedule appointments, we tracked to see if the show rate improved. Not surprisingly, attention to context matters. The probability of a good outcome was significantly higher when the care plan was contextualized (71%) than when it was not (45%).

**Barriers to Contextualizing Care**

Noticing patients are struggling with a life challenge or some other contextual factor, asking questions until the underlying story is revealed, and addressing those factors in the care plan improves healthcare outcomes, reduces costs and doesn’t even take more time. If contextualizing care were a drug it would be a miracle drug. So, why doesn’t it happen more?

First, physicians are trained to think biomedically. It’s true that most medical schools have a “doctoring” course, typically in the first year, that teaches good communication, empathy and cultural competence. But the instruction is generally isolated from the rest of the medical curriculum. Imagine, instead, if during pharmacology class, when students are asked what the pharmacotherapy is for a complex condition and then, after they give the right answer are further challenged with “Okay, but your patient can’t afford that. What are you going to do now?” That’s what medical practice is really like. Why not simulate the complexity during medical school, conveying the message that “these are not just your patients’ problems—they’re yours too if you want to make a difference in the health of your patients.”

Second, doctoring courses may not be specific enough about the importance of figuring out what a patient really needs and then acting on that information, rather than simply being empathic. The shortcoming was evident when we listened to empathic doctors in our unannounced standardized patients study who seemed well-meaning but nevertheless unhelpful. When our actor said it was “tough since he lost his job,” doctors often sounded sympathetic (“I’m sorry to hear that. It’s a tough economy”) but then moved on (“Do you have any allergies?”) rather than asking and learning the patient couldn’t afford his medicine.

A third reason physicians may not contextualize care is that it’s not valued in performance review. Doctors are evaluated based on whether they follow guidelines, but not on whether they know when not to follow them, or when guidelines are not enough. This is probably because tracking guideline adherence can rely on the medical record. If the patient has atrial fibrillation, were they prescribed an anticoagulant? If the patient turned age 50 did he get a colonoscopy? But what if the patient with atrial fibrillation is frail, lives alone and has fallen several times? How do we recognize the physician who probes, learns that the falls are related to a slippery floor and sliding rugs, and contacts the patient’s daughter to address those factors before considering anticoagulation?

**Strategies for the Future**

We think that will require more direct observation and listening to how medicine is practiced. One approach is to adopt the unannounced standardized patient method we’ve employed in our research to collecting data for the purpose of improving quality and performance. We’ve established the Institute for Practice and Provider Performance Improvement (I3PI) for the purpose of doing that. Last year I3PI partnered with the American College of Physicians to send fake patients to a small number of practices in Washington, DC, and Virginia, portraying common presentations of inadequately controlled diabetes related to contextual factors. One young woman, for instance, had stopped taking her insulin when vacationing with friends because she had not fully come to terms with her chronic illness.
When physicians missed clues, we provided them with feedback after the visit. Some improved when assessed weeks later with different actors portraying analogous contextual factors. In only a few instances did physicians detect when they were seeing an unannounced standardized patient.

Another approach we are exploring is inviting real patients to audio record their visits, not for research purposes as described above, but to gather data that we can provide as feedback to physicians about how effectively they are contextualizing care. We’ve done this for about two years at two VA facilities in Chicago. Hundreds of veterans have volunteered to carry small encrypted digital recorders into their visits and return them as they leave. Based on 4C coding of those encounters, we’ve generated reports for physicians that contain both quantitative and qualitative data on their performance at contextualizing care. The information is entirely for professional development, with the goal of improving clinical practice. Identifiers are removed so that it cannot be employed for punitive purposes. The audio recordings are protected by peer review laws, meaning they cannot be subpoenaed. We’ve found that the more feedback we provide, the more physicians think about patient context when they are talking with challenging patients, as reflected in fewer contextual errors and more contextualization of care. We reported this project and described our findings in a paper published in the *Joint Commission Journal on Quality and Patient Safety*.

We believe that both of these approaches—unannounced standardized patient visits, and patient recorded audio—hold great promise as strategies for helping physicians improve their practice. We are embarking on further research to assess the efficacy of these approaches. In October, with funding from the U.S. Department of Veterans Affairs, we will embark on a study that expands patient collected audio to VA clinics in five cities, with a rigorous design for assessing the impact of feedback on physician attention to context in care planning, and on patient outcomes and costs. I3PI is planning a parallel study with several partners to explore the efficacy of unannounced standardized patient generated feedback on similar outcomes measures.

Placing a greater emphasis on patient context is a critical frontier for healthcare. Patients need doctors not just for their technical knowledge but also for their ability to apply what they know in a highly personalized manner that takes into account each individual’s unique circumstances and needs. Contextualizing care is also a large part of what makes medical practice feel fresh and rewarding. Two patients may have the same disease but they never have quite the same illness. Contextualizing care is very likely what Dr. Francis Peabody had in mind when he wrote “the secret of the care of the patient is in caring for the patient.”

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**Costly Avoidable Errors**

[Graph showing the cost of avoidable errors in different contexts]

Medical Students Step into Advocacy Roles
Impressions from Capitol Hill

THE JOURNEY to becoming a doctor today calls for mastering the art of advocacy. And thanks to a new education policy series, students are getting a grounding in the legislative, economic, and political processes. The Chicago Medical Society program, which launched in 2015, has sparked strong interest, with more than 150 participants from the region’s seven medical schools. The series host leaders from different health sectors who discuss issues like graduate medical education, value-based care, and public health.

Already a group of students has put their knowledge to work, flying out to Washington, DC, for two days of intensive legislative lobbying last April 26-27. Led by Student Trustee Member Christiana Shoushtari, MPH, MS, and Student Section President Anna Zelivianskaia, the visit was the capstone to a year of advocacy preparation. Shoushtari, a former Capitol Hill staffer, says she has made it her mission to expose students to the complex forces of the healthcare system “before the long hours of medical training, pressure of the profession, and the emotional toll of caring for
patients.”

Prior to their arrival on the Hill, each student became an “expert” in a specific topic—GME funding, public service loan forgiveness, heroin epidemic and gun violence—which meant immersion in facts and figures so they could best represent CMS and their own teaching institutions. In practice sessions students polished up their two-minute “elevator pitches” with personalized messages. Once on the Hill, they broke up into teams assigned different topics.

The student contingent made rounds on the offices of U.S. Reps. Mike Quigley; Robin Kelly; Jan Schakowsky; Danny Davis; Bobby Rush; Peter Roskam; and U.S. Sens. Richard Durbin and Mark Kirk, and Dr. Shantanu Agrawal, deputy administrator at the Centers for Medicare and Medicaid Services. On the following pages, seven CMS student advocates report on their eye-opening journey to Washington.

NELLY GONZALEZ MONTES

“We need more of you to come. We know medical students are busy, but we need your voice.” The senate aide's words stayed with me well after my plane departed from Washington, DC, en route to Chicago. Despite having three years of policy experience, this trip was my first in-person lobbying visit to Capitol Hill. I arrived expecting to discuss the skyrocketing cost of medical school tuition and shortage of residency spots with Illinois senators and representatives. What I did not expect was to discover just how lost the voice of medical students, medical professionals, and underserved patients has become in the intricacies of lawmaking and government bureaucracy.

The majority of legislators we met were sympathetic with our request for them to support a bill that would increase residency spots or to contest a bill that would modify graduate school loans rules, making loans more costly and difficult to pay off. However, it quickly became clear that policymakers could be more knowledgeable about the day-to-day reality of medical students, physicians and the patients we serve. We need to increase our communications with them. Senators and representatives were quite surprised to hear many of us had worked for years to pay for and apply to medical school, to learn how our loan payments affect our decision to pursue specific specialties, and that as a group, we would be graduating with over one million dollars in debt.

On the last day of the trip I could not help but notice just how diverse the CMS group seemed against the backdrop of everyone else eating lunch in the congressional cafeteria. It felt like we were truly representative of not only Illinois constituents, but also of the diverse patients we were advocating for. Whether your goal is to make medical education less costly or more diverse, or you want to be able to do more for your patients and work autonomously, we clearly need a diverse collective voice, just like the body of medical students representing CMS, to be always present and active on Capitol Hill. Besides sharing what we learned, I encourage all other medical students to become involved. Please reach out to your student groups and learn how to be part of the positive change you want for our profession and our future patients.

Nelly Gonzalez Montes is a second-year student at Loyola University Chicago Stritch School of Medicine.

JONATHAN JOU

Our trip to Washington was a smashing success overall. The caliber of the meetings was outstanding. For a mixed group of M1s and M4s to be able to secure such high-profile audiences is not only uncommon but also highly rewarding. Content and context trump mere meetings. To hear Dr. Shantanu Agrawal of the Centers for Medicare and Medicaid Services emphasize the location of training as a strong influence on his personal practice and view of medicine was both timely and powerful for first-year medical students.

Remarks by Senator Mark Kirk on the state of “Free Stuff Politics” shined a light on the current views of conservatives in Congress. Fiscally conservative thinking continues to bar the passage of reform on graduate medical education and loan forgiveness programs. Such insight can lead to development of more pointed arguments (those which counter the idea that increased government spending always equates to doling out “free stuff”) in future advocacy trips.

We were also there to lend our insight. In meeting with U.S. Rep. Jan Schakowsky and her staff, we were able to share our thoughts and experiences about pursuing medical education in an environment of rampant inflation. We also produced a document detailing the distribution of payments during a single cycle of medical education, thanks to the work of the administration and students at the University of Illinois College of Medicine. It was a powerful moment and big payoff. An e-mail with the fiscal budget distribution and demographics of the UICOM was promptly sent to Amy Kelbick, senior policy advisor for Representative Schakowsky.

Hearing about the best strategies to continue our advocacy from U.S. Rep. Danny Davis’ staffer was equally enlightening. Multiple, repeated, individualized contacts between a group of advocates and a single legislative staffer ensures that a lawmaker is briefed on the subject. Ongoing communication provides an additional tool we students may use to advocate for causes we believe are in the best interest of patients and future physicians.

I strongly recommend that medical students...
MEMBER BENEFITS

embrace the opportunity to meet with lawmakers, especially in Washington, DC. It is a wonderful way to learn about the different facets of medicine while simultaneously observing the broad impact physicians can have on the well-being of patients.

Jonathan Jou is a medical student at the University of Illinois at Urbana-Champaign.

MAHIR KHAN

As I embarked on my journey to Washington, DC, on an early April morning following a neurology exam, I was transitioning into the mindset of lobbying and advocacy. I felt excited to join a group of students representing all the Chicago-area medical schools. At the time, I knew that I wanted to help invigorate positive change on the Hill, and was interested in the topics we chose to focus on, including graduate medical education, student debt, and gun violence. However, I had no premonition of the immense passion, enrichment, and joy I would experience in the next two days.

Upon meeting as a cohort for the first time outside of a congressional building, our group rehearsed a brief pitch on GME funding. We memorized the details of the Resident Physician Shortage Reduction Act of 2015, which is referred to as HR 2124. By collaborating, we were quickly able to extract pertinent information about each piece of legislation. As we entered meetings with members of Congress, we guided these conversations based on how the individual lawmaker had voted on certain bills. We also asked thoughtful questions to accompany each presentation. With each session, we gained confidence, and our newly assembled group became increasingly cohesive.

The highlights of our discussions were definitely the testimonials from my fellow students. Nothing could replace the voices and perspectives of students affected by policy change. The most compelling moments came, for example, when a senior medical student would offer personal details about the perils of astronomically high student loan debt, even expressing genuine distress about marriage and family planning. We became close as a group while making convincing arguments for the consideration of lawmakers.

Throughout our meetings, the majority of points we made were well-taken, and we found this to be encouraging. In some cases, however, we were met with friction and challenges to our logic and reasoning. I believe these were the most formative opportunities for us as a team. We realized that advocacy on the Hill is complex and that we need to be prepared to make our cases with diligence and elegance. Despite our best efforts, we still could not guarantee that others would share our position on every topic. I was proud of our group for accepting this and finding ways to adapt.

Thankfully, our schedule, though packed with meetings, allowed time for some rapid sightseeing and bonding as a team. Whether we debated, laughed, or yawned at various moments, we did everything together. Sometimes, one person researched a topic and explained while others listened carefully. Other times, we offered each other constructive feedback in a respectful manner. There was a shared notion among us that our work was for the benefit of medical students at large. It was a tremendous pleasure to participate in the CMS lobbying trip this year, and I am hopeful about returning to continue our work soon.

Mahir Khan is a medical student at Rush Medical College who will graduate in 2019.

PAIGE PEARCY

I come from a family with no physicians in it, which lends itself to frequent phone calls and questions about a particular illness someone might have and late-night texts of pictures of cuts, scrapes and bruises with the same questions. Mind you, I have only completed my first year of medical school and I am quick to think of the most obscure ailments before a typical rhinovirus because, well, we only learn the weird stuff in our first year. That being said, without any other physicians in my family, everyone now turns to me for medical questions and advice, but I have no one to turn to for questions about my profession and the changing healthcare world as a whole.

I went on the CMS student advocacy trip equipped with a slew of questions I haven’t been able to ask anyone, and hoped to find real answers from the politicians who are shaping the world in which I will practice medicine. I think what surprised me most on this trip was the accessibility of legislators. While we didn’t always talk to the senator or representative directly, we did speak with the appropriate member of their staff who was extremely well-informed about the issues we were there to discuss. Before going to Washington, I felt that many of the politicians were far removed from their constituents, making decisions on bills that could or could not help those they actually represent. While perhaps that may be true for some, those members we met with were not only willing to listen to what we had to say, but they also asked questions and were understanding of our views, even if they didn’t agree. That sort of response is encouraging in the polarized political world we live in today.
Some of the leaders and staffers we met with appreciated talking to us because they hadn’t heard from students or medical professionals about the issues we were raising—they hadn’t heard opinions from those who would be affected. This was the most important lesson learned from our trip: one cannot assume that one’s opinion is known by politicians in Washington. Even with all the briefings they receive, it’s possible they haven’t heard from someone who shares views similar to ours—and it’s important to make an effort to share those thoughts with the people who will ultimately cross the T’s and dot the I’s.

Paige Pearcy is a third-year student at the Chicago Medical School, Rosalind Franklin University of Medicine and Science.

ARTURO DEERING SALOW

“What you see is all there is.” That’s what psychologist Daniel Kahneman calls what is often known as the availability bias: the tendency to make decisions as if the only information is that which is recently and conveniently available. How does this bias impact our lives as medical students and advocates? The recent Chicago Medical Society trip to Washington, DC, was a poignant reminder that when it comes to policy, we have an option: be seen and thought of come decision time or be invisible and have decisions made for us as if we do not exist.

As we conducted our meetings with staffers, a congresswoman, and both Illinois senators, my shock grew. This is DC? These people listen? They want to help? They care about us? This is not the DC that I’ve learned from the media to love to hate.

With medical students from each of the seven Cook County medical schools present to advocate for issues important to our lives as students and future doctors, I watched as those directly involved in creating health policy intently listened and probed our position statements. They asked deep questions and they were shocked to hear about the massive amounts of debt we were facing and the challenges posed by a relative reduction in residency opportunities. To say that I was a little skeptical of the utility of this trip is an understatement.

Having spent the two years before medical school teaching in a failing public school, I do not hold our lawmakers in high esteem. I figured this would be a quick photo opp for them, and they would move us along so they could meet with a group with money. However, despite our negative net worth, these people showed they cared and that they want to help us. They want to help the patients we serve.

That being said, let’s not mistake whose job it is to fight to make healthcare better. If we don’t advocate, then our voices will not be a part of the policies that we love to bemoan. So more than anything, this trip made it clear we have two options when it comes to health policy. We can spend our time upfront advocating for policies that enhance our careers and ability to serve patients, or we can spend more time on the back end crying about how broken the system is. We’re in medical school and so I assume we’re pretty smart people. When it comes to health policy, I hope we make the smart choice.

I definitely didn’t assume our legislators were concerned about the issues that affect us non-super PAC wielding citizens. However, if my prior assumptions were true, we must have caught Washington during an uncharacteristically empathetic week.

To start, what the heck are these legislators doing meeting with us medical students? They realize my net worth is negative, right? My answer became obvious. We are windows to a world about which they know next to nothing.

Arturo D. Salow is a student at Northwestern University Medical School. He graduates in 2019.

ANTONIOS VARELAS

My first year of medical school has been just that, a year of firsts. Comprised of dissecting cadavers in the anatomy lab, interacting with simulated patients, and scrubbing into surgical procedures, each new first has made me appreciate the magnitude of the moment.

As part of a team that spent several days on Capitol Hill advocating on behalf of Chicago-area medical students, I found myself re-experiencing those same feelings. Throughout this past year I have been exposed to the numerous limitations physicians face when it comes to imparting meaningful change in their profession. It quickly became apparent that one of the few tools in a physician's arsenal is collaboration with elected officials to create sensible new policies. This realization motivated me to represent my school, Rush Medical College, to the Chicago Medical Society, and to participate in CMS' advocacy efforts.

For many of us this was our first foray into the world of advocacy and politics. We knew our talking points, yet we also understood that nothing could adequately prepare us to speak with the men and women in the U.S. House and Senate—individuals capable of enacting tangible change nationwide. Each topic on our agenda had been prepped in advance by different teams of medical students participating in the trip. My team’s topic centered on expanding graduate medical education. In short, GME expansion will help all medical students match into a residency program while also ameliorating the physician shortage in predominantly rural areas of our nation.

What quickly became apparent as we spoke with our representatives, however, was how pervasive and divisive issues can be across party lines. We were faced with staunch opposition across the
“What I did not expect was to discover just how lost the voice of medical students, medical professionals, and underserved patients has become in the intricacies of lawmaking and government bureaucracy.”

Our lobbying trip with the Chicago Medical Society to Washington, DC, provided an invaluable learning experience, giving my peers and me the opportunity to open doors, as well as conversations, surrounding healthcare policy. We raised several topics with our Illinois senators and representatives while on Capitol Hill, but none more important than graduate medical education funding, our looming student loan debt, ever-rising cost of tuition, and the combined repercussions of all these trends.

It became quite apparent during these constructive discussions with Illinois lawmakers that our worries about financial sustainability for budding physicians are also broad issues related to the future of public health. Not only are these financial concerns integral to our future individually, but also to healthcare’s future collectively.

For example, most of our CMS medical students will owe anywhere from $300,000 to $500,000 by the time we graduate, and the majority of us, as hospital residents, will care for underprivileged and under-served communities. Clearly, we need flexible loan repayment options to manage the egregious amounts of debt. Otherwise, the economic strain will push many to pursue careers in higher-paying specialties. And this will further limit access to adequate and affordable primary care for our under-privileged and underserved communities.

We also discussed broad issues of holistic importance, including gun violence and the opioid epidemic sweeping the nation. The willingness of our lawmakers to discuss these sensitive topics with us was promising and reassuring. Even more encouraging was their interest in policy changes to improve health and well-being. It was eye-opening to see how knowledgeable and dedicated our physicians-in-training and legislators are on these issues.

Our experience on Capitol Hill was educational in other ways. Before going to Washington, advocacy seemed simple. Our requests seemed reasonable: increased funding for graduate medical education so that our nation can produce adequate numbers of competent physicians to meet the healthcare needs of the future; offer diverse repayment plans and loan forgiveness programs for new physicians who wish to work in socioeconomically underprivileged communities. In reality, however, the fulfillment of these requests requires the voices and efforts of many individuals.

My peers and I realized that many intricacies we had come to know and understand in our healthcare system are also apparent in politics. By gaining more understanding of the arduous policymaking process, we were able to appreciate the power of advocacy, and recognize that change comes when we work together in greater numbers.

Ultimately, our experience taught me an important lesson: medical students must speak up because we are responsible for treating patients tomorrow.

Without activism in healthcare policy, even the most brilliant minds will be ineffective. Although a daunting and complicated task, it is a privilege to be an activist in our field of medicine. I am proud to work to improve healthcare delivery.

Athina Bouroukas is a student at Rush Medical College who will graduate in 2019.
SERVICE IS at the core of the medical profession. And whether it is servicing their patients or the profession itself, physicians are among the most dedicated when it comes to giving of their time and talent. The Chicago Medical Society congratulates the following members for their exemplary service in organized medicine:

**Thomas M. Anderson, MD**, a former president of CMS, was named president of the Illinois State Medical Society (ISMS) 2016-2017. Board-certified in diagnostic radiology and nuclear medicine, Dr. Anderson serves full-time at the University of Illinois at Chicago Medical Center. He is a senior attending radiologist at Mercy Hospital and Medical Center, where he chaired the Department of Radiology for 20 years. Dr. Anderson received his medical degree from Harvard Medical School and completed both his internship and residency at the University of Chicago Hospitals. He is also a member of the American Medical Association, the Chicago Radiological Society, the Illinois Radiological Society, the American College of Radiology, and many other specialty societies.

**Kenneth G. Busch, MD**, also a former president of CMS, was appointed vice-president of ISMS. A board-certified psychiatrist, Dr. Busch has been in private practice since 1975 and serves on staff in the Department of Psychiatry at Advocate Lutheran General Hospital. He received his medical degree from Indiana University School of Medicine, completed his internship at Evanston Hospital and his residency at Northwestern University Medical School. Dr. Busch has consulted nationally for the U.S. State Department and the U.S. Department of Health and Human Services. He is a past president of the Illinois Psychiatric Society, the Chicago Radiological Society, the Illinois Radiological Society, the American College of Radiology, and many other specialty societies.

**Adrienne L. Fregia, MD**, the newly named chair of the ISMS Board of Trustees, has served ISMS and CMS in major capacities for more than 20 years, most recently as an ISMS trustee and chair of the CMS board, CMS. A board-certified internist specializing in gastroenterology, Dr. Fregia is in private practice in Matteson. She is also on active staff at Advocate South Suburban Hospital, Ingalls Memorial Hospital, and St. James Hospital. Dr. Fregia completed her undergraduate studies at Tennessee State University and earned her medical degree from the University of Illinois. She completed her residency and fellowship at Rush-Presbyterian St. Luke’s Medical Center in Chicago. She is a member of the American Medical Association and the American Gastroenterological Association.

**William A. McDade, MD, PhD**, a past president of both CMS and ISMS, was recently elected to the AMA Board of Trustees. In another major career move, Dr. McDade, an anesthesiologist, was named executive vice president and chief academic officer for the Ochsner Health System in New Orleans. There he is leading undergraduate and graduate medical education activities for the System as well as leading research efforts for its physicians. Prior to joining Ochsner he served as a professor of anesthesiology and critical care at the University of Chicago Medicine. Committed to reducing cultural and health care disparities in the U.S., Dr. McDade has spent nearly 20 years helping to increase opportunities for minorities. Dr. McDade received his PhD in biophysics and theoretical biology from the University of Chicago Pritzker School of Medicine, and trained in anesthesia at Massachusetts General Hospital.

**Christiana S. Shoushtari, MPH, MS**, a board of trustee member at both CMS and ISMS, is the recipient of the AMA Foundation’s Excellence in Medicine Leadership Award. Ms. Shoushtari, a third-year medical student at the University of Illinois-Chicago, formed a policy series leadership program with CMS that trained more than 150 medical students from all seven medical schools in the Chicago/Cook County area. She led a team of 12 medical students in discussions with U.S. Sens. Dick Durbin and Mark Kirk and U.S. Rep. Jan Schakowsky about the public service loan forgiveness program, GME, heroin epidemic and gun violence. Her prior work experiences include serving as health legislative correspondent for then-Senate Majority Leader Sen. Harry Reid. Ms. Shoushtari earned her MPH from the University of Michigan School of Public Health, and her MS from Georgetown University.
MEMBER BENEFITS

Calendar of Events

AUGUST

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

17 CMS Board of Trustees
Meets every other month to make financial decisions on behalf of the Society.
9:00-10:00 a.m. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

20 CMS Leadership Meeting
9:00 a.m.-12:00 noon. Location TBA. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

27 The Illinois State Neurosurgical Society Downstate Meeting
In Springfield. For information, please go to: www.ilneuro.org.

SEPTEMBER

10 Philippine Medical Association in Chicago
56th Anniversary Inaugural Ball and Induction Dinner Dance.
6:00 p.m.; Hyatt Regency O’Hare; 9300 W. Bryn Mawr Ave., Rosemont, Ill. For information, call 847-780-7617.

13 CMS Governing Council
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, committees, councilors, or other CMS members.
6:00-9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

14 Chicago Gynecological Society Annual Dinner Meeting
The CGS will hold its first meeting of the program year at the International Museum of Surgical Sciences. Join your colleagues for an enlightening talk on what health professionals can do in response to human trafficking.
6:00 p.m. Space is limited.

For information, please go to: www.chicagogyn.org.

14 OSHA Training Workshop:
Bloodborne Pathogens & Beyond
Intended for all physicians, nurses, dentists, dental hygienists, and physician/dental assistants. OSHA requirements state that all healthcare employers must maintain a written Exposure Control Plan. This plan must include a risk analysis, Hepatitis B vaccinations, follow-up procedures, and an evaluation of safer sharps and training. In this session, participants will learn how to identify appropriate personal protective equipment (PPE), implement a training program for employees who may be exposed to bloodborne pathogens, identify commonly violated OSHA regulations in the medical field, create a written Exposure Control Plan for the assigned first-aid responders, and understand and explain the latest hazard communication requirements. Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA Chicago North Office. Registration: 9:30 a.m.; lecture: 10:00 a.m. – 12:00 p.m. Hilton Oak Lawn Hotel, 9333 S. Cicero Ave., Oak Lawn, IL. Up to 2.0 CME credits. $99 per person for CMS members; $109 for CDS members; $129 for non-members or staff. Register online at: www.cmsdocs.org or contact Rachel Burns at rburns@cmsdocs.org or call 312-670-2550, ext. 338.

16 Polish-American Medical Society in Chicago’s 70th Annual Gala Banquet.
6:00 p.m.; University Club of Chicago. For information, go to: PolAmMedSoc-Chicago@ZLPChicago.

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

21 CMS Public Health Committee
Open to all members, this committee studies and responds to local public health concerns, developing policy and working with outside public health organizations and agencies.
6:00-7:00 p.m. In-person & teleconference. For information, contact Liz 312-670-2550, ext. 335, or esidney@cmsdocs.org.

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

23-24 Illinois Medical Directors Association 6th Annual Meeting and Conference
Join IMDA as it hosts a must-attend conference on long-term and post-acute care, hospital readmissions, antipsychotics, Parkinson’s disease, and MACRA navigation.
Location: Oak Brook, Ill. For more information and registration, please visit www.ilmda.org or call Abigail 312-670-2550.

OCTOBER

12 OSHA Training Workshop:
Bloodborne Pathogens & Beyond
See the description for the September 14 event.
Registration: 9:30 a.m.; lecture: 10:00 a.m. – 12:00 p.m. Chicago Medical Society, 33 W. Grand Ave., Chicago, IL. Up to 2.0 CME credits. $99 per person for CMS members; $109 for CDS members; $129 for non-members or staff. Register online at: www.cmsdocs.org or contact Rachel Burns at rburns@cmsdocs.org or call 312-670-2550, ext. 338.

15 Indian American Medical Association of Illinois Annual Gala and Banquet Dinner.
Begins at 6:00 p.m.; Rolling Meadows Country Club, 2950 W. Golf Rd., Rolling Meadows. For more information, please call 630-522-3990 or go to www. iamaill.org.
**Personnel Wanted**

MDs/RNs/CRNAs needed in Chicagoland area: part-time anesthesiology, urology, gynecology, gastroenterology, ophthalmology, family medicine, pain management, ENT, urogynecology, plastic surgery, orthopedics, ENT & general surgery for multi-specialty surgical out-patient centers located in northwest and west suburban Chicagoland. Physicians to bring patients to our surgery center, RNs for two-four days per week morning shifts; CRNA one-three days per week, morning shift. Please send resumes by fax to 847-398-4585 or to kimberleeo@officegci.com and vino878@aol.com.

Board-certified or board-eligible anesthesiology, urology, gynecology, gastroenterology, ophthalmology, family medicine, pain management, ENT, urogynecology, plastic surgery, orthopedics, ENT & general surgery for multi-specialty surgical out-patient centers located in northwest and west suburban Chicagoland. Active part-time physicians wanted. Please send resumes by fax to 847-398-4585 or to kimberleeo@officegci.com and vino878@aol.com.

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

Fully built-out medical office space for rent in Grayslake, Ill. Call 773-807-9083 or marinee24@yahoo.com.

Active solo family medicine practice located 90 miles southwest of Chicago available. Please call 815-672-2417.

For sale: medical office at 6151 W. Belmont Ave., Chicago; five exam rooms and two administrative rooms on ground floor; three rental apartments, garage in back. Doctor retiring. $320,000. Call Janina 773-909-0890.

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HE SAYS HE honed his skill and compassion as a doctor in a “simmering cauldron of conflict and third-world patient care.” David Ansell, MD, MPH, is referring not to some far away, impoverished country, but to Chicago’s Cook County Hospital, one of the nation’s most storied and notorious public hospitals. That’s where he came to train in 1978 and remained for 17 years, before moving on to continue the battle for healthcare equity for all Americans. Quite simply, he says, “Healthcare is a right, not a privilege.”

Today, Dr. Ansell is senior vice president of System Integration at Rush University Medical Center, where he formerly was chief medical officer. His work involves integrating population health and community health and reducing health inequities. He has been at Rush since 2005, and before that spent 10 years as chairman of the department of internal medicine at Mount Sinai, Chicago’s major private hospital caring for the poor. It was at Mount Sinai that he founded the Sinai Urban Health Institute, a major health-disparity research and intervention center. And he has been a tireless champion when it comes to fighting health disparities in Chicago’s diverse communities. In 2006, he and colleagues helped expose the glaring breast-cancer mortality gap between black women in Chicago who die of breast cancer at twice the rate of white women. They also teamed with others to establish the Metropolitan Chicago Breast Cancer Taskforce, a group dedicated to the elimination of this disparity. He has testified in Congress on the “immoral and deadly practice” of inter-hospital transfers of critically ill, uninsured patients (or “dumping”). And he has written extensively about healthcare disparities.

But it was undoubtedly his searing experience at County that propelled him to spread the gospel of healthcare as a human right, and to become an unabashed advocate for a single-payer system. He chronicled his experience in his critically acclaimed book, “County: Life, Death and Politics at Chicago’s Public Hospital,” published in 2011. He writes about how, after finishing medical school in 1978 in Syracuse, New York, he and four other idealistic classmates headed to Chicago to train at County, which had been one of the nation’s most renowned public hospitals. County was famous for providing some of the best medical and surgical training in the U.S. It was also the birthplace of America’s first blood bank, and home of America’s first trauma unit. But County had also been the site of the longest doctors’ strike in U.S. history, when, in 1975, more than 400 house staff walked off the job, protesting the horrific patient-care conditions at the deteriorating institution.

That was three years before Dr. Ansell arrived for his internal medicine internship, and while conditions had improved somewhat by the time he came, the young resident recalled seeing poor, uninsured patients in a waiting room “stuffed as tight as a stockyard cattle car,” and restrooms so filthy he had to go across the street to use the facilities.

He referred to his internship as “white knuckle scary,” but was grateful for the unparalleled training, and the commitment and camaraderie of the doctors and nurses, and how much he learned from his fellow residents. But most of all he says he is grateful how much he learned from the patients themselves, the “high degree of dignity” they maintained during the most extreme suffering. “I learned to become relentless in caring for my patients.”

Dr. Ansell’s Career Highlights

Dr. David Ansell earned his medical degree from the State University of New York at Syracuse, served his residency in internal medicine at Cook County Hospital, and earned a master’s of public health from the University of Illinois at Chicago School of Public Health. He served as chairman of the department of internal medicine at Mount Sinai Hospital in Chicago, and was executive vice chairman of internal medicine at Rosalind Franklin University, the Chicago Medical School. Dr. Ansell is currently senior vice president for system integration at Rush University Medical Center.
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