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MESSAGE FROM THE PRESIDENT

MACRA: Still a Work in Progress

The Final Rule for MACRA payment reform on how the government reimburses physicians by tying treatment to quality measures has been announced.

And thanks to collaboration with physician-stakeholders, MACRA will be eased into practices across the country.

The Medicare Access and CHIP Reauthorization Act of 2015, known as “MACRA,” is already a significant departure from a lot of federal policy in that it was bipartisan and passed into law last year by a Republican-controlled Congress and signed into law by Democratic President Barack Obama whose healthcare policies are key talking points for the GOP in this year’s election.

When MACRA payment reforms were proposed, physicians were worried these landmark measures and reimbursements would come without the input of organized medicine. The head of the Centers for Medicare and Medicaid Services even came last summer to Chicago to address the American Medical Association’s House of Delegates.

At that time, CMS Administrator Andy Slavitt told AMA delegates he wanted “to make it clear” that MACRA is a “constant request for feedback and the need to improve will continue.”

“Things won’t change overnight,” Slavitt told hundreds of physicians gathered at the Hyatt. “The first year of this new program will hit bumps as new policies run into the realities of everyday medicine. Systems will need to adapt to your needs.”

Slavitt stayed true to his word by working in collaboration with medical societies across the country including the AMA. In announcing the final rule, Slavitt reported that CMS received over 4,000 comments and that nearly 100,000 people attended outreach sessions, which he described as “record levels of clinician engagement.”

As a result of these collaborative efforts, MACRA’s final rule allows physicians to participate “at their own pace.”

“The first couple of years are aimed at getting physicians gradually more experienced with the program and vendors more capable of supporting physicians,” Slavitt said in a letter he wrote to providers in October. “We have finalized this policy with a comment period so that we can continue to improve the program based on your feedback.”

My point in describing the final rule is that the federal government listened because physicians were engaged and collaborated. They got the message because doctors didn’t draw a line in the sand.

There’s bound to be headaches with MACRA, but CMS is taking input all along the way.

And we must remember that MACRA repealed the flawed sustainable growth rate (SGR) formula that we complained about for years because it cut payments to doctors’ practices. The SGR, which was part of the Balanced Budget Act of 1997, created 17 cuts to physician Medicare reimbursement.

We want to keep CMS administrators involved, along with our lawmakers from Washington and Springfield to Chicago’s City Hall. I encourage you to contact me or the Medical Society office either directly or through our online community to share your concerns and ideas on issues over this next year. Let’s not stop at MACRA.

Clarence W. Brown, Jr., MD
President, Chicago Medical Society
PHYSICIANS SHOULD take note that the Centers for Medicare and Medicaid Services (CMS) has once again proposed changes to the Stark Law regarding per-unit based rental formulas in certain office space and equipment rental arrangements. CMS proposed a requirement that rental charges for office space or equipment are not determined using a formula based on per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

If these proposed changes are included in the final CY 2017 Medicare Physician Fee Schedule, any office space or equipment rental arrangement would need to meet this requirement as part of the space and equipment rental exceptions to the Stark Law. CMS commented that this proposal is based on its long-standing concerns regarding overutilization and steering of beneficiaries resulting from arrangements in which a physician’s referral may provide future remuneration back to a referring physician.

CMS noted several studies that have found that physicians with financial relationships with entities to which they refer ordered more services than physicians without those relationships. However, CMS did make it clear that this proposed restriction is not intended to be an absolute ban on per-unit of service or per-click formulas for rental rates in office space or equipment rental arrangements. These proposed changes are only applicable to those lease arrangements under which the lessor generates the payment from the lessee through a referral to the lessee for services to be provided in the rented office space or using the rented equipment.

Generally, under the proposed changes, per-unit of service or per-click rental charges for the rental of office space or equipment is permissible (could meet the space or equipment rental exception). However, if the referral for the services was generated by the lessor, then the proposed restriction would apply and the rental charges would have to be calculated in a manner that did not reflect the services being ordered by the lessor.

CMS had previously proposed the same restrictions to the space and equipment rental exceptions to the Stark Law. However, in response to a challenge to these restrictions for certain rental rate formulas, the D.C. Circuit Court on June 12, 2015, issued an opinion in Council for Urological Interest v. Burwell that required CMS to address the legislative history of the Stark Law in regard to per-click rental charges for space and equipment rental arrangements. In the current proposed CY 2017 Medicare Physician Fee Schedule, CMS provided an overview of the regulatory history of the Stark Law and several passages from Congressional Committee reports that CMS considers to support its proposed restrictions.

In further support of these restrictions to the space and rental exceptions, CMS referred to two advisory opinions in which the OIG raised issues under the Anti-Kickback Statute. In Advisory Opinion 03-08, the OIG addressed a proposed per-patient management fee to manage a distinct in-patient rehabilitation unit in a general acute care hospital. The OIG had commented that per-patient, per-click, per-order, and similar payment arrangements with parties in a position, directly or indirectly, to refer or recommend an item or service payable by a federal healthcare program are suspect under the Anti-Kickback Statute. The principal concern in such an arrangement is that a per-click payment promotes overutilization.

CMS also cited Advisory Opinion 10-23, in which the OIG addressed a “per-click” fee structure for a company to provide certain sleep testing equipment and services on a turn-key basis. The OIG concluded that this proposed arrangement could generate prohibited remuneration under the Anti-Kickback Statute because the arrangement “involves a per-click fee structure, which is inherently reflective of the volume or value of services ordered and provided.”

In addition, CMS also noted that there are similar restrictions in the newly adopted exception to the Stark Law for timeshare office lease arrangements. For example, CMS excluded from the exception any timeshare arrangements that incorporate compensation formulas based on: (1) a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to services provided while using the timeshare space; or (2) per-unit of service fees to the extent that such fees reflect services provided to patients referred by the party granting permission to use the timeshare to the party to which the permission is granted.

Because CMS is re-proposing this prohibition on per-click payments for certain leases of space and equipment, there are questions about the enforceability of these restrictions if finalized later this fall, especially in light of the D.C. Circuit Court ruling. However, physicians and other providers should be mindful of these concerns with per-click or per-service rental formulas used in space, equipment and other types of service arrangements.

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Are You Ready to Be Chief of Staff? 

It’s a tough job that requires special skills By Susan Reynolds, MD, PhD

For many years it was considered a great honor when mid- to late career physicians were elected to be chiefs of staff at their hospitals. They were elected by their physician colleagues because they were considered to be excellent clinicians as well as effective leaders. These chiefs of staff would dedicate a significant amount of time to their leadership duties, often with little or no pay, the only reward being the satisfaction that they had made a contribution to their medical staff, hospital and community.

Times have changed dramatically as has the position of chief of staff. At one of our biannual Chief of Staff Boot Camps, one chief said he became chief because “Nobody else wanted the job.” That comment got a great laugh and considerable agreement from the other chiefs in the room.

The role of the organized medical staff is to make sure that all members deliver excellent quality patient care. The chief of staff has the ultimate responsibility to ensure the quality of care. Reimbursement is now based on quality outcomes and patient satisfaction more than fee-for-service, so overseeing quality in the hospital setting has become an increasingly important issue. In fact, most best-practice hospitals now have chief medical officers who are full-time administrators working in partnership with chiefs of staff to make sure that the quality of patient care, patient safety, and patient satisfaction are as high as possible.

With the arrival of hospitalist services and payment reform, physicians have become more and more disengaged from hospital functions and medical staff affairs. Many don’t even come into the hospital anymore or attend medical staff meetings, leaving a much smaller pool of candidates for the chief of staff position. The remaining physicians need new knowledge and skills so that they can succeed as incoming chiefs of staff.

These new chiefs need to understand the rapidly changing healthcare marketplace and learn how to lead change. They need to be excellent written and oral communicators who can persuade their colleagues to perform at the levels now required to maximize reimbursement. The time constraints and new performance pressures on physicians have led to increased levels of stress, disruptive behavior, and burnout in the physician community. Chiefs of staff as well as chief medical officers must learn how to deal with these issues.

Most chiefs of staff are now paid a stipend for their work, but many tell me it does not make up for lost time in direct patient care. It is certainly a tough job! Our Chief of Staff Boot Camps aim to ease the pain so that being a chief is once again an honor and a sought-after position. The Institute for Medical Leadership’s next Chief of Staff Boot Camp will be Jan. 27-28, 2017, at the DoubleTree Suites by Hilton in Santa Monica, CA. All CMS members will receive a $100 discount when attending. Please go to www.medleadership.com to register.

Susan Reynolds, MD, PhD is president and CEO of the Institute for Medical Leadership.

Medical Licensure Renewal Goes Online 

Make sure your information is up-to-date

This upcoming year, 2017, is a licensure renewal year. In an effort to make the process more efficient, the Illinois Department of Financial and Professional Regulation (IDFPR) has switched to a paperless licensing system. Online renewal means that it’s never been more important to have all of your contact and professional data current with the IDFPR.

It’s especially important to make sure that your primary email address is correct since IDFPR will automatically forward a renewal notice via email to each physician prior to the license expiration. Missing an IDFPR notice can lead to financial penalties and the risk that you’ll miss renewing your license. IDFPR will conduct random audits of physicians for compliance with the CME requirements.

For the July 31 renewal, licensed physicians are required to complete 150 hours of continuing medical education (CME). The CME courses must have been taken on or after Aug. 1, 2014.

Physicians should visit two areas of the IDFPR website to check and update their information. These two areas are the contact information page and the professional profile information page. Required information includes your primary office location, hospital affiliations, your program information for Medicare and Medicaid, board certification, and medical school and post-graduate education data.

For questions, contact the IDFPR at 888-473-4858 or email FPR.LMU@Illinois.gov.
Time-Saving Tips
Hints to help you make the most of your day By Cheryl England

ARE THERE any physicians with too much time on their hands? That's highly doubtful. With so much going on in their day-to-day work world, physicians would be well-served to begin putting some proven time management practices into place. Here's just a sampling of some of the things you can do to save time and, perhaps, your sanity.

1 Establish a strategy for dealing with messages. There's no one-size-fits-all approach here but you do need a strategy of some sort. Some physicians may find it easiest to tackle a few messages between appointments while others may find it easiest to create pockets of time every hour or two to handle large blocks of messages. But don't wait longer than three hours to handle messages because then you'll start getting call-backs from patients.

2 Set an agenda with each patient. When patients raise questions about new and unrelated concerns at the end of the visit, it can throw your schedule completely off track. Try to head off those moments at the outset by setting an agenda for the visit. Have your nurse find out the patient's priorities for the appointment as part of the rooming process. After listening to the patient's complaint, at the outset of the visit, recap what he or she said, agree that that's what you'll be focusing on, and ask if there is anything else that needs to be discussed. That initial time investment keeps the encounter focused and prevents last-minute diversions.

3 Organize your work day. If your workday starts at 8 a.m., go in 15 to 30 minutes early to get organized. Clean off your desk, scan journals, and prioritize what you need to get done. Make a list of your tasks, including how long it will take to get each one done. Then post the list in a prominent place and check it frequently. Adjust it as necessary. You might be surprised how much you can get done when you keep yourself accountable with a to-do list.

4 Know when to say no. Saying this can take many forms. For example, you might need to say “no” to new patients if your practice is already maxed out. Or, if you have been invited to speak at a conference you might need to say “no” if it doesn’t help further your career goals. It’s always a compliment to be invited to speak but if it doesn’t fit into your schedule or help your long-term goals then it might not be worth the time, effort and added stress to do. Always keep your priorities straight.

5 Minimize interruptions. Every day, your time is frittered away with numerous brief interactions. But you can minimize these interruptions. For example, when you are not seeing patients with appointments, try to avoid talking to anyone except fellow physicians, nurses or out-of-town family members of sick patients. Everyone else such as patients, pharmaceutical representatives and even family members should book an appointment to talk to you. Do not make exceptions once you have set up the rule. A patient handout can go a long way toward helping your patients understand why it is not OK for them to interrupt you for just a quick minute. You can also schedule times during the week that these patients can come in to see you to address their concerns.

6 Multi-task. For example, have two or more examination rooms running at once. You may be able to pop in to see a patient with a minor concern while another patient is undressing. If you are stuck on hold while making a phone call, complete some easy paperwork such as reviewing lab work or check and answer emails while you wait. On your drive to work, listen to DVD recordings of courses or journal articles that are pertinent to your practice.

7 Touch paper only once. Do your paperwork daily and touch paper only once, either to file it, complete it, shred it, pass it along or direct an appropriate action. When returning from time off, even if it is only a day, your in-box will often be overflowing. Book yourself extra time to catch up with paperwork.

8 Analyze appointment patterns. Together with your staff, take some time to analyze trends in your schedule, such as slow and busy times of the day, week and year. Then adjust your schedule to reflect these trends. For example, many physicians fail to allow enough time for acute visits during busy periods of the week. Your staff will also be able to help you identify consistent problems with your schedule. For example, you may always be running 15 minutes late when you are dealing with elderly patients or patients with dementia. Adjusting your schedule to accommodate these special cases can save you time at the end of the day.

9 Schedule hospital rounds early in the morning. Early rounds let you catch patients before they are taken for tests, thus eliminating return visits. Plus, since patients are eager to talk to you, you won’t be interrupted during the morning by calls to find out when you will come by to see them.

“Do your paperwork daily and touch paper only once, either to file it, complete it, shred it, pass it to someone else or direct an appropriate action.”
Combating Heroin Addiction

Mayor Emanuel proposes a series of measures to protect Chicago residents from the hazards of opioids.

T'S NO SECRET that overdose deaths from heroin and other opioids have skyrocketed in recent years, locally and across the country. Data from the Cook County Medical Examiner's office reveals that in 2015, there were 609 opioid-related overdose deaths in Cook County, 403 of which were in Chicago. The numbers for heroin, specifically, were 424 in Cook County and 285 in Chicago, respectively. Evidence shows that addiction to prescription opioids is often a gateway to heroin addiction and law enforcement officials report the illegal heroin trade is a catalyst for other crime.

As a result, on Oct. 6, Mayor Rahm Emanuel announced a series of measures to combat heroin and opioid addiction throughout Chicago. The efforts are based on a final report issued by the Chicago-Cook County Task Force on Heroin, which Mayor Emanuel convened with Ald. Edward Burke, and Cook County Commissioner Richard Boykin. These proposed efforts would increase the City’s annual investment in addiction treatment by 50%—approximately $700,000—and create improved regulation of pharmaceutical representatives. The treatment investments will first be directed to areas of greatest need to protect residents from the hazards of opioids.

“To educate residents and generate awareness on prevention and treatment, the City has secured $350,000 for education campaigns—funded by a $300,000 grant from Pfizer and two $25,000 grants from CVS and Walgreens.”

Additionally, these efforts include a $250,000 investment to increase the availability of naloxone, an overdose reversal medication that saves lives, as well as a privately funded $350,000 city-wide campaign to educate residents and healthcare providers. “We know that opioid and heroin addiction destroys lives and families, which is why we are making investments to protect the health of our residents and to prevent this epidemic from claiming any more lives,” said Mayor Emanuel. “By investing more resources smartly and by educating residents and providers about the real dangers these drugs pose, we can help those dealing with addiction while preventing residents from becoming addicted.”

Down Payment on the Future

The Mayor’s new efforts are a down payment on the 36 recommendations made in the final Task Force Report, which was created in response to the growing epidemic of opioid addiction in Chicago and the surrounding region. To stop addiction, the report recommends a series of reforms in six areas: education of the community; education of healthcare professionals; treatment, data, law enforcement, and overdose reversal. Mayor Emanuel planned to convene a regional opioid summit on Oct. 27 with DuPage County Chairman Dan Cronin where leaders from collar counties will join those in Chicago and Cook County to create an even larger and more coordinated response to the epidemic.

“The City of Chicago and Cook County are joining efforts to face an epidemic that must be attacked at every level of government,” said Ald. Edward Burke, co-chair of the Task Force. “No one entity can fight this problem alone. We have to do it together, and today's investments represent a way forward in protecting our residents from the harm of this deadly epidemic.”

In recent years, marketing from pharmaceutical drug representatives to medical professionals has played a key role in the overprescribing of opioids, helping to fuel a nationwide epidemic of addiction and overdose. To ensure better oversight of these representatives, the City proposes to establish a pharmaceutical representative license above the current Limited Business Licensing required for these individuals in Chicago. Similar to the license in Washington, DC, pharmaceutical representatives will be required to receive additional training and education and provide the City with information on opioid sales and marketing. Through this license, the City would also enable medical professionals to report complaints against pharmaceutical representatives and monitor, audit and adjudicate complaints against pharmaceutical representatives.

Due in part to the wide-ranging impact opioid promotion has had on substance use, the mayor will expand investments to treat heroin and opioid addiction. The approximately $700,000 in new funding will be focused on opioid treatment deserts where there is a disproportionate level of addiction and the need is greater than the availability of services. By directing more resources, the City will help health clinics and physicians develop or improve programs in the communities of greatest need.

The $250,000 investment in naloxone is going to the Chicago Recovery Alliance to increase access to the overdose antidote in the communities hit hardest by the epidemic—including the West Side, which has a disproportionate number of heroin arrests and overdoses. In addition, the City will expand naloxone deployment to the entire Chicago Fire Department fleet, which often is the first responder to overdose calls.

To educate residents and generate awareness on prevention and treatment, the City has secured $350,000 for education campaigns—funded by a $300,000 grant from Pfizer and two $25,000 grants from CVS and Walgreens. These will include outreach both to communities and to healthcare providers who prescribe opioids. The City will help prescribers understand the dangers of opioid addiction and apply recent guidelines from the Centers for Disease Control and Prevention to prevent overprescribing.

“Opioid addiction is a public health issue impacting cities like ours across the country,” said Chicago Department of Public Health Commissioner Julie Morita, MD. “Law enforcement alone cannot solve the problem. That’s why healthcare providers, social service agencies, advocates, and the law enforcement community are working together across the City and county to confront the opioid epidemic.”

PUBLIC HEALTH
Expanding Mental Health Services

Chicago partners with Cook County Health to create new programs

A NEW PARTNERSHIP between the Chicago Department of Public Health (CDPH) and the Cook County Health and Hospitals System (CCHHS) will expand services in Roseland by creating new specialized programs to serve children and youth on the far South Side and expand overall citywide capacity.

To increase service options for residents, CCHHS will assume management of mental health services at CDPH's Roseland Neighborhood Health Center in early 2017. The partnership not only increases service options in Roseland, but also provides more opportunities for CDPH to expand mental health services at other locations across Chicago.

Specifically, the new partnership will provide mental health services to children and youth at the Roseland Neighborhood Health Center location, populations not currently served there. Additionally, all clients at this site will now have direct access to CCHHS' comprehensive healthcare network, providing access to an array of quality mental and physical healthcare providers, clinics and hospitals across Cook County. “This expansion will provide a wider range of services to more Chicagoans and increase access in more of our city's neighborhoods,” said CDPH Commissioner Julie Morita, MD. “Through this renewed partnership with Cook County, our residents will soon have more opportunities to access the care they need to live a safe and healthy life.”

To ensure a seamless transition for clients at the Roseland location, CDPH staff will be in contact with them in the coming weeks to discuss the new opportunities available through the partnership. CCHHS will continue to see CDPH's current clients, regardless of their ability to pay. As part of the partnership agreement, CDPH will continue to cover any costs for mental health services for those clients who are not eligible for health insurance.

The partnership at the Roseland Neighborhood Health Center is an expansion of service, and CDPH will maintain current funding and staffing levels for its mental health clinical services program. Thanks to the new partnership, CDPH can now redeploy its Roseland staff, allowing the city to increase the number of visits and services for residents in 2017. CDPH will have providers on-site at select Department of Family and Support Service Centers, providing direct care to residents at those sites also in need of mental health services.

CDPH will also expand group therapy programming and increase case management for its current clients, providing more comprehensive services for those most in need. The increase in services will result in 500 additional visits for residents per year.

“A person's physical and mental health are interdependent,” said CCHHS CEO, Jay Shannon, MD. “With CCHHS taking on these mental health outpatient services, we will be able to provide patients receiving mental health services seamless connectivity to health care providers within our system to address any physical health needs they may have, supporting their overall health and wellness.”

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Managing Disruptive Conduct in an Era of Disruption

The likelihood for tension in today’s healthcare system is greater than ever, and organizations can adopt commonsense strategies. By Sidney Welch, Esq.

Disruption IS a common buzzword in today’s healthcare. Clayton M. Christensen coined the phrase “disruptive innovation” back in 1995 to refer to an innovation that creates a new market and value network and displaces established market leaders and alliances. Subsequently applied by Christensen and others to the healthcare industry, today’s disruptive innovation includes initiatives such as new patient-centric delivery models, mobile health apps, crowdsourcing knowledge applied to patient visits—the goals of which are improving quality and efficiency.

However, juxtaposed against this mostly positive spin is the negative and physician-focused connotation that the term “disruption” or “disruptive” has had in the medical staff context for more than a decade. This term often conjures up images of the surgeon throwing surgical trays in the operating room or the physician yelling at nursing staff.

Disruptive Behavior Defined
The Joint Commission, in its Sentinel Event Alert in 2008 (“Sentinel Event”) documented the general description of disruptive behavior as “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.” It further noted that “intimidating and disruptive behaviors are often manifested by healthcare professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation and impatience with questions.”

Interestingly, this described problem is not unlike the general concepts of bullying or workplace bullying, also referred to in the employment world as “hostile work environment” or tied to legal concepts of discrimination and/or intentional infliction of emotional distress, since no federal legislation has been adopted. Also, in the workplace where this behavior has been adopted by persons in leadership positions, it has been referred to as “bully management,” characterized by leadership practices that make subordinates feel uncomfortable, inadequate, angry or sad, with the so-called leaders yelling at subordinates (especially during meetings or in public spaces), voicing excessive negativity towards a subordinate’s work, making threats or personal insults, micromanaging and demanding unreasonable expectations, and even physical violence.

These ties to employment-related claims become particularly relevant today since many more physicians are employed by hospital systems and hospitals often are blurring the lines between employment-related and medical staff processes. Further, this broader employment context acknowledges that poor behavior is not limited to physicians but extends beyond this group to include all personnel.

Hospitals Focus on Physicians
This expanded concept in the employment context is reflected by some of the guiding parameters in healthcare. As contemplated by TJC standards, technically “disruptive behavior” could apply to any conduct by any individual in the organization, not just physicians. However, the reality is that since TJC adopted its Leadership Standard in 2009 (LD 03.01.01), which required accredited healthcare organizations to have a “code of conduct that defines acceptable and disruptive and inappropriate behaviors,” hospitals were quick to adopt “Disruptive Physician” policies, which were designed to discipline the physician under the organization’s medical staff bylaws.

This physician focus is reflected in comments in 2013 from Dr. Ronald M. Wyatt, TJC Medical Director: “While disruptive and intimidating behavior can be displayed by nurses, pharmacists, and managers, it is the behavior of doctors which most often causes problems, perhaps because medical culture has had a history of tolerance or indifference to this, or because organizations have tended to treat doctors differently from other staff.”

Similarly, the AMA Medical Code of Ethics Opinion 9.045, Physicians with Disruptive Behavior, focuses on and encourages medical staffs to develop and adopt bylaws provisions or policies for intervening in situations where a physician’s behavior is identified as disruptive. While the AMA Opinion promotes due process and referral to wellness committees, it, like the industry trend following the adoption of LD 03.01.01, focuses on physician disruption.

All of this background brings us to the challenges in today’s disruptive healthcare environment—one of great change. As delivery and payment are being reengineered, the likelihood for tensions between business and care delivery, hospital administrators and acquired physician practices, physicians and nursing staff and other ancillary providers, is greater than ever. Physicians may not completely understand business ramifications of certain decisions, just as hospital administration and staff may fail to comprehend certain clinical implications of business decisions.

Constructive vs. Disruptive
Although, as noted by the AMA Medical Code of Ethics
“The medical staff process, particularly the disruptive physician policies and the peer review process, is being used more than ever in situations where a physician may be expressing concern about patient care or otherwise is an annoyance to the health system’s administration.”

Opinion 9.045 adopted in June 2000—a concept which is absent from the current TJC standards—“Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior,” the medical staff process, particularly the disruptive physician policies and the peer review process, is being used more than ever in situations where a physician may be expressing concern about patient care or otherwise is an annoyance to the health system’s administration—a concern that was noted by physicians following publication of TJC’s Sentinel Event.

Often, this problem is accompanied and exacerbated by an absence of a structure to deal with bully management, administrative personnel who may be struggling with ineffective management, unhappy nursing or ancillary staff, or myriad other sources of friction within a health system.

The failure to handle these problems effectively may distract from fiscal and clinical goals; lead to costly litigation; and, as reflected in TJC’s 2012 language changes from “disruptive behavior” to “behaviors that undermine a culture of safety,” lead to patient harm. Disruptive behavior can also create conflict between leadership groups and plunge hospitals into costly bouts of litigation. So, what’s the solution?

Commonsense Code of Conduct

There are several pro-active steps that your organization can take to manage disruptive conduct in this era of disruption. These are outlined below:

- **Step 1:** First, determine what requirements and processes exist/do not exist and where they are housed, and assess what works/does not work. Specifically, what documents address conduct within the organization and how to manage conflict? Medical Staff Bylaws? Fair Hearing Plan? Employment Manual? Employee Policies & Procedures? Corporate Bylaws? Joint Conference Committee? Conflict Management/Dispute Resolution Process?

- **Step 2:** Identify what you need that you don’t have or what you need to revise. A good place to start is with a universally applicable Code of Conduct. To be effective, the Code of Conduct should apply equally to all actors within the healthcare delivery system, including hospital staff, physicians, and vendors. Not only should the Code of Conduct define desired behavioral standards, but it also should identify behaviors deemed unacceptable and be clear as to what disruptive behavior is not—such as the absence of complete harmony; an isolated incident of behavior that is not reflective of seriously inappropriate behavior; or respectful disagreement with decisions, the presentation of controversial ideas, or a respectful complaint about processes or incidents that endanger patient care. Ideally, the Code of Conduct will either describe or reference the consequences for divergence from appropriate behaviors.

- **Step 3:** Incorporate fundamental principles of conflict management. This task begins with efforts to identify the source of the conflict. This process starts by allowing the parties directly and indirectly involved in the conflict to share their sides of the conflict in a non-adversarial (non-“investigatory”) environment, sometimes in front of a neutral third party. Their information should be acknowledged as received.

  Next, everyone involved must look beyond the triggering incident to see its root cause. Is it due to individual or systemic factors? Clearly, in psychiatric or personality disorders, candid, proactive, privileged evaluations are key to successful resolution.

  Identify solutions that the parties can both support. Once the root cause is identified, the parties may arrive at a solution more quickly and in a more invested manner if they are part of the solution—so get their suggestions for solutions. The parties may need to be guided by questions to elicit responses, such as asking them to identify how the situation can be changed. The goal for this stage of the process is to move past finger-pointing. The parties should identify the pluses and minuses of various solutions, not only from their personal perspective but also from the organization or patients’ viewpoint.

  Finally, reach agreement and build consensus around solutions. The parties may consider documenting the solution to avoid miscommunication. Whether in writing or otherwise, the parties should identify any follow-up, an action plan, and a plan for resolving any future dispute(s).

- **Step 4:** Execute a robust implementation plan. To ensure the Code of Conduct becomes a source of guidance for all individuals, organization staff should receive training about the code and learn what to do in the event they witness a violation. After having the opportunity to digest the Code of Conduct, organizations may require all individuals associated with the organization to sign a statement of intent to comply with the Code of Conduct. Doing so signals to the associated individuals the importance of the code and provides the organization with evidence that the individual read and understood the policy.

  Effective implementation of the Code of Conduct will also require implementation of policies and procedures to ensure accountability. These may include a zero tolerance policy (or, alternatively, take the AMA Opinion approach of identifying any patterns requiring intervention), whistleblower protections, and progressive disciplinary measures that can track TJC’s leadership standard. In addition to these reactive solutions, organizations should consider preventative strategies to decrease the likelihood of disruptive behavior occurring in the first place, including screening for health and personal issues in a legally compliant manner.

Play Nicely in the Sandbox

These concepts are commonsense, but the players in today’s healthcare often get caught up in the increasing demands to deliver on quality, affordable care. Remember, all you really need to know, you learned in kindergarten. Play nicely in the sandbox, be sure to share your toys, and never underestimate the value of a good nap.

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Physician Non-Competes

Recent court cases clarify elements of an enforceable restrictive covenant
By Ryan A. Haas, Esq. and Kimberly Boike, Esq.

A greements that restrict a medical professional’s right to work for a competitor are precarious at best. When entering into an employment agreement, many physicians agree to abide by certain post-employment restrictive covenants prohibiting them from practicing medicine in competition with their employer in a defined area for a certain period of time. Most physicians sign their employment agreement when they are hired. The new employer and new employee are not thinking about how their new relationship will end. But, they should.

In Illinois, a medical practice has a protectable business interest in its practice and patients as a matter of law. Yet, Illinois courts also recognize that “the right of an individual to follow and pursue the particular occupation for which he is best trained is a most fundamental right.” As such, a medical practice may require physicians and other medical professionals to enter into covenants prohibiting them from working in a competitive position for a competing medical practice or from soliciting patients of the practice, but only if such restrictions are appropriately limited in time, territory and scope.

Illinois’ Post-Employment Restrictions
A physician who leaves a medical practice to work for a competing practice down the street must be careful not to violate such agreements. Illinois courts have found that post-employment restrictions on competition that are limited to a radius of between 10 to 25 miles and a timeframe of two years or less may be reasonable on a case-by-case basis and, as a result, enforceable. Yet, the consideration given by the employer to the employee is another element courts will review in deciding whether to enforce such agreements. Consideration is something of value that must be given to create a legally binding contract.

When physicians and other medical professionals are initially hired and agree to post-employment restrictions, they often are given only the promise of employment as consideration for their agreement. Even if the restriction is reasonable in geographic and temporal scope, this promise of continued employment may not be enough consideration to render the agreement enforceable under Illinois law.

In Fifield v. Premier Dealer Services, Inc., the Illinois Appellate Court held that when the promise of at-will employment is the consideration supporting a restrictive covenant, “there must be at least two years or more of continued employment to constitute adequate consideration in support of a restrictive covenant.”

Recent decisions in Illinois following Fifield have largely applied this decision and have expressly rejected the argument that new employment itself is adequate consideration for a restrictive covenant.

All Restrictive Covenants are Not Equal
Reiterating this principle, the Illinois Appellate Court in Prairie Rheumatology Associates v. Francis recently held that a physician’s restrictive covenant with a medical group was unenforceable due to insufficient consideration. In the case, Dr. Francis, a physician specializing in rheumatology, signed an employment agreement that contained a restriction prohibiting her from engaging in any competitive activity for two years after the end of her employment within a 14-mile radius of Prairie Rheumatology’s office. After 19 months on the job, Dr. Francis voluntarily resigned her employment. This was five months short of the two-year requirement set forth in Fifield. Shortly after her resignation, Dr. Francis began working for a competing medical group within the 14-mile radius prohibited by her employment agreement.

Prairie Rheumatology filed a lawsuit seeking to prohibit Dr. Francis from working for the competing practice within the 14-mile radius. The trial court enforced the restrictive covenant and entered a preliminary injunction against Dr. Francis. However, on appeal, the Court held that, other than the promise of at-will employment, the physician received no additional benefit from her employer in consideration for the restrictive covenant. Dr. Francis did not remain employed at Prairie Rheumatology for two or more years. Therefore, the Appellate Court reversed the injunction and held that the restriction on competition was unenforceable because it lacked adequate consideration.

This case is a cautionary tale that the parties to a restrictive covenant may not ultimately be agreeing to an enforceable covenant. Any employer seeking to protect its legitimate business interests through a post-employment restriction on an employee should ensure not only that the restrictions are reasonable, but that such restrictions are supported by adequate consideration to be enforceable in Illinois.

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The Problem with Patient Satisfaction Surveys

Physicians and researchers say these tools can do more harm than good

By Delia O’Hara
OUR HEALTHCARE system is moving steadily toward a patient-centric model of care, but have we figured out how to assess how well that model is working? The patient experience, or patient satisfaction, survey is a commonly deployed yardstick, but some Chicago physicians, researchers and other observers say that metric is far from perfect.

The Centers for Medicare and Medicaid Services (CMS), various constructs of the Affordable Care Act, and ratings programs initiated by private insurance companies and employers, like hospitals and group practices, are moving compensation away from pay-for-service toward rewarding outcomes, access, efficiency and yes, patients’ experience of care. The Consumer Assessment of Healthcare Providers and System (CAHPS) Health Plan Survey, a public-private initiative under the federal Agency for Healthcare Research and Quality, generates many of the surveys patients fill out.

The Shift to Customer Service

“Quality metrics are a central part of what we do,” says Michael Hanak, MD, a family practitioner at Rush University Medical Center in Chicago and a chair of Rush's quality committee. Physicians employed by the hospital are assessed internally by how satisfied patients are with their experience there, but Dr. Hanak says that what gets measured in a clinical setting may be more about the environment such as wait time, cleanliness, and how the patient is greeted. Physicians in private practice are in the same boat. “Scores are used as a grade of the physician’s work,” says Dr. Hanak, “but it’s more about keeping patients happy than keeping patients well.”

Christine Bishof, MD, an emergency physician who is the assistant director of the emergency department at Metro South Medical Center in Blue Island, says, “The numbers of surveys returned are sometimes quite small. The survey companies say, ‘Oh, by the time we do our magic to the numbers, the results are valid,’ but it seems like with one bad review, the entire rating is brought down. Physicians just want to practice good medicine. They don’t want to have this threat hanging over them.”

Emergency physicians are in “a high-stress situation,” says Dr. Bishof, who is also vice-chair of the Chicago Medical Society Council. “You have to bond with patients very quickly, get their information, make your diagnoses and move on. You’re not in the room for 30 minutes to build up a rapport, and so scores may suffer as a result.”

ER doctors also see a high number of patients demanding inappropriate treatments, most distressingly opioid painkillers, Dr. Bishof says, “It’s a matter of expectations. Everyone expects the pain level to be zero now. We’re stuck between a rock and a hard place.”

Dr. Bishof adds, “We’re leaning far too much on the side of making it a customer relationship rather than a professional one. When you’re dealing with a medical issue, the patient should be brought into the decision. I don’t think there’s anything wrong...
with surveys; the problem comes from linking patient satisfaction to pay.”

Alison Tothy, MD, chief experience and engagement officer at the University of Chicago Medicine and a pediatric emergency physician, agrees that the growing importance of patient satisfaction in physician assessments can be “frustrating” to deal with, but she adds that providers have always been mindful of the need to satisfy their patients on some level. “Patients have a choice about where they want to go, and they’re not shy about exercising it,” Dr. Tothy says. “Part of the discomfort [with patient-experience surveys] is about how healthcare in general is shifting. Electronic medical records are challenging, and surveys add to what we may see as non-value-added work. The surveys get bundled in together with all the things that are getting in the way of why we went into medicine in the first place.”

“It’s frustrating for physicians to have their compensation tied to something they have no control over. They know they’re practicing good medicine, but then they’re getting a bad score on patient satisfaction surveys.”

Still, Dr. Tothy believes “it’s important to let the voice of our patients shape the way we take care of them. We can help patients engage in their care and the care of their families, and [use what we learn from them] to prevent admissions and readmissions. But we need to be asking the right questions.”

Highlighting Patient-Centered Care

A December 2014 opinion piece in JAMA by Paul J. Hershberger, PhD, and Dean A. Bricker, MD, entitled “Who Determines Physician Effectiveness?” notes that medical care accounts for only about 10% of variance in outcomes. Especially with chronic diseases like diabetes and cardiovascular ailments, physicians can “identify risk factors, diagnose disease, prescribe treatments and educate patients regarding relevant lifestyle factors” like diet, exercise and smoking cessation, but adherence to the prescribed course is wholly up to the patient. And that is not even to mention environmental factors that affect outcomes, like education and income.

Amy Mullins, MD, medical director of quality improvement for the American Academy of Family Physicians in Leawood, Kan., says her group is concerned about the surveys as a tool for judging how well doctors are performing their job. She says it’s frustrating for physicians to have their compensation tied to something they have no control over. They know they’re practicing good medicine, but then they’re getting a bad score on patient satisfaction surveys. We’re not against learning and improvement, and it’s definitely good to measure whether people are getting better. But humans are complex organisms; they’re complicated to treat. There’s always room for clinical judgment,” Dr. Mullins says.

Patient-centered care was highlighted in a big way in Crossing the Quality Chasm: A New Health System for the 21st Century, an influential 2001 publication of the Institute of Medicine (now the National Academy of Medicine). The six aims for improvement of
healthcare outlined in Crossing the Quality Chasm were toward safe, effective, timely, efficient and patient-centered care. That last aim was defined as “providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Crossing the Quality Chasm held that patients should have access to information and the “opportunity to exercise the degree of control they choose over healthcare decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision-making.”

Ideally, that would lead to beneficial changes to the system. In a 2011 paper they wrote for The Annals of Family Medicine entitled “The Values and Value of Patient-Centered Care,” Ronald Epstein, MD, and Richard Street, PhD, noted, “Training physicians to be more mindful, informative, and empathic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration.”

Yet, 10 years after Crossing the Quality Chasm posited the goal of a physician-patient collaboration, “researchers are only beginning to model pathways through which patient-centered care behaviors contribute to better outcomes,” and that “sometimes what patients think they want (for example, a drug) is not what they need (for example, information),” Drs. Epstein and Street wrote in 2011, and physicians still remark on those issues today.

In fact, requests for superfluous pharmaceuticals, like the ones both the Street-Epstein paper and Dr. Bishof mention, come up frequently when physicians talk about their frustrations with patient satisfaction surveys—along with antibiotics requested as a treatment for viral illnesses, and MRIs for pain, most notably back pain. This suggests that patients as a group may need to get up to speed about some of the basics of healthcare.

“You’re talking about approaches that are based on science, that a physician thinks are appropriate, and then you’re asking, ‘Is the patient happy?’ You have to drill down into specific aspects of the experience. A person can get poor care and be satisfied. We need to talk with patients, and we don’t always do that.”

The Meaning of High Scores

“Medical quality assessment needs to be about more than customer satisfaction,” says Dr. Street, a communications professor at Texas A&M University in College Station, Tex., and professor of medicine at Baylor College of Medicine in Houston. “You’re talking about approaches that are based on science, that a physician thinks are appropriate, and then you’re asking, ‘Is the patient happy?’ You have to drill down into specific aspects of the experience. A person can get poor care and be satisfied. We need to talk with patients, and we don’t always do that,” he says.

Physicians may believe they’ll get better scores if they avoid conflict with their patients, and also if they can skirt the nasty
business of conveying bad news, says Dr. Epstein, professor of family medicine, psychiatry and oncology at the University of Rochester Medical Center in New York. Those issues can definitely affect scores. But most patients will most often give their doctors the highest possible score, a five out of a possible five, Dr. Epstein says. After all, patients are entrusting their lives to this doctor; how can the doctor be an inferior practitioner?

“But most patients give their doctors great scores, even a physician who gets a score of four on a scale of five may be ‘dinged.’”

But Dr. Epstein also adds that high scores don’t necessarily mean patients and their families are happy about their care. “People are angry and disappointed about all sorts of things,” he says. He gives the example of prognosis. Surveys of people with advanced cancer have found that even when physicians discuss prognosis, and the physicians themselves are confident they have delivered a clear message, 70% of patients are far more optimistic about their chances than the doctors actually gave them reason to be, Dr. Epstein says. That can lead to greatly upset feelings, on the part of family members even after the patient has passed away.

As to those mostly high scores, Dr. Epstein says, “There are a whole bunch of issues with surveys. We may get more useful information from a 10-person focus group than a 10,000-person survey, but we probably need to do both.”

Dr. Street notes that because most patients give their doctors great scores, even a physician who gets a score of four on a scale of five may be “dinged.”

Dr. Street says, “On the patient’s side, the biggest problem is passivity. We need patients to be more engaged. The doctor needs to know what’s important to the patient. A good metaphor is dance partners: The actions one party takes influence what the other party does. That takes communication skills, on both sides.”

Communication is Key

That 2014 JAMA paper by Drs. Hershberger and Bricker endorses enlisting patients in their treatment, and really listening to what patients have to say. While physicians are frustrated by the fact that patients don’t follow their recommendations, patients often believe physicians don’t understand where they’re coming from.

Dr. Tothy agrees that communication is key. “We’re told in medical school that some fairly high percentage of what’s wrong with patients can be found by getting their histories—their stories. That’s the art of medicine. That’s how we build relationships. Every patient is different. That’s part of the fun.”

Delia O’Hara is a Chicago-based freelancer who frequently writes about healthcare and science topics. She was previously a longtime features reporter for the Chicago Sun-Times.

A Resource for Patient Conversations

CHOOSINGWISELY.ORG, a website sponsored by the ABIM Foundation, partners with 70 medical specialty societies to provide 75 lists of procedures that may be unnecessary or even harmful to patients. The website, an initiative designed to cut healthcare waste and increase patient safety, contains targeted sections for both physicians and patients. “When patients demand certain procedures, physicians need resources to guide them in having conversations about what is the right thing to do for the optimal outcome,” says Daniel Wolfson, executive vice president of the ABIM Foundation.

The Foundation, an arm of the American Board of Internal Medicine, has partnered with a number of organizations, including the Robert Wood Johnson Foundation, on choosingwisely.org. Consumer Reports has created easy-to-understand patient materials on such hot topics as the proper use of antibiotics and pain-killers, and how best to treat back pain, Wolfson says.

Choosingwisely.org began with a 2010 New England Journal of Medicine perspective piece by Howard Brody, MD. “Medicine’s Ethical Responsibility for Health Care Reform—The Top Five List.” Written in the run-up to the implementation of the Affordable Care Act, Dr. Brody’s article called for every medical specialty to itemize the five most commonly overused tests or treatments in its practice. Brody wrote, “Having once agreed on the Top Five list, each specialty society should come up with an implementation plan for educating its members as quickly as possible to discourage the use of the listed tests or treatments for specified categories of patients.”

The National Physicians Alliance responded with the first recommendations, and in April 2012, the ABIM Foundation and Consumer Reports formally launched Choosing Wisely with the “Top Five” lists from nine specialty societies.
Communication **saves lives.**
Just ask Dr. Singh.

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

*DocbookMD is a free benefit of your CMS membership. Learn more about the app at [docbookmd.com](http://docbookmd.com).*
The CHICAGO Medical Society’s 168th president took office on a theme of collaboration and communication, stressing that physicians cannot afford to sit on the sidelines at a time when the healthcare political landscape is changing. During inauguration ceremonies on Sept. 13, dermatologist Clarence W. Brown, Jr., MD, said that working with legislators of both political parties, hospital associations, and even the insurance companies is crucial to making sure that physicians are not left out of the conversation. As the system grows more complex, no single industry or group has all the solutions, Dr. Brown stressed. Working across boundaries, CMS will bring a collaborative mindset to the problems patients and physicians face. “We don’t want to be limited by policy positions that prevent us from having a seat at the table, Dr. Brown added.

Passing the baton of leadership, Outgoing President Kathy M. Tynus, MD, told annual dinner guests that CMS is well-positioned to meet new challenges. Her address recapped CMS’ legacy of accomplishments. Founded in 1850, the public health, educational, and physician advocacy missions remain as strong as ever, she noted. Dr. Tynus also gave a full report of the legislative outreach and collaboration that occurred during her presidential term on issues such as insurance network adequacy, maintenance of certification, opioid prescribing, medical research funding, and medical necessity determinations among other items.

And keynote speaker Stephen Ondra, MD, gave physicians and guests a preview of the new world of value-based care. No matter which candidate wins the U.S. presidential election, large insurers are forging ahead, shifting tens of billions of dollars to value-based models. Indeed, the Centers for Medicare and Medicaid Services is well on its way to shifting half of all Medicare payments to alternative payment models by 2018. Physicians need to plan now for the new regime, which offers bonuses and incentives for improving care and reducing cost, Dr. Ondra said.

A nationally recognized leader in healthcare strategy and healthcare reform planning, Dr. Ondra is former senior vice president and enterprise chief medical officer for Health Care Service Corp., which is the parent company of Blue Cross and Blue Shield of Illinois.
FIRST, I WANT to thank all of you for having the confidence in me to be your president of the Chicago Medical Society. I am humbled and honored to be chosen to lead an organization that has not only withstood the test of time since it was founded more than 165 years ago but has also flourished in its advocacy and education of physicians. It’s that advocacy and education that I want to stress as we look ahead to the coming year—a year in which we will emphasize the need for cooperation.

As a practicing dermatologist for two decades who is currently attending law school, I’m passionate about the need for education and continual learning, particularly in the highly regulated and complex field of medicine. Meanwhile, our advocacy for our patients comes at perhaps the most critical time in our nation’s medical history since change is rapidly sweeping the healthcare system and our country is divided politically.

Patient Advocacy
Against that backdrop, I believe that we need to engage our membership as well as our non-member physicians to help us set priorities. We want to make sure we are working with stakeholders and policymakers at all levels in order to reach our goal of the betterment of patient care as a whole. We know the Affordable Care Act is bringing more health care coverage to patients, including those who were previously unable to afford care. And these patients need us to help them navigate this complex new world even as some payers decide participating in exchanges is no longer in their best interest.

These newly insured patients face restrictions in their choice of physicians due to the lower cost exchange options resulting from health plans with narrow networks. As narrow networks flourish, patients will need us to advocate for ways in which they can choose the particular physician that they wish to treat them. We are doing this in our advocacy for Illinois HB 6862. This legislation, known as the Network Adequacy and Transparency Act, addresses health plan adequacy, accessibility and transparency as patients come in more contact with narrow networks or what insurers call “high performance networks.”

But we should not be adversarial with insurance companies as new models like this emerge. If we draw a line in the sand against narrow networks and other new models, insurers will move forward, implementing these networks without our involvement. You can oppose narrow networks and decide not to participate in them, but they aren’t going away. Consumers—our patients—are picking these plans because they are more affordable.

Already, the state’s largest health insurer, Blue Cross and Blue Shield of Illinois, got rid of its statewide PPO last year. Instead, BCBSIL this year offered a narrow network plan called BlueDirect with Advocate Health Care. This narrow network plan has grown to 60,000 covered lives in less than one year. BlueDirect is one of the lowest cost plans in the Illinois Public Exchange.

It’s a national trend and it is growing. The Blue Cross and Blue Shield Association reported earlier this year that the number of exclusive provider organization products which limit providers “within a predetermined network” increased to 52%—a little more than half-of the health plan offerings on public exchanges. That is a jump from 40% in 2015 and is expected to rise even more for next year. And this doesn’t include what employers and Medicare Advantage plans are doing when it comes to creating networks. Put simply, insurers are attracting tens of thousands of patients to these narrow network plans.

If we resist these ideas, we won’t even be part of a conversation that is already taking shape. But as these new models develop, payers need physicians...
to be involved as the healthcare system moves to a value-based proposition and away from fee-for-service medicine. It’s better for the insurers when we are working with them.

**New Payment Era**

Insurers want to work with us. They need to work with us. They cannot do it without us.

For example, new alternative payment models are emerging on all fronts that will make providers responsible for improving health outcomes. These models include bundled payments, patient-centered medical homes or accountable care organizations (ACOs) and perhaps others yet to be created. Despite uncertainty about whether these models will lower costs and improve quality, physicians are at the center of them. And physicians will figure in whether these new models are successful or not.

Providers in the value-based world are supposed to receive bonuses or higher reimbursement if they improve outcomes for their patients. This is also true of payers in a value-based system. Take an ACO for example. If the providers achieve health outcome goals and reduce expenses, they split the amount of money saved with the insurance company or Medicare under the shared savings model. So you see, the payers need us to make this new order work.

But we should not be fooled into believing that we hold all the cards. We need to be open to these new payer ideas because they are not going away. Already, the Centers for Medicare and Medicaid Services (CMS) under the Obama Administration is well on its way to shifting half of all Medicare payments to alternative payments models by 2018.

But even if a new presidential administration comes in and slows the move to value-based Medicare payment, fee-for-service medicine is rapidly disappearing. No matter what government payers do, large health insurers are forging ahead, shifting tens of billions of dollars to value-based models. AETNA, for example, reports that it plans to move 75% of its contracts to value-based care models by 2020. That’s less than four years from now.

Physicians can still be involved with perhaps the biggest value-based initiative yet to come—MACRA, which is short for the Medicare Access and Chip Reauthorization act of 2015. Andy Slavitt, the administrator for CMS told the American Medical Association’s House of Delegates last June that doctor input is needed as CMS implements measures that will be instituted in the next three years. The MACRA rules will forever change the practice of medicine under Medicare.

**Legislative Outreach**

Aside from the federal level, we need to be visible at the state and local level, demonstrating that we are a cooperative group. And we know we can do it. In the last year, we met with leaders at City Hall including Ald. Edward Burke, Chair of the Chicago City Council’s Committee on Finance, to make sure physicians and other providers weren’t subject to the city’s move to a cloud tax on businesses. A cloud tax on doctors and other providers that are required to move to electronic health records and cloud-based architecture would have been a disastrous economic burden to doctor practices. Though the city doesn’t interpret health records as being sent in a cloud, city leaders respected CMS and were willing to work with us.

We need to continue to be visible to our local leaders at the city and state level, particularly during these unprecedented budgetary times. When there are issues, we shouldn’t use policy as a barrier to sitting down at the table with them to discuss solutions. If we do, it prevents as from being involved.

Whether we have a seat at the table or not, decisions will be made. We need to engage and work with other organizations outside of the government as well. Only by joining together with a diverse group of stakeholders including our patients, their insurance companies, our lawmakers, regulators and fellow medical providers can physicians improve the healthcare system. Relationships are built on trust over long periods of time.

**Digital Communications Aid Collaboration**

A key to the collaboration is communication and we are making a solid effort there by bringing CMS into the digital age. We are using social media and repurposing print content from *Chicago Medicine* magazine and other resources into messages that are mobile, online and available via our smartphone app. We want to reach more people more quickly. Digital communication is the future.

We want to widen our circle in a positive way and we want people to understand what we are doing. Going forward, we will advocate for physicians and their patients but we will also educate our profession about changes in this complex and complicated world. Therefore, I’m calling on all of you to work with me in the coming year. CMS needs and wants your help, input, and feedback.

As one of the largest county medical societies in the nation, our organization brings together physicians of all specialties, and therefore has a voice on all aspects of medicine. We will continue to work both inside and outside of our organization to educate lawmakers and the public. Legislators in Springfield and Washington do not always understand the intricate details of certain aspects of legislation yet they are eager to learn about technical information from physicians who have specific expertise.

I look forward in the coming year to working with CMS members in collaborating with the larger healthcare community and working together toward overcoming the challenges ahead.
Soon after it hit stores in 1993, the Apple Newton was a target of ridicule. It cost a lot and performed poorly. Yet today many credit the early touchscreen device with paving the way for iPods and iPads. Can a similar case be made for the Affordable Care Act? Yes, according to former health insurance executive and presidential health policy advisor Stephen Ondra, MD. Indeed, healthcare is at a similar crossroads the technology industry faced years ago, Dr. Ondra said.

As keynote speaker at the Chicago Medical Society’s annual meeting on Sept. 13, Dr. Ondra said the historic health reform law is a catalyst for greater change to come. His talk included a preview of that future, which replaces fee-for-service with value-based pay.

Regardless of who wins the presidential election, repeal of the Affordable Care Act remains unlikely, Dr. Ondra predicted. And no matter what the next administration decides, large insurers already are forging ahead, shifting billions of dollars to value-based models. The Centers for Medicare and Medicaid Services (CMS) is on track to shift half of all Medicare payments to alternative payments models by 2018. Said Dr. Ondra: “The consensus now is that we need to fundamentally change the economics of the healthcare delivery system to incentivize more efficient, higher quality, and more easily accessible care.”

Dr. Ondra’s career spans every sector of healthcare. The former senior vice president and enterprise chief medical officer for Health Care Service Corp., parent company of Blue Cross and Blue Shield of Illinois, Dr. Ondra is a leader in healthcare strategy and healthcare reform planning. His past experience includes positions as senior policy advisor for health affairs at the U.S. Department of Veterans Affairs, appointed by President Obama, and as co-chair of the National Science and Technology Council for Health Information Technology. Some may remember him as vice chief of neurological surgery at Northwestern Memorial Hospital, a position he left to work in government.

A New Taxonomy

The brave new world of value-based care will forever change the practice of medicine, starting with Medicare. Indeed, the Affordable Care Act set the stage for passage of the Medicare Access and CHIP Reauthorization Act of 2015, known as MACRA. That legislation repealed the sustainable growth rate formula, or SGR, which for years threatened annual physician pay cuts. More important, MACRA created a path for a new payment framework that phases out fee-for-service. The MACRA framework links compensation to quality, then to alternative payment models built on the architecture of fee-for-service, and finally, to population-based payment. In time, value-oriented payment will overtake commercial insurance as well. Physicians can choose how fast they proceed with the transition. Medicare’s “pick your pace” policy includes an optional reporting period in 2017.

For the first time, streamlined and consistent core sets of quality measures will provide the yardstick or common language that payers,
providers and patients use. It’s critical to have a way to measure quality in a clinically relevant way, Dr. Ondra said, or “it will be a race to the bottom on cost.”

Physicians should plan now for these payment shifts so their practices are best positioned to earn bonuses and other incentives that begin in 2019. It’s no different than investing in infrastructure, technology and other capabilities to better serve patients, Dr. Ondra pointed out.

Payment Takes Two Paths

Starting in 2019, physicians who want to remain in Medicare must commit to one of two payment tracks: MIPS or APM. Annual baseline Medicare Part B payments of 0.5% will continue until 2019.

The Merit-Based Incentive Payment System, or MIPS, is Medicare Fee-for-Service. MIPS will score individual performance from 2019-2024 on four dimensions—quality, resource use, meaningful use of electronic health records and clinical practice improvement—using a 100-point scale. Providers will see Medicare Part B payment adjustments the following year, positive or negative, up to 4% in 2020 and up to 9% by 2023. Physicians won’t want to end up on the wrong end of the average.

Under the Alternative Payment Model, or APM, providers who assume more risk can earn an incentive payment of 5% of services under the Medicare Physician Fee Schedule. Such providers must show that a significant part of their business comes from an APM. For example, 25% of revenue must be in an APM starting in 2019, with the percentage increasing each year. APM reimbursement from both Medicare and private payers will count towards reaching the required levels.

All the models—whether bundled payments, patient-centered medical homes or accountable care organizations (ACOs)—place the physician front and center in the quest to lower cost and improve care.

The ACO is just one form of an alternative payment model, but it’s not the most disruptive to the fee-for-service status quo, Dr. Ondra said. Unlike the ACO, an HMO calls on consumers to take on real responsibility for their care, working with a designated primary care physician who coordinates their healthcare needs and makes referrals. By way of example, Dr. Ondra described two alternative payment models in the Blue Cross Blue Shield of Illinois system. One is saving about 2% to 3% per year over what would be expected from a traditional PPO. Meanwhile, another plan, an HMO, is saving 20% to 25% over the amount generated by a traditional PPO.

In the real shared-risk HMO, where consumers have a stake in the game, only 5% of care occurs out of the network. While he’s not advocating for HMOs, Dr. Ondra said that benefit design makes a huge difference. Consumers are “the third leg of the tripod.”

Technology’s Promise

For a value-based system to work, hospitals and health systems need to invest in new infrastructure. For example, electronic health records that “talk” to one another. Other innovations, such as virtual care, can make care more convenient for patients and broaden access.

Wearable devices and other connected tools, will generate huge amounts of patient data. But it’s crucial to know which signals to listen to and how to analyze them, Dr. Ondra said.

The data will yield insights that help providers monitor their patients’ conditions outside of traditional medical settings. Physicians can more closely personalize care and intervene when necessary to avoid costly complications.
Looking Back
A year of achievements on physicians’ behalf By Kathy M. Tynus, MD
AM VERY FORTUNATE to have been
given the opportunity to lead and represent the
Chicago Medical Society (CMS), and continue
our close collaboration with the Illinois State
Medical Society (ISMS). The role of CMS and
all of organized medicine is crucial in recapturing
our lost autonomy and maintaining the high
standards of professional practice that we hold so
dearly. Now more than ever, we need the strongest
voice possible when advocating with legislators on
critical issues.

As the old saying goes, if you’re not part of the
solution, then you’re part of the problem. CMS
together with ISMS serves to amplify our collective
voices in this ongoing struggle. Since our founding
in 1850, CMS has been active in promoting public
health through quarantine, vaccination, sanitation
and educational campaigns. CMS also has been a
strong advocate for physicians’ rights, justice and
scope of practice limitations.

Our long legacy of public health and healthcare
policy advocacy serves as a foundation for today’s
challenges. There are many forces that are shaping
the way we practice, the way our patients access
and pay for healthcare, and ultimately the amount
of control that we as physicians have over our
work environment. Much of this change has led to
physicians giving up private practice and seeking
employment in record numbers. Maintaining com-
pliance with myriad regulations while maintaining
a profitable practice has become increasingly
difficult.

That’s why I’m pleased to report on some major
strides that we made during my year in office.

Advocacy Success
When it comes to advocacy, CMS has your back.
We achieved many “wins” this year including:

• Maintenance of Certification (MOC) CMS
brought a strong measure to both the ISMS and
AMA House of Delegates, pushing for both state
and national legislation to prevent hospitals and
insurers from requiring MOC as a condition of
employment or plan participation. This measure
applies also to regulatory agencies and govern-
ment payers, barring them from discriminating
against physicians economically through fee
schedules. We can take heart in the groundswell
of support among physicians fighting to reclaim
control. Last year, backlash against the newest
MOC requirements forced the American Board
of Internal Medicine to admit they “got it wrong”
and promise to make big changes.

• Medical Necessity CMS was the point of origin
for Senate Bill 2807, legislation that amends the
Illinois Insurance Code to ensure that health
insurance policies do not refer to the term “medi-
cally necessary” in any publication, contract, or
explanation of benefits sent to a patient when
the health insurer is referring to a “coverage
determination.” The purpose is to clarify the dis-
tinction between what is “medically necessary”
and what may or may not be paid for by a health
insurer under a health insurance policy. Medical
necessity decisions are and always will be the
domain of treating physicians.

• GME Funding The Society’s ongoing campaign to
strengthen GME has brought us to Capitol Hill,
to the local offices of our Illinois Congressional
Delegation members, to high-profile meetings
with medical education leaders. As a direct result
of our advocacy, a growing number of lawmakers
have agreed to support raising the cap on
Medicare-sponsored residency slots. CMS also
built a coalition of deans from all eight Illinois
teaching institutions, as well as medical students,
that lives on through each CMS president.

• E-Cigarettes CMS gave testimony at City Hall in
support of a successful measure to tax smokeless
tobacco and electronic cigarettes. As you know,
among our youth, e-cigarettes are replacing com-
bustible tobacco or conventional cigarettes, which
they often buy over the Internet. We emphasized
that e-cigarettes and all other such devices
should be taxed out of our children’s reach. This
testimony came after we adopting comprehen-
sive new policies aimed at further discouraging
tobacco use and other nicotine delivery products.

• Raising the Smoking Age CMS was the point
of origin in Illinois for a bill that would raise the
smoking age in Illinois to 21. The bill requires
anyone purchasing or possessing tobacco prod-
ucts and electronic cigarettes to be 21 years of
age, up from the current age of 18. Anyone using
a false identification card to obtain tobacco prod-
ucts would be guilty of a Class B misdemeanor.
SB 3011 passed the Senate after multiple attempts.
It is currently in the House awaiting action.

• Food Allergies in Restaurants CMS proposed
legislation modeled after the Massachusetts Food
Allergy Awareness Act to make restaurants and
food service establishments safer for those with
allergies by educating food service employees
and customers about the health risks of allergies.
While there have been some efforts in Illinois
to enact legislation regarding the notification
of food allergies, none have been signed into
law. Many restaurants in Illinois have already
taken steps to protect employees and customers
from exposure to food allergies. As such, ISMS
supported the introduction of Senate Joint
Resolution 47 urging further study of the issue,
including consideration of the provisions of the
Massachusetts Food Allergy Awareness Act as a
model for legislation here in Illinois.

• Network Adequacy CMS was instrumental in
raising awareness of the need to establish rules
for healthcare exchange insurance products to
meet a minimum standard for network adequacy.
Because of our advocacy, ISMS drafted HB 6562,
which was introduced in the Illinois legislature

Kathy Tynus, MD, immediate past presi-
dent, gave testimony
at City Hall in support
of a measure to tax
smokeless tobacco and
e-cigarettes. Passed
in 2015, this was just
one of the advocacy
“wins” during her CMS
presidency.
this spring with bipartisan support. I encourage you all to contact your state legislators and voice your support for this important bill.

- **Advocacy at the AMA Level** There are many other CMS-led policies that passed the ISMS HOD. Some were introduced at the AMA House of Delegates meeting this year including:
  - Preventing Hearing Loss in Children Caused by Noisy Toys
  - Primary Care Interventions to Support Breastfeeding
  - Study on Health Care Payment Models (Formerly Single Payer Health Care Study)
  - Gun Violence and Public Health Research
  - Eliminating Pain as the Fifth Vital Sign
  - Classifying Dry Needling as an Invasive Procedure
  - Promoting Transparency in TV Ads of Unregulated Medications and Medical Devices
  - Banning Triphenyl Phosphate in Nail Polish
  - Autofill Prescriptions and 90-Day Fax Requests
  - Increasing the U.S. Investment in Medical Research
  - Health Education: Sexual Assault and Violence

**More than Advocacy**

While CMS remains strong in its advocacy efforts, your Society also hosted several meetings with legislators and healthcare leaders as well as offered numerous educational events. We maintained a close working relationship with the Cook County Health and Hospitals System. Highlights include:

- **Medical Research Summit** CMS held a Medical Research Summit with Congressman Danny Davis, attended by representatives from all the major research institutions in Cook County. As a result of that summit, we’re working with Congressman Davis to establish a Congressional Medical Research Strategic Planning working group, to help guide long-term funding appropriaions and prioritize allocations to where research is needed most.

- **Outreach to Blue Cross Blue Shield of Illinois** CMS approached BCBSIL to learn more about its decision to remove its broad blue PPO network from the marketplace exchange. We were able to help the insurer bridge a communications gap with the provider and patient communities about transition of care services.

- **Opioid Crisis Collaboration** Your Society took the lead in addressing this issue at the highest levels of government, to make sure that legislative measures are reasonable and most effectively targeted. We met several times with U.S. Senator Dick Durbin to educate him from the physician perspective while expressing our interest in collaboration. These talks led to positive agreement on several issues, such as tying opioid education to DEA Schedule II licensure, and only for those physicians who are frequent prescribers of opioids, more than 100 prescriptions per year. In addition, we agreed that accessing prescription drug monitoring programs (PDMPs) is a useful tool. However, to be most useful, the PDMPs should be nationwide and incorporated into our EMRs. We also cautioned against any mandated use of PDMPs, but rather allowing physicians to use their clinical judgment as to when and how often to access these important records. The opioid epidemic requires an “all hands on deck” approach. We think that increasing access to naloxone, lifting the cap on buprenorphine prescriptions, increasing funding and coordination of evidence-based addiction treatment programs and removing the pain control questions from patient satisfaction surveys are all measures that can be part of the solution to this problem. It’s important for us to be at the table, to be willing to explain our position and to make some reasonable accommodations.

- **Educational Events** CMS hosted two major conferences:
  - The Midwest Clinical Conference 2016 was “Thrive in a Dynamic Healthcare Environment,” and featured participation from 20 specialty societies covering a wide range of topics. Participants included the American Heart Association, American Bar Association, the Genetics Task Force of Illinois, and the Institute for Medical Leadership.
  - CMS co-hosted its annual Physician Legal Issues conference in conjunction with the American Bar Association’s Health Law Section. It covers topics of legal concern to physicians.

**Cook County Health and Hospitals System**

CMS screens individuals to serve on the Cook County Health and Hospital System Board. This is a nominating committee on which CMS has participated since 2008, helping to select candidates for Board President Toni Preckwinkle’s consideration. This is one more example of our positive impact on public health.

It’s been a busy and productive year, and I’m grateful to have been a part of it. It has truly been an honor and privilege to serve this historic Medical Society and you, my distinguished colleagues and friends. I would like to thank the many outstanding leaders who have come before me, and served as my mentors, role models and cheerleaders. I would also like to thank my outstanding executive team; I couldn’t have done this without their support and guidance. Thanks also to those of you who volunteered your time and energy to serve on committees, and attend meetings, educational and social events. Without your participation, we could not have accomplished so much this year. Last, but most important, I would like to acknowledge the hard work, dedication and talent of the staff at CMS. Thanks for keeping the CMS engine running smoothly.
Welcome, New Members!
The Chicago Medical Society greets its newest members. We are now 60 voices stronger!

Student District
Pauline Ahn
Amber Alberts
Murad M. Alqadi
Anam Aslam
Saara-Anne Azizi
Omar Calderon
Jillian Caldwell
Po-han Chen
Sebastian Cruz
Shyam A. Desai
Jay Dumanian
Nimra Elahi
Karisa Falden
Morgan Fallor
Kaitlyn Fruin
Catherine M. Groden
Eiftu Haile
Robert J. Heuermann
Emily Higgs
Hsiang-Hua Hung
Olivia J. Jordan
Elise Kornreich

Betty Li
Lisa Liu
Nicholas Lyon
Ian B. Magruder
Ariana L. Melendez
Vince Morgan
Michael Murphy
Bilal Naved
Andy Nian
Maulik Patel
Shivani Patel
Trisha Patel
Daneel M. Patoli
Jacob Pierce
Christopher M. Rivard
Kellie E. Schueller
Chirag K. Shah
Shaina Shetty
Eugenie Suter
Tracey Thompson
Imo Uko
Erinma Ukoha
Kevin C. Varghese

Chetan Velagapudi
Aaron S. Wallace
Weilun Wang
Nicholas Welsh
Todd R. Wojtanowitz
Jaclyn Yeung
Daeun Yoon
Alexa Zajecka
Alien Zhu

Resident District
Kathleen Biblowitz, MD
Mary E. Hardin, MD
Diana M. Plata, MD
Pinar J. Smith, MD

District 3
Julianne Z. Morton, MD

District 6
Aaron F. Zirk, DO

This year’s event features:

Teaching Residents about High Value Cost-Conscious Care
Susan Hingle, MD, FACP
Professor/Vice Chair of Education
Southern Illinois University School of Medicine

Preparing Today’s Residents for Tomorrow’s Era of Medicine
Maurice Lemon, MD, MPH
Principal, Health Management Associates

Establishing a Meaningful Mentor Relationship with Your Residents
Sharon Strauss, MD, FRCP, MSc, HBSc
Director, Knowledge Translation Program
University of Toronto

As well as a “reactor panel” of residents, small-group problem solving, networking opportunities and much more!

Who can attend?
Residency program directors and physicians involved in medical education.

Breakfast will be served.
The meeting will conclude early in the afternoon, giving you plenty of time for an afternoon of holiday shopping on Chicago’s Magnificent Mile.

The Illinois State Medical Society designates this live activity for a maximum of 3.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The Illinois State Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

To learn more or register, visit www.isms.org/RPD today!

Tickets are $40 for ISMS/CMS Members, $150 for Others

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Calendar of Events

NOVEMBER

1 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.

9 OSHA Training Workshop: Bloodborne Pathogens and 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. Saint Francis Hospital, 355 Ridge Ave., Evanston. 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 Candace at ccole@cmsdocs.org or call 312-670-2550, ext. 338.

12-14 American Medical Association House of Delegates & Interim Meeting CMS actively participates in the American Medical Association’s policymaking meetings, advocating for both members and their patients. Resolutions adopted at the CMS governing Council frequently travel to the Illinois State Medical Society, where they are implemented, before ultimately reaching the AMA. CMS delegates to the AMA may submit a resolution directly to the AMA House for consideration and support. Physicians are encouraged to exercise this membership privilege, ensuring their voice is heard at the highest levels of organized medicine and beyond. Location: Orlando, Fla. For information, please go to www.ama-assn.org.

16 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 and teleconference. For information, contact Liz 312-670-2550, ext. 335, or esidney@cmsdocs.org.

23 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.

DECEMBER

3 Residency Program Directors Meeting 2016 Come for this annual event hosted by the Illinois State Medical Society and the Chicago Medical Society. Includes lectures on latest issues in graduate medical education and panel discussion. 7:30 a.m. (breakfast); program begins 8:00 a.m.-1:00 p.m. Location: ISMS Headquarters Building, 20 N. Michigan Ave., 8th Floor, Chicago. For information and registration, go to: www.isms.org/RPD.

9 Chicago Neurological Society Fall Symposium Learn the latest in neuro-rehabilitation, neuro-repair, and neuro-prosthetics. 8:00 a.m.–2:00 p.m.; Location: Gleacher Center, Downtown Chicago. For information, go to www.chineurosociety.org or call Abigail 312-670-2550.

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

The Residency Program Directors Meeting takes place on Dec. 3. It is hosted by the Chicago Medical Society and the Illinois State Medical Society. See details above.
**Personnel Wanted**

Urology & gynecology physicians wanted: gynecology for D & C and tubal sterilization. Urology primarily for vasectomy. Active part-time physicians wanted for 1-3 days a week in Des Plaines, Wood Dale, Downers Grove and Chicago. Please send resume and salary requirements by fax to 847-398-4585 or to kimberleeo@officegci.com and vino878@aol.com.

In search of anesthesiologist for D & C and tubal sterilization. Active part-time physicians wanted for 1-3 days a week for Family Planning and Birth Control Centers in Des Plaines, Wood Dale, Downers Grove and Chicago. Please send resume and salary requirements by fax to 847-398-4585 or to kimberleeo@officegci.com and vino878@aol.com.

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ODDLY ENOUGH, it was a barbershop that proved to Jay D. Bhatt, DO, that his future was medicine. While in college at the University of Chicago, he interfaced with Project Brotherhood, a Chicago clinic designed to address poor health outcomes for black men. The clinic was held in the back of a barbershop and the men were given free haircuts as a way to connect with care. “It was an extraordinary shaping experience for me,” says Dr. Bhatt. “I saw how a physician in an underprivileged community could make a big impact.”

With that experience, Dr. Bhatt, who now wears multiple hats including chief medical officer of the American Hospital Association, president and CEO of the Health, Research and Educational Trust, and an internist at Erie Family Health Center, formed two goals: to become a physician in an underserved community as a vehicle for change; and to work as a physician to partner with communities in a way that could change their future. “I realized that medical school would not be enough for me to meet these two goals,” he says. “So I took the opportunity to find skills-based training outside of medical school.”

By the time Dr. Bhatt graduated from the Philadelphia College of Osteopathic Medicine in 2008, he had also received his master’s of public health, policy and administration from the University of Illinois at Chicago School of Public Health. During his time in residency training and beyond, he completed a master’s in public administration at Harvard University’s Kennedy School of Government. Combined with his undergraduate degree in economics and his desire to help underserved communities, it wasn’t much of a stretch for Dr. Bhatt to end up as the managing deputy commissioner and chief innovation officer at the Chicago Department of Public Health. While at CDPH, Dr. Bhatt used his experience analyzing data to improve community health, in areas such as reducing foodborne illnesses and lead exposure. He also led the implementation of Healthy Chicago.

Next, Dr. Bhatt was named chief health officer for the Illinois Health and Hospital Association and president of the Midwest Alliance for Patient Safety, where he continued combining his background in medicine, economics, policy and administration to issues on a state level. Among his accomplishments, he reduced readmissions and patient harms, preventing nearly 6,000 harms and saving $28 million in the first six months of the program across Illinois as well as significantly reducing falls, blood clots and early elective deliveries. “I care about Chicago, I care about Illinois,” he says. “This position gave me an opportunity to work in the government and in the field to help communities.”

These days, Dr. Bhatt brings his skills to the national level at the AHA. In his first 30 days on the job, he launched a network improvement initiative in partnership with the CMS Hospital Improvement Innovation Network with 1,700 hospitals and 32 state partners, with a goal of having zero patient incidents, reducing harms by 20% and reducing readmissions by 12%.

How does this busy physician battle burnout? “Working with patients and their families helps me keep my humility, empathy and resilience,” he says. “I also start each day expressing three moments of gratitude,” he adds. “Before I go to bed I remember one thing that made me smile that day.” Small moments that yield big results.

As chief medical officer for the American Hospital Association, Jay Bhatt, DO, is working hard to reduce harms and readmissions as well as to eliminate patient incidents.

WHO’S WHO
Making Strides for the Community
Internist combines medicine, economics and policy to better healthcare
By Cheryl England

STARTING IN HIS student days as the national president for the American Medical Student Association, Dr. Bhatt has always been a leader. He has been appointed to HHS, CDC, and IOM committees and he is an appointee to the State Health Improvement Planning Council. In 2012, he received his master’s in public administration from the Harvard Kennedy School of Government as a Zuckerman Leadership Fellow and Mongan Commonwealth Fund/Harvard Minority Health Policy Fellow. He was a White House Fellows National Finalist in 2013. He has been awarded the American College of Physicians Walter McDonald Young Physician Award and has been selected for the Presidential Leadership Scholars Program in 2016.
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