Selling Your Practice?

More and More Independent Groups and Solo Practitioners Seek Refuge in Employment

Corporatized Medicine: Time for Physicians to Unionize?

U.S. Healthcare Overhaul Update
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Your Education Portal

As payers and hospitals continue to drive consolidation across the healthcare system, it is becoming more and more difficult for physicians to maintain an independent practice. As noted in this month’s lead feature article, physicians who don’t join a larger medical group or related professional corporation essentially become employees of hospitals or their parent corporations. Over the years, and as described in a second feature piece, some physician-employees and groups have formed unions and engage in collective bargaining, with mixed success. But as employment overtakes medicine, will a stronger union movement emerge for physicians?

These topics are apropos of our June 7-9, 2018, Physician Legal Issues Conference, which will delve into today’s evolving practice world. Physicians can earn up to 21.5 CME credit hours. Each year the Chicago Medical Society teams up with the American Bar Association’s Health Law Section to cohost this wide-ranging program. It is conveniently held on Chicago’s Magnificent Mile, at the InterContinental Hotel. CMS members enjoy a discounted rate.

In addition to contract negotiation, sessions will cover employer and hospital relationships; physician and hospital collaboration; formation of physician super groups; healthcare dispute and conflict resolution; payer-provider contracting; private equity and physician investment; and communication in medicine. Some of our own physician members will serve as speakers during sessions. You’ll also learn more about new payment models and regulatory changes. We have arranged for networking events where you’ll mingle with physician colleagues and health law attorneys.

Last year’s Physician Legal Issues Conference saw attendance nearly triple among CMS members. This interest confirms that physicians want help navigating a rapidly changing practice environment. CMS and ABA answer that need. All medical specialties will find the content useful and informative. Topics include:

- Physician burnout and physician health.
- Clinical integration and physician leadership.
- False Claims Act trends and practical ideas to address and prevent exposure.
- Minimizing the risks in prescribing controlled substances.
- Treating patients who struggle with addiction.
- Current and proposed public policy on addiction issues.
- The Quality Payment Program, MIPS and Advanced APMs.
- How physicians can avoid a payment penalty in 2019.
- Commercial reasonableness of physician compensation.
- Key issues when facing an audit and successful appeals strategies.
- Revisions and clarifications to Stark regulations.
- Advances in technology and professional responsibility concerns.

This is my final call to you urging your attendance. Please check for more details and register by calling 312-670-2550 or visiting: www.cmsdocs.org.

I look forward to seeing you there.

Vemuri S. Murthy, MD
President, Chicago Medical Society
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Healthcare Worker Safety: California Leads the Way

Initiatives address workplace violence and hazardous surgical plumes By Erik Dullea, Esq.

Congressman Khanna’s legislation and California’s workplace violence regulations could serve as templates for other states to follow in developing their own laws and regulations.

IN THE last two months, the healthcare industry has seen both federal and state efforts to further regulate healthcare worker safety. Stakeholders and other jurisdictions are keeping an eye on these developments, which could spread to other states, as well. While the federal legislation is focused on reducing workplace violence at healthcare facilities, an initiative in California will decide what additional regulations should be imposed to remove surgical plume and limit the exposure of healthcare professionals to surgical smoke in the state’s operating rooms.

What Are These Hazards?

On March 8, 2018, thirteen Democrats in the U.S. House of Representatives introduced a bill aimed at reducing the levels of workplace violence at healthcare facilities. The bill is sponsored by Congressman Ro Khanna, who represents California’s Santa Clara and Alameda counties. Unlike other industries where workplace violence may arise between coworkers, in the healthcare profession, violence more often is inflicted by patients against their providers—nurses and residential care providers in particular. When the Government Accountability Office (GAO) analyzed the injury rate for healthcare workers due to workplace violence in 2016, it concluded that the nonfatal workplace violence injury rate for healthcare workers was 5 to 12 times higher than that estimated rate for American workers overall. A few weeks earlier, February 15, the California Occupational Safety and Health Standards Board conditionally granted a petition for rulemaking filed by the California Nurses Association and National Nurses United (CAN/NNU) and ordered the Division of Occupational Safety and Health (Division) to convene a committee to consider the development of additional regulations.

Surgical plume/smoke is a term for the emissions or byproducts from the use of lasers or electrosurgical units. Federal OSHA reports that surgical plumes have contents similar to other smoke plumes, including carbon monoxide, polyaromatic hydrocarbons, and a variety of trace toxic gases. According to the National Institute for Occupational Safety and Health, these plumes could contain biological hazards such as viruses, or toxic chemical vapors including benzene, hydrogen cyanide and formaldehyde. While some remain skeptical about the health risks (not to mention the sales pitches from smoke evacuation equipment manufacturers), other states are now looking into the research and debating whether to enact legislation to limit exposure to surgical plumes.

One of the First Regulatory Responses

While workplace violence and surgical plumes may seem unrelated at first glance, it is worth noting that California and CAN/NNU are both playing key roles in these governmental efforts. Congressman Khanna’s workplace violence legislation is based heavily on California’s existing workplace violence regulations. California’s workplace violence regulations went into effect in January 2017 and are one of the first regulatory responses to the problem of workplace violence in the healthcare sector. CAN/NNU was a strong supporter of California’s new regulations.

CAN/NNU also filed a petition for rulemaking in California, asking the agency to take substantive steps to develop regulations to address the potential hazards posed by surgical plumes. The Cal/OSHA Standards Board approved the petition, and
it directed the agency to consider in its analysis: the proper operation and upkeep of protective equipment; engineering controls; and local exhaust ventilation requirements.

**What’s Ahead for Other States?**
In today’s political climate, there is little likelihood that a piece of federal legislation, sponsored solely by Democrats in one house of Congress is going to become law. However, Congressman Khanna’s legislation and California’s workplace violence regulations could serve as templates for other states to follow in developing their own laws and regulations. Case in point, Massachusetts and Pennsylvania recently introduced workplace violence bills in their legislatures. Accordingly, when California assembles its committee to analyze potential surgical plume regulations, the healthcare sector would be well served if the state solicits input from the full spectrum of providers and stakeholders, because the committee is likely to be developing a solution that other states will emulate.

Even if the proposed laws are not ultimately enacted, oftentimes they prompt stakeholder discussions that lead to changes in workplace policy. For this reason, healthcare providers should consider reviewing their current policies on workplace violence prevention and elimination of surgical smoke in operating rooms. Both are hot topics in healthcare regulation that will continue at the forefront of policy discussions.

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**Patient Rideshares Enter Healthcare**

OIG’s safe harbor protects providers who want to offer transportation services as long as they meet certain conditions **By Darren C. Coates, Esq.**

**THE DEBATE** over providing transportation to patients is nothing new. Hospitals, doctors and other providers have long struggled with whether they can provide free or discounted taxis, shuttles, metro cards or other transportation means to patients to come to appointments and receive care. On one hand, there is evidence that without reliable transportation options, patients are more likely to miss preventative, primary care appointments, increasing the risk of more costly and unnecessary medical services down the road. On the other hand, certain federal laws like the Anti-Kickback Statute (AKS) and Civil Monetary Penalty (CMP) law have given providers serious concerns that such transportation services might be considered an illegal “kickback” to gain patients, or an illegal inducement to receive care.

**So, What Is New?**
First, after years of debating the issue, in early 2017, the Office of Inspector General (OIG) announced a safe harbor that protects a health care provider or other eligible entity (any individual or entity, except those who primarily supply health care items) from AKS and CMP penalties if it provides free or discounted local transportation to Medicare patients and other federal health care program beneficiaries, so long as all of a number of conditions are met.

Second, in early 2018, the two most popular rideshare apps—Uber and Lyft—began partnering with healthcare providers to offer transportation options to patients. Specifically, Uber launched Uber Health that will offer a transportation platform for providers to schedule rides for their patients and caregivers who need help getting to and from medical appointments. Meanwhile, Allscripts is joining forces with Lyft to incorporate patient transportation directly into Allscripts Sunrise EHR so that when a patient’s transportation needs are noted in his or her medical record, a Lyft is automatically scheduled for that patient.

**What Does This Mean?**
Providers are now able to leverage the convenience of these ubiquitous apps to ensure better care for their patients. However, care should be taken to ensure patient rideshares are done in a legally compliant way. Primarily, providers should adhere as closely as possible to the OIG’s safe harbor regulations which require, among other things, that there be a written policy in place which restricts how transportation services are used and advertised. Additionally, since drivers will have access to individually identifiable and/or protected health information, providers must have appropriate business associate agreements in place to comply with HIPAA. Providers should consult with legal counsel well-versed in these laws before implementing a patient rideshare program.

**Darren C. Coates, Esq., is an associate in the Austin, Texas, office of Husch Blackwell, a law firm with offices across the United States.**

“In early 2018, the two most popular rideshare apps—Uber and Lyft—began partnering with healthcare providers to offer transportation options to patients.”
Patients Fear Health Costs

Two in five Americans skip physician appointments due to cost

By Bruce Japsen

Due to the high cost of healthcare, 44% Americans didn’t go see a physician last year when they were sick or injured, according to a new survey from The West Health Institute and NORC at the University of Chicago. The West Health Institute/NORC national poll comes as policymakers and health insurance companies are predicting a jump in health premiums and out-of-pocket costs, particularly for Americans with individual coverage under the Affordable Care Act.

But the new poll indicates physician practices are being hurt by the continued higher costs, which continue to be a barrier to treatment with 40% of Americans saying they “skipped a recommended medical test or treatment in the last 12 months due to cost.” Another 32% were “unable to fill a prescription or took less of a medication because of the cost,” the West Health/NORC poll of more than 1,300 adults said.

“The high cost of healthcare has become a public health crisis that cuts across all ages as more Americans are delaying or going without recommended medical tests and treatments,” West Health Institute chief medical officer Zia Agha, MD, said in a statement accompanying the poll results. “Most Americans do not feel they are getting a good value for their healthcare dollars, and the rising cost of healthcare is clearly having a direct consequence on American’s health-and-financial well-being.”

The poll comes despite an estimated $3.3 trillion that the U.S. spends annually on healthcare and 74% of adults don’t think Americans “get good value for what the country spends on healthcare.” Meanwhile, 25% of Americans feel they do get good value for what the country spends. “It’s shocking and unacceptable that medical bills strike more fear in the hearts of Americans than serious illness,” West Health Institute president and chief executive officer Shelley Lyford said.

Yet even as Americans don’t think they get a good value of what the U.S. spend on healthcare, most would like to see increased spending across areas of the federal budget including Obamacare and programs under the ACA. Take the Medicare health insurance program for the elderly as an example. More than half, or 56% of American adults would like to see their “representative in Congress vote to increase spending.” Just 10% would like to see Medicare spending decreased while 33% would keep spending the same.

When it comes to Medicaid health insurance for the poor, however, not as many Americans want to see more spending. Less than half, or 42%, of adults want to see their “representative in Congress vote to increase spending” on Medicaid. Still, there are far more Americans who want to see an increase in Medicaid spending than see such spending on poor patients decrease. There are just 17% of Americans who want to see Medicaid spending decreased and 39% want to see such spending kept the same.

In addition, Americans want to see more spending on government subsidized individual private coverage under the ACA known as Obamacare,

Fear of Paying for Care vs. Fear of Serious Illness

Healthcare costs are a looming fear for many Americans. Those who report experiencing negative financial impacts due to healthcare costs say they are more afraid of the expenses that come with serious illness than of the illness itself.

Question: How afraid are you of...

Source: West Health Institute/NORC poll conducted February 15-19, 2018, with 1,302 adults nationwide
Support for Single Payer System Increased Over the Past Year

Question: Would you favor or oppose a single payer healthcare system, in which all Americans would get their health insurance from one government plan?

Source: West Health Institute/NORC

In February 2018, 46% of Americans strongly or somewhat favored a single payer healthcare system, compared to 38% who said the same in an AP-NORC poll conducted in January 2017. Opposition to single payer decreased during the same period, to 28% in 2018 from 39% in 2017. The number who say they neither favor nor oppose has remained steady.

Several recent polls have indicated healthcare is back on the top of voters’ concerns as they head to the polls this November for mid-term Congressional and statewide general elections. A Kaiser Health Tracking poll published earlier this month ranked “healthcare costs as the top health care issue mentioned by voters when asked what they want to hear 2018 candidates discuss.”

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poll conducted February 15 - 19, 2018, with 1,302 adults nationwide

with 37% wanting their Congressional representatives to increase spending on the ACA. Just 33% want to see ACA spending decreased and 27% want to keep such ACA spending the same.

It’s the latest poll showing Americans have increasing concerns with the healthcare system and it comes in a critical election year. “Americans are paying more for healthcare than they should and getting less than they deserve,” Lyford said. “Bold action is required to lower the sky-high cost of healthcare. The very health and wealth of our nation and its people are at stake.”

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Adverse Childhood Experiences
Understanding and addressing the health implications

By Anna Gonzales, MPH, Michelle D. Hoersch, MS, and Lesley J. Craig, MPH

May is National Mental Health Month. It was established in 1949 to raise awareness of the importance of mental health, overall wellness, and to celebrate recovery from mental illness. Nearly 70 years later, the observance serves to increase awareness of trauma and the impact it can have on the physical, emotional, and mental well-being of individuals of all ages and backgrounds, as well as their communities. The U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) also recognizes National Children’s Mental Health Awareness Day each May 10 to emphasize the importance of children’s mental health and demonstrate that positive mental health is essential to a child’s healthy development.

Childhood experiences, whether positive or negative, can have a tremendous impact on a child’s future health and wellbeing. Among health professions, there is growing attention to the influential nature of Adverse Childhood Experiences (ACEs). ACEs are stressful or traumatic events, such as abuse, neglect, and exposure to household challenges, which can impact neurologic and physiologic development; they are associated with a wide range of health problems throughout an individual’s life.

Health and Social Impacts of ACEs
The seminal Adverse Childhood Experience (ACE) Study, conducted by Kaiser Permanente and the Centers for Disease Control and Prevention (CDC), confirmed, with scientific evidence, that adversity early in life increases the risk for negative physical, mental, and behavioral outcomes later in life. The ACE Study administered confidential surveys to more than 17,000 individuals looking retrospectively at their childhood experiences, as well as current health status and behaviors. The study looked specifically at the following: physical abuse; mother treated violently; sexual abuse; emotional abuse; emotional neglect; physical neglect; household substance abuse; mental illness in household; parental separation or divorce; criminal (incarcerated) household member. Nearly two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. The results demonstrate that ACEs are very common and that in aggregate, a dose-response relationship exists in which the number of ACEs an individual experienced is associated with an increased risk of poor health and social outcomes.

When children are exposed to stressful or traumatic events, their neurodevelopment can be disrupted or dysregulated. This can impair a child’s cognitive functioning and emotional regulation. To cope, during sensitive times like adolescence, children may engage in unhealthy coping behaviors, such as substance misuse or self-harm. Eventually, such coping mechanisms may contribute to disease, disability, social problems, and even premature death.

For example, ACEs have been shown to increase risk for health consequences such as ischemic heart disease, chronic obstructive pulmonary disease, liver disease, sexually transmitted infections, unintended and adolescent pregnancy, issues associated with substance misuse (alcohol, smoking, and illicit drugs) and poor mental health (depression and suicide attempts). ACEs have also been associated with increased risk of social outcomes including, intimate partner and sexual violence, poor work performance and academic achievement, and financial stress.

Providing Health Care
We can all play a role in preventing ACEs by creating and sustaining safe, stable, nurturing relationships and environments for all children. Health care providers can also employ integrated approaches to care for the needs of children, youth, and young adults, as well as their families, most of whom have experienced some degree of ACEs and trauma.

SAMHSA and the Health Resources and Services Administration (HRSA) have partnered to develop the Center for Integrated Health Solutions (CIHS). CIHS promotes the development of integrated health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care medical settings. This may include use of care managers or behavioral health consultants in primary care settings and meetings between those care facilities/settings to discuss specific patient cases and/or systems coordination.

CIHS provides training and technical assistance to support systematic coordination between primary care and behavioral health organizations to better address chronic illnesses, like hypertension and diabetes, substance misuse, and behavioral health issues to produce improved patient outcomes and streamline care for those with multiple health care needs. For a free one-hour integration consultation, contact integration@thenationalcouncil.org or 202-684-7457 to learn more.

Anna Gonzales, MPH, is a Captain in the U.S. Public Health Service and Acting Regional Health Administrator at the U.S. Department of Health and Human Services (HHHS), Office of the Assistant Secretary for Health (OASH) – Region 5 (IL, IN, MI, MN, OH, WI). Contact us at Lesley.Craig@hhs.gov.
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Revolutionizing Payment

Alternative model combines payment for treatment of opioid use disorder

“A CONCEPT PAPER by the American Medical Association and the American Society of Addiction Medicine describes a “groundbreaking” alternative payment model (APM) that would not only increase the number of clinicians who provide medication-assisted treatment (MAT) but also increase the utilization of such treatments for opioid use disorder.

Patient-Centered Opioid Addiction Treatment (P-COAT) expands medical, psychological and social support services for individuals with opioid use disorder, and it coordinates the delivery of these office-based services among multiple treatment providers. While the model would require appropriate financial support to succeed, the investment would lead to improved quality of life and reduced spending, according to the authors. Patients with opioid use disorder, the authors point out, make frequent ED visits and have longer hospital stays.

Two-Part Payment Structure
Payment would no longer be segregated, making it easier for patients to receive comprehensive care. P-COAT consists of two types of payments for phases of office-based opioid treatment—initiation of MAT and maintenance of MAT. An initial payment covers evaluation, diagnosis and treatment, as well as initial outpatient MAT. The second payment supports ongoing outpatient medication, psychological treatment and social services.

The authors present different treatment scenarios based on the intensity and level of services for individual patients. Options for medical management and delivery of services are fully discussed.

Patients taken to the ED for a drug overdose could be referred to a physician practice, or unit inside the same hospital for assessment and placement on a treatment plan, the concept paper says. Currently, patients who go to the ED may end up waiting in a hospital detox unit to stabilize while a provider seeks to refer them to an outside treatment facility. If no facilities are available, a hospital has few other options but to discharge the patient.

P-COAT would enable physicians/clinicians and addiction specialists other than psychiatrists to communicate by phone or email to help primary care practitioners to diagnose and develop effective treatment plans. The paper calls for add-on payments to support the integration of technology-based treatment.

The Blue Cross Blue Shield Association recently reported that the number of members with an opioid use disorder diagnosis surged 493%, while the number of BCBS individuals using MAT only rose by 65%. This means the rate of diagnoses grew

Chicago and Cook County Data
LIKE MUCH of the United States, Illinois faces a shortage of providers who prescribe buprenorphine compared to the number of opioid overdose deaths.

As of February 2017, there were 715 private physicians in Illinois with waivers to prescribe buprenorphine for the treatment of opioid use disorder, according to the Illinois Department of Human Services. More than 400 of these physicians were in Cook County but that does not mean every physician with a waiver prescribes buprenorphine.

Of the 2,278 statewide drug overdose deaths during 2016, more than 80% were opioid-related fatalities. The 1,826 opioid-related overdose deaths among Illinois residents in 2016 represent an increase of more than 70% from 2013, and a 32.1% increase from 2015.

Cook County accounted for nearly 50% of opioid overdose deaths in Illinois during 2016. The 911 opioid overdose deaths reported for Cook County in 2016 represent an 87.4% increase from 486 such reported deaths in the county during 2013. In Chicago itself, the 581 reported opioid overdose deaths in 2016 represent a 93% increase from the 301 deaths reported in 2013.

The counties bordering Cook and other counties with relatively high resident populations, particularly Madison, Peoria, St. Clair, and Winnebago counties, were major contributors to the statewide number of opioid overdose deaths in 2016.

The data also show the number of EMS runs that required two naloxone administrations increased by over 50% from 2013-2015, and the number of runs that required three administrations increased by over 75% during this time period. This increase can be attributed to the presence of fentanyl and other synthetic opioids in the substances being used.

Public health agencies encourage patients (and their family and friends) to carry naloxone. Any pharmacy with a standing order for the medication can dispense it over the counter. Naloxone comes in a nasal spray (Narcan) or an injectable form that can be given intramuscularly, subcutaneously, or intravenously. Naloxone does not work on benzodiazepine or barbiturate overdoses.
nearly eight times as quickly as the MAT use rate.

As of January 2018, more than 45,000 physicians were certified to prescribe buprenorphine, a drug used in MAT, according to the Substance Abuse and Mental Health Services Administration. Although that number has significantly increased in recent years, 72% of certified physicians are limited to treating 30 patients, with the remainder certified to treat up to 275 patients. An estimated 40% of physicians who become certified do not write any prescriptions for buprenorphine.

SAMHSA started allowing clinicians to treat up to 275 patients with buprenorphine in 2016, up from the prior limit of 100. The Comprehensive Addiction and Recovery Act, which was signed into law in 2016, allows nurse practitioners and physician assistants to prescribe buprenorphine to 30 patients a year if they obtain a federal waiver and complete 24 hours of training. Physicians must complete eight hours of training.

**Current Treatment Barriers**
P-COAT seeks to overcome the following barriers within the current healthcare payment systems:

- Poor integration of MAT as a pharmacy benefit into insurance coverage and mental health benefits.
- Payments for behavioral health services agencies do not require coordination with medical therapies delivered by physician practices.
- Inadequate payment for behavioral health services delivered by primary care and addiction specialist practices; unnecessarily and unrealistically high credentials required for billing.
- Prior authorization requirements for medications and intensive outpatient services.
- Insufficient E&M service payments to support the time needed to identify and diagnose an opioid use disorder and to develop a treatment plan a patient is willing to pursue.
- E&M service payments require face-to-face visits with patients and there is limited support for telephone, email, or other electronic communications with patients.
- Lack of insurer payment for technology-based treatment and recovery support tools, and remote monitoring.
- Highly complex billing for substance use disorder services that continues to evolve with passage of federal and state legislation.
- Lack of insurer reimbursement for transportation, housing or other non-medical services related to patients’ addiction treatment.

The ASAM and the AMA are seeking physician practices and insurers to participate in pilot testing P-COAT. Interested parties can provide their contact information at [https://www.surveymonkey.com/r/PCOAT](https://www.surveymonkey.com/r/PCOAT). To read the concept paper, go to [https://www.asam.org](https://www.asam.org).

"As of February 2017, there were 715 private physicians in Illinois with waivers to prescribe buprenorphine for the treatment of opioid use disorder."

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HE TRUMP administration has shown itself willing, and able, to make numerous policy and regulation modifications throughout its incumbency thus far. U.S. healthcare has been no exception, with a continuing stream of alterations to existing policy and practice in April 2018.

On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) released its final 2019 payment notice rule, a lengthy document that makes substantive changes to numerous provisions contained within the Patient Protection and Affordable Care Act (ACA). In addition, on April 10, 2018, President Trump signed an executive order entitled “Reducing Poverty in America by Promoting Opportunity and Economic Mobility,” which imposes work requirements on U.S. beneficiaries of low-income federal aid programs. Both of these actions, consistent with the president’s campaign promises, were implemented with little fanfare, but they will have a potentially substantial impact on American consumers.

Essential Health Benefits

Along with the 2019 final rule, CMS published several guidance letters to clarify many of the provisions contained within the extensive text. Those with the most potential to directly impact consumers include the lifting of several restrictions related to the Essential Health Benefits (EHB) requirement of the ACA; under the new rules, states will no longer be limited to the existing ten (10) EHB options, but will have the flexibility to utilize any of the 50 state EHB plans used in 2017, or select their own unique set of EHB requirements, so long as they fall within the scope of federal guidance.

Medical Loss Ratio

In addition, the Medical Loss Ratio (MLR) requirements of the ACA, which stated that insurance issuers were required to spend at least 80% of their annual earned premium on Quality Improvement Activities (QIA) for the benefit of consumers, were relaxed to make it easier for payors to request a downward adjustment of the standard 80% MLR.

Hardship Exemptions

Perhaps most significant, the rule has expanded the criteria related to the “Hardship Exemptions” that were originally imposed under the individual

Medicare Part E for All Proposed

A NEW MEDICARE program has been proposed but passage remains uncertain. Since the fall of 2017, the Trump Administration has used its executive and regulatory authority to roll back coverage requirements for Affordable Care Act health plans and expand access to association health plans that would be offered outside of ACA’s exchanges to small businesses and self-employed individuals. In response to the administration’s efforts, Congressional Democrats recently released The Choose Medicare Act, a legislative proposal that would permit, but not require, non-Medicare age individuals and businesses to opt into health insurance coverage offered under a new Medicare Part E program financed by premium payments just as private insurance is today. The Choose Medicare Act, which was released on April 18, would not replace ACA exchange plans. Instead, new Medicare Part E plans would be offered on the ACA exchanges alongside other private exchange plan options. The Choose Medicare Act is intended to build on ACA’s protections. Key features are:

- Make new Medicare Part E plans available to individuals of all ages in all 50 states.
- Open Medicare to allow all employers to purchase health coverage for employees without replacing employment-based health insurance.
- Provide employees an option to choose Medicare Part E over their employer offered coverage.
- Mandate coverage of essential health benefits plus all items and services covered by Medicare.
- Increase the generosity of premium tax credits and extend eligibility of these credits to middle-income earners.
- Allow Medicare to negotiate prices for prescription drugs (a proposal that enjoys bipartisan support as well as support from the Trump administration).

The Choose Medicare Act is the fifth Democratic proposal to support the ACA. Without action to ensure the long-term viability of the ACA’s exchange plans or Trump administration initiatives to stabilize the exchange marketplace, the Choose Medicare Act aims to provide an alternative to the ACA.
mandate of the ACA. The expanded criteria allowing consumers to opt out of purchasing health insurance will account for those consumers who:

- Live in an area where no qualified health plan (QHP) is offered through the federal health exchanges.
- Live in an area where there is only one insurer offering coverage through the exchanges.
- Only have access to QHPs that provide coverage for abortion services, contrary to one’s beliefs.
- Have other demonstrable “personal circumstances that create hardship in obtaining health insurance coverage under a QHP.”

This guidance, effective immediately, will allow increased flexibility for U.S. healthcare consumers to avoid purchasing healthcare insurance until the repeal of the individual mandate becomes effective in 2019.

Lower Premiums, Fewer Benefits

The multitude of changes in the 2019 final rule are the latest efforts of the current administration to reduce or otherwise undercut the impact of the ACA, which Congress so far has failed to repeal. However, while couched as tools with which to “mitigate the harmful impacts of Obamacare” (skyrocketing premiums) and increase flexibility; affordability; integrity; and, stability of marketplace insurance options, the proposed changes may not have the intended effect. For example, with more leniency regarding EHB requirements, insurers may be able to provide decreased premiums, but at the cost of fewer consumer benefits.

Additionally, the new changes are not expected to offset the Congressional Budget Office’s (CBO) estimated 34% premium increase of silver-level insurance plans in 2018 (and expected $33 billion increase in the federal deficit by 2028 related to health insurance subsidies) as a result of the administration’s Oct. 12, 2017, decision to stop funding cost-sharing reductions under the ACA. However, it’s important to note that the deficit would be an estimated $297 billion more from 2018 to 2027 if the individual mandate were still in effect during that time frame.

Medicaid Work Requirements

In a separate (but equally impactful) move, the April 10, 2018, executive order signed by President Trump essentially requires implementation of work restrictions for any individuals utilizing low-income assistance (welfare) programs. This action builds upon the recent guidance by the federal CMS, which permits states to acquire a Section 1115 Medicaid waiver for the purpose of imposing work requirements as a condition of Medicaid eligibility. As of April 9, 2018, ten states have been approved and/or are pending approval of a Section 1115 Medicaid waiver to implement work requirements.

The executive order, which seeks to address “the economic stagnation and social harm that can result from long-term government dependence,” targets any federal assistance program for “people, households, or families that have low incomes...the unemployed, or those out of the labor force,” which notably includes not just cash assistance programs, but several safety net programs, the Supplemental Nutrition Assistance Program, formerly known as food stamps, and Medicaid.

Less Regulation, Record Deficits

In contrast to the arguably more publicized political stalemate that has plagued Republican congressional efforts to “repeal and replace” the ACA since 2010, within the past few weeks, the current administration has clearly illustrated its willingness and capability to make rapid changes to policy and practice within the confines of the executive branch of U.S. government. The most recent examples of this—the 2019 final rule and the April 10 executive order—both demonstrate a principle that continues to underpin the trajectory of the Trump administration, for example, “loosening the reins” of federal healthcare regulation. However, with a federal budget threatening to break deficit records, it remains to be seen whether the administration’s tactics will be effective at achieving its long-term overall goals.

Todd A Zigrang, MBA, MHA, is president of Health Capital Consultants, a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, and serving clients in 49 states. Jessica Bailey-Wheaton, Esq., is vice president and general counsel of HCC.

“While couched as tools with which to ‘mitigate the harmful impacts of Obamacare,’ the proposed changes may not have the intended effect.”

Working With the Bar

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

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

If you have a particular question or would like more information on a subject, please send us your suggestions. You can send an email to Elizabeth at esidney@cmsdocs.org.
New Standard of Materiality in FCA Litigation

Escobar decision gives wake to new vigor for defense By Adrienne Dresevic, Esq.

IN THE world of litigation healthcare providers can potentially fall victim to the False Claims Act (FCA) when they file medical claims for reimbursement from either Medicaid or Medicare. FCA claims against hospitals and other healthcare related entities usually involve allegations that the healthcare provider knowingly or recklessly filed a false claim for payment from a federally funded government program. Under the FCA qui tam provisions, private citizens, known as “relators,” can file lawsuits when they have suffered no personal injury. Instead, these relators allege the federal government was defrauded and can obtain a substantial monetary reward if they are successful in recovering a judgement from the court.

A hotly contested issue in qui tam cases is whether the violation of the regulation alleged in the case is material to the government’s obligation to pay a healthcare claim. For instance, whenever a physician or supplier of medical services completes a form 1500, it certifies the claims were medically indicated and necessary and that any “false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.”

Historically, the issue in a lot of cases involving alleged false claims is whether the claim made by the healthcare provider is either a “condition of payment” or a “condition of participation” in the governmental program. If the alleged false claim only violated a condition of participation, as opposed to a condition of payment, then there could be no false claim in violation of the FCA.

Courts reasoned that conditions of payment were central to the government's decision to pay claims as opposed to a mere violation of a condition of participation that could be handled administratively by the enforcing governmental agency.

Court Abandons Old Condition of Payment Standards

After the U.S. Supreme Court’s ruling in Universal Health Servs. v. United States ex rel. Escobar 136 S. Ct. 1989 (2016), the old condition of payment or condition of participation standards for materiality were largely abandoned. Instead, the Supreme Court, adopted a new “rigorous” materiality standard. Although promulgated conditions of payment in statutes or regulations are relevant in attempting to establishing materiality, they are not “automatically dispositive.”

Moreover, the Supreme Court held that “a misrepresentation cannot be deemed material merely because the government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the government would have the option to decline to pay if it knew of the defendant’s noncompliance.” Escobar, a relator, is now faced with a steeper climb to show that the violation of a particular statute or regulation is material to the government's decision to pay the medical claim.

Recent cases show that healthcare providers may have an opportunity to end litigation early from would be relators at the motion to dismiss stage because of a lack of materiality. A motion to dismiss can be used to show the court at the beginning of a lawsuit that a healthcare provider’s alleged regulatory violations were not material to the government’s decision to pay claims. More specifically, district courts have ruled that mere conclusory allegations that the false statement is material to the government’s payment decision is inadequate to avoid dismissal. See, for example, United States ex rel. Payton v. Pediatric Servs. of Am., Inc., (holding that a complaint “must do nothing more than simply state that compliance is material”); United States v. Scan Health Plan, (dismissing claim based “only on conclusory allegations that the defendants’ conduct was material”). Moreover, a relator must show “how the misrepresentations or false claims were material” to the government’s decision to pay claims (United States ex rel. Mateski v. Raytheon Co.).

Thus far, Escobar’s materiality standard has only been applied to implied certification cases. Implied certification means that the healthcare provider certifies that when it completes form 1500 or “certifies” the accuracy, truthfulness, and completeness of a medical claim to the government, it is implied that it did so in conformance with applicable law. Express certification, on the other hand, involves claims that specifically state the regulation or statute to be adhered to when filing claim.

The question of whether the Supreme Court will apply its new materiality standard to express certification cases is due for review this year and may shed light on the scope of Escobar’s materiality standard when applied to express certification cases.

Adrienne Dresevic, Esq., practices in the New York City office of Greenberg, Dresevic, Iwrey, Kalmowitz, Lebow & Pendleton Law Group, a division of The Health Law Partners, PC. She can be reached at adresevic@thehlp.com.
When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela’s EKG, and sent an image of the recording to the on-call cardiologist via DocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quick thinking and the secure mobile app, DocbookMD.

DocbookMD is a free benefit of your CMS membership. Learn more about the app at docbookmd.com.
**Feel Like Selling Your Practice? You’re Not Alone**

Independent physician practices are disappearing at a breakneck pace

By Bruce Japsen

Physicians are selling their practices at an unprecedented pace in Chicago and across the United States as quality measures from government and private insurers take hold and doctors need the financial help of larger entities to practice the medicine of the future.

Historically, the reasons for practice sales are many and range from an aging physician workforce that is retiring to the need for doctors to gain leverage against rapidly consolidating health insurance companies that are squeezing reimbursement to physicians.

But lately practice sales and related consolidation are being fueled by additional administrative burdens from the need to invest more in information systems and technology, thanks to the Medicare Access and CHIP Reauthorization Act, known as MACRA. Independent physician groups are under more pressure to seek refuge in a larger practice or health system if they cannot afford what’s necessary in the move to quality measurements under value-based care payment models.

“While final MACRA rules issued in late 2017 ease or delay some of the impacts on small practices, patient outcomes are much more important under MACRA, driving the need for strong data collection and analysis infrastructure and capabilities, and contributing to the trend of physician practices seeking to join larger, more developed, and better capitalized entities,” Skokie-based healthcare business consulting firm Kaufman Hall said in a new report out this spring.

The trend of the disappearing independent solo practitioner was escalating even before MACRA, with just one-third of U.S. physician groups considered independent today, the Kaufman Hall report shows. That compares with nearly 60%, or 57% of physician groups considered independent in 2000.

**The Percentage of Employed Physicians Increased by Nearly 11% in July 2016 Compared to the Prior Year**

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<th>EMPLOYMENT OF PHYSICIANS</th>
<th>PERCENT OF HOSPITAL-EMPLOYED PHYSICIANS</th>
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<tr>
<td>26% July 2012</td>
<td>27% January 2013</td>
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<tr>
<td>29% July 2013</td>
<td>30% January 2014</td>
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<td>31% July 2014</td>
<td>36% January 2015</td>
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<tr>
<td>41% July 2016</td>
<td>42% January 2016</td>
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- 42 percent of physicians were employed by hospitals in July 2016, compared to just one in four physicians in July 2012.
- Growth occurred throughout the four-year period, with some of the fastest acceleration occurring in late 2014.

*Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

*In July 2016, the total number of physicians decreased. As a result, the number of employed physicians decreased slightly but the percentage employed physicians increased.*
“The employed physician model is not going away in part because many physicians, overwhelmed by the costs and pressures of private practice, are seeking employment as a refuge.”

But in recent years, independent practices are consolidating much faster than a decade ago. Physician group “transactions” are up 37% over 2016, Kaufman Hall said with the number of deals recorded in 2017 reaching 160, which was nearly double the 88 deals recorded just two years earlier in 2015.

The increasing number of practice sales is being driven by more than just hospitals and health systems looking to expand. Health insurance companies, too, see an opportunity to grow their market share, in effect taking advantage of vulnerable independent practices. Health insurance companies are gaining more leverage through mergers and melding their operations with larger medical care providers as well.

Measuring Doctors Requires Capital Physician Groups Don’t Have

“As payers and hospitals continue to drive consolidation across the health care system, it is becoming more and more difficult for a physician to maintain an independent practice,” Robert Seligson, president of the Physicians Advocacy Institute, which in March issued a new report with healthcare research and consulting firm Avalere Health on physician practice consolidation. “Payment policies mandated by insurers and government heavily favor large health systems, creating a competitive advantage that stacks the deck against independent physicians, who are already struggling to survive under expensive, time-consuming administrative and regulatory burdens.”

As one example, insurers and the Medicare program are contracting with more accountable care organizations (ACOs), which organize groups of doctors and hospitals beneath the same umbrella entity. The ACO then contracts with private insurers or the Medicare program to care for a population of patients that can involve hundreds or even thousands of health plan enrollees.

UnitedHealth Group, the nation’s largest health insurer, now contracts with more than 580 ACOs compared with 400 just two years ago. UnitedHealth’s ACOs pay doctors via alternative value-based payment models like ACOs and bundled payments. By 2020, UnitedHealth is expected to pay $75 billion in reimbursement to providers via value-based models compared to $13 billion in such payments in 2011.

In Just One Year, 5,000 Independent Practices Bought by Hospitals

For those physicians who don’t join a larger medical group or related professional corporation, they are essentially becoming employees of hospitals or their parent corporations. To get an ACO contract, for example, analysts say they would need the ability to care for large numbers of patients and have adequate technology and related information system infrastructure.

A snapshot of this rapidly evolving trend can be seen in a new analysis published in March by the Physicians Advocacy Institute, which said 5,000 independent physician practices were acquired by hospitals from July 2015 to July 2016. That translates into an increase of nearly 11%, or 14,000 total physicians who became employed by hospitals during the same time period. By July 2016, 42% of physicians were employed by hospitals, compared to just 25% in 2012, the Institute said. That’s a 63% increase from 2012 to 2016.

The Institute’s numbers echo the trends documented by Avalere Health, which has compiled data on hospital/health system ownership of physician practice locations. The Institute’s analysis was based on Medicare 5% Standard Analytic Files.

As of July 2016, the Percentage of Hospital-Employed Physicians Increased Between 5% and 22% from the Prior Year in Every Region Across the Country

HOSPITAL-EMPLOYED PHYSICIANS BY REGION

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<td>Northeast</td>
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<td>South</td>
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<td>Midwest</td>
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More than half of all physicians in the Midwest are employed by hospitals. Rates of employment are lowest in the South, where 37% of physicians are employed by hospitals, and in Alaska and Hawaii, where 33% are employed.
by the physician staffing firm Merritt Hawkins for the Physicians Foundation, which reported last year that less than one-third or 32.7% of physicians were independent practice owners in 2016. That compares to almost half, or 48.5%, of physicians that were independent practice owners in 2012 and then further falling to 34.6% of physicians in 2014. “The employed physician model is not going away in part because many physicians, overwhelmed by the costs and pressures of private practice, are seeking employment as a refuge, and because the market is pushing for greater integration,” said Phil Miller, vice president of communications for Merritt Hawkins and its parent company, AMN Healthcare.

No region of the country is immune to the trend. In Chicago, for example, Advocate Health Care said its “fastest growing segment” is Advocate Medical Group thanks in part to buyouts of smaller practices and the growth of physician services. In the last year, Advocate has added more than 230 new physicians, which is a 17% increase from the previous year, Advocate said. This includes the acquisition of more than 15 private practices that have brought more than 40 physicians into Advocate Medical Group.

“We are in the throes of an arms race between hospitals and payers to acquire physician practices and control the means of production in healthcare.”

Advocate said many of the practices being acquired are physicians approaching the larger health system. “Today, many physicians do not want to manage all the operational aspects of running an independent practice,” Dr. Bufalino says. “Leading a small business enterprise can leave significantly less time for the practice of medicine. Being responsible for human resources, information technology, contracting, regulatory compliance and more can be a burden for some physicians.”

“Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

Northeast | South | Midwest | West | AK & HI | National
--- | --- | --- | --- | --- | ---
Percent of Practice Locations in Region


More than one-third of Midwest physician practices were hospital-owned in 2016. Rates of practice ownership increased in every region over the entire time period.
physicians who really want to concentrate on patient care and service.”

**A Bidding War for Doctor Practices**

Though Advocate wouldn’t disclose financial terms of their transactions, industry consultants say independent practices looking for a good price will likely get one. Some doctors who want to sell could become subject to a bidding war, according to analysts.

Aside from large hospital systems like Advocate Health Care, large health insurers are snatching up doctor practices. Hospital systems that have historically done battle with their own are now facing new rivals like the Optum medical care provider unit of UnitedHealth Group, the nation’s largest health insurer, which last year said it would spend $5 billion to get DaVita Medical Group and its clinics and urgent care centers that treat 1.7 million patients annually in about six states. Meanwhile, CVS Health, which owns pharmacies and retail clinics, is buying Aetna for $69 billion and plans to fill out its networks with other outpatient facilities including doctor practices over time, analysts say.

Rival insurers like Centene, Anthem and Humana that haven’t historically been big operators of doctor practices say they, too, are looking to grow their medical care provider businesses. Humana last month said it would be rebranding all of the doctor practices it has purchased in Florida and Texas in recent years under the “Conviva” name and isn't ruling out expanding in other markets it operates including the Chicago area.

Aside from a good price for their practice, hospital and health insurers buying practices say independent physicians will avoid rising expenses down the road, analysts say. Says John Gorman, founder and executive chairman of The Gorman Group: “We are in the throes of an arms race between hospitals and payers to acquire physician practices and control the means of production in healthcare.”

**Bruce Japsen** is a health care journalist, speaker, author and regular contributor to Chicago Medicine who also writes for Forbes. He is a regular analyst on health, business and political topics to WBBM Newsradio and WTTW television’s Chicago Tonight program and Fox Business News and Fox News Channel’s weekend business news shows. He can be reached at brucejapsen@gmail.com.
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In 1512, King Henry VIII of England struck a deal with a group of doctors who offered to treat his country’s subjects being ravaged by the plague, in return for his endorsement for the creation of the Royal College of Physicians. The deal was a historic compromise—the gift of “[physician] autonomy in return for fidelity.”

Since that time, the healthcare industry has experienced a significant and unprecedented amount of change. Physician autonomy and practice have continuously been transformed into an industry enterprise, “…whereby healthcare services have been unitized, protocolized, and homogenized, in order to facilitate their sale in the market, just as if they were any other fungible market commodity, little differentiated from soybeans and pork bellies.” In other industries, such as manufacturing and transportation, this imbalance in power between the workers and their corporate employers has spurred the development of unions, so that workers could obtain better leverage to negotiate for better wages and/or working conditions. The popularity of physician unions, however, has not grown at the same rate as in other industries.

The concept of unions and collective bargaining was born in the labor industry and has been entrenched in American society for centuries. However, the adoption of unions was only popularized in the healthcare sector during the past several decades, beginning with the passage of the National Labor Relations Act (NLRA), aka the Wagner Act, in 1935, which gave most private-sector employees, including healthcare workers, the right to unionize. Since that time, the NLRA has undergone several iterations that have both directly and indirectly affected the healthcare industry (see “Timeline of Regulatory Changes Affecting Healthcare Labor Unions” on the next page).

Healthcare union membership has steadily climbed over the past several years, including as recently as 2015, concurrent with the healthcare hiring boom. However, these increases do not appear to be a continuing trend. According to the Bureau of Labor Statistics (BLS), union membership has, on average, declined over all industries from 2015 to 2016, including the healthcare industry, despite its employment increases. Although unions have been utilized by various industries over the years, including the nursing profession, to vie for workers’ rights, physicians have not followed that same path, in spite of increasing regulation and scrutiny of the medical profession.

Why is Medicine Slow to Embrace Unionization?
The healthcare industry in general, and hospitals and physician practices in particular, have progressively consolidated over the past several decades. This comes in response to a multitude of factors, including the need for greater leveraging power against payors and specialty competitors, and more recently, as a strategy to reduce costs and improve efficiency and quality through economies of scope and scale.

However, the physician population has been slow to unionize, for several potential reasons: (1) regulatory hurdles, such as the NLRA and antitrust laws; (2) lack of incentive due to the availability of other options; (3) historical use of trade and industry associations as a lobbying alternative to unions; (4) the intrinsic autonomy of physicians; and (5) an inherent professional conflict with the use of strikes (refusing to treat patients) as a tool for collective bargaining.

Anti-trust Laws
Physicians have been hesitant to engage in collective bargaining partly because independent practitioners who engage in this activity may potentially run afoul of antitrust laws, such as the Sherman Act and the Clayton Act. Under antitrust laws, it would be considered illegal for independent physicians and physician groups that are not already affiliated, or financially integrated, to pursue collective bargaining. To do so would be construed as anti-competitive, or as a horizontal agreement among competitors with the potential to restrain trade (by fixing prices).

However, antitrust regulations do not apply to physicians employed within affiliated hospitals or health systems, allowing for the reality of physician
unions in the hospital setting. The growing trend of physician employment (in contrast to the historically large numbers of independently practicing physicians who would be subject to antitrust violations) has allowed physicians the opportunity to participate in collective bargaining.

**Surplus of Employment Options**

Another reason physicians may be slow to organize is the availability of other options, which may be less onerous, and thus render unions unnecessary. Demand for physician services in the U.S. has remained high for decades, prompting increases in medical school and residency training enrollment, and is expected to remain so, due to changing patient demographics, aging of Baby Boomers and longer life expectancy. The surplus of employment options for physicians allows them to simply leave a position if unsatisfied; it may take an exodus of only a few physicians from a given hospital or system before c-suite executives are convinced to change the organization’s policy.

**Trade Associations**

Physicians and residents have relied heavily on medical trade associations to lobby for federal legislation or conduct high-level negotiations. While individual hospitals and organizations have their own individual policies, practices, and idiosyncrasies, many of the sweeping changes to healthcare have occurred on a federal level in the last few years, through the Affordable Care Act (ACA).

Medical associations have been the chief voice on behalf of physicians during these federal debates, groups such as the American Medical Association; American Association of Medical Colleges; American College of Physicians; American Academy of Family Physicians, and other physician specialty groups actively opposed the recent attempts to repeal and replace the ACA. Other legislative changes, such as proposed updates to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act (MACRA), were also met with contentious debate by various medical groups, like the AMA, the American Medical Group Association, and the Medical Group Management Association.

“Physicians have historically clung to individual autonomy not only in practice, but in voicing their opinions.”

**Ingrained Individual Autonomy**

Even with the use of medical trade associations for lobbying power, physicians have historically clung to individual autonomy not only in practice, but in voicing their opinions. The reason for this is the same as that which underlies physicians’ inherent distrust of hospitals and other large employers—the professional oath to practice “medicine...one patient at a time” often seems to be directly at odds with an organization that often must consider the good of “all” over the good of “one.” Even the largest physician trade association, the AMA, has felt the backlash of physicians who disagreed with its decisions. For example, in 2016, three physicians wrote a letter to the AMA opposing its support of the nomination of Tom Price, MD, for Secretary of Health and Human Services (HHS), which garnered over 6,000 physician signatures and stated, “the AMA
represents approximately a quarter of physicians in the U.S.—a loud, but minority voice. It certainly does not speak for us.”

The “Right to Strike” vs. “First Do No Harm”

Despite the reasons discussed here that may dissuade physicians from joining unions, at the center of the debate about physician unionization is an ethical dilemma: the utilization of the “right to strike.” The right to strike has been characterized as a “fundamental human right,” and without it, “collective bargaining is reduced to collective begging.” Yet the existing professional and ethical concerns related to the “right to strike” are unique to healthcare professionals, particularly physicians. Although striking is allowed within the confines of the NLRA, it is directly at odds with the professional imperative to care for patients and the injunction of “primum non nocere” or to “first do no harm.”

The AMA has asserted that physicians should be free to pursue advocacy and collective action activities, but it warns against unionizing in concert with other workers who “may not share physicians’ primary and overriding commitment to patients,” such as administrative and support workers within the healthcare delivery system. The AMA further acknowledges the ethical dilemma of engaging in strikes or collective action and has urged physicians to refrain from such activity and consult with legal counsel as appropriate.

The crux of the dilemma behind a physician’s “right to strike” is this: will it, or will it not, cause harm to patients? A 2008 literature review found that patient mortality is either unaffected, or decreases, during a strike. The authors list several variables that may explain these unexpected findings, including, but not limited to: the continued provision of emergency services during a strike; the relatively small geographic regions impacted; and the relatively short duration of the strikes studied. It should be noted that given the rarity of physician strikes, there is a dearth of literature concerning this topic and its effect on patient outcomes. Regardless, the right of physicians to utilize striking as leverage in collective bargaining practices, although possibly considered taboo, has not been forbidden.

Not Going to Take It Anymore?
The healthcare industry has undergone transformative change since the cottage industry of Marcus Welby-type practices—when solo physician practices and small community hospitals were the rule, and not the exception. The consolidation and corporatization of medicine over the last several years, as evidenced by the growth in large hospitals and healthcare systems, increasing employment of physicians, and consolidation of payors, has contributed to the historic distrust between physicians and hospital employers. By essentially transforming independent physicians into a regulated and codified labor force, the 1512 covenant that exchanged autonomy for fidelity has been broken, and how to renegotiate that relationship and restore a level of trust between these groups has yet to be determined.

Despite these changes, U.S. physicians have not seen fit to unionize in any significant way, potentially due to one or more of the reasons discussed here. However, given the continuing consolidation and employment of physicians in a healthcare market that is more heavily regulated than ever before, it begs the question: how long can physicians maintain meaningful autonomy without a collective bargaining tool?

Todd A Zigrang, MBA, MHA, is president of Health Capital Consultants (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, and serving clients in 49 states. Jessica Bailey-Wheaton, Esq., is vice president and general counsel of HCC.

“Anti-trust regulations do not apply to physicians employed within affiliated hospitals or health systems, allowing for the reality of physician unions in the hospital setting.”

ON FRIDAY, June 7, the Chicago Medical Society (CMS) and the American Bar Association (ABA) open the two-day Physician Legal Issues Conference. At 4:45 Friday afternoon, they will be hosting a non-CME session on the formation of physician unions, including why physicians unionize, the potential benefits and pitfalls of unions, and various legal issues that may arise from unionization. The session will also provide practical insight and examples of when physicians have successfully used unions to accomplish their goals and the challenges they faced along the way. CMS and the ABA’s Health Law Section urge you to attend this informative chat. The Physician Legal Issues Conference takes place on Chicago’s Magnificent Mile at the InterContinental Hotel. For registration details or more information, please call 312-670-2550 or visit: www.cmsdocs.org.
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Dates/Locations
Wed., April 18, Advocate Christ Medical Center
Wed., June 27, NorthShore University HealthSystem
Wed., Sept. 5, Chicago Medical Society

Registration 9:30 a.m.; Lecture 10:00-12:00 noon

Questions?
Contact Candace at ccole@cmsdocs.org or call the CMS Education Department: 312-670-2550.
MEMBER BENEFITS

HICAGO MEDICAL Society resolutions led the way, shaping new policies and directives at the Illinois State Medical Society’s Annual House of Delegates. As a wellspring of these measures, CMS creates a powerful ally for local physicians and opportunities for those who want an active and personal role in shaping legislative agendas. The ISMS House met April 20-22 in Oak Brook. Meeting highlights include the installation of CMS Past President Kathy M. Tynus, MD, as ISMS president for 2018-2019 (see “Chicago Physician Installed as ISMS President”) and election of officers and trustees.

When it came to new policy, most CMS resolutions won approval by the House or were referred for study. Part of the Annual Meeting was also devoted to progress reports on efforts of years past such as CMS proposals for the elimination of restrictive covenants and anti-compete agreements and a physician bill of rights. In today’s evolving practice environment, CMS keeps its promise to fight vigorously for the interests of Chicago-area physicians. This representation comes with topnotch medical education and opportunities for physicians who want to influence legislation and public health advocacy.

Here’s a recap of CMS resolutions that won adoption or referral for study:

**Use of HSAs for Direct Primary Care (Referred for Study)**

**Original Sponsor:** Howard Axe, MD

This measure from CMS would expand access to primary care through state and national policy supporting patients’ use of health savings accounts to pay for direct primary care (DPC) services. CMS’ resolution seeks federal legislation that addresses and clarifies Internal Revenue Code (IRC) Section 223(c) so that DPC medical homes do not constitute a health plan; the measure also seeks to establish the legality of treating periodic payments to

Shaping Debate at State

CMS works at the grassroots to set legislative agendas in Springfield and Washington

Prior to advancing key resolutions, Chicago-area physicians debate and strategize at CMS (Cook County) Caucus meetings during the ISMS House of Delegates on April 20-22. CMS is the largest county medical society in the state and one of the largest in the U.S.
MEMBER BENEFITS

DPC practices as qualified medical expenses under IRC Section 213(d). Allowing periodic-fee agreements without IRS interference or penalty would improve access to all primary care providers, including those who practice in a DPC model.

Physician Compensation Reporting by Drug and Device Companies (Adopted)
Original Sponsor: Amy Derick, MD

Under this CMS measure, any compensation reported under the Physician Payments Sunshine Act must be accompanied by a verifiable receipt signed by the physician acknowledging receipt of that compensation. The resolution also seeks the immediate removal of contested reported compensation from the OpenPaymentsData.CMS.gov website until the reporting company validates the compensation with a signed receipt. Finally, the measure calls for fines when companies reporting physician payments do so without proper documentation. Such companies would be fined $1,000 per occurrence.

ISMS will transmit the resolution to the AMA for implementation with the federal Centers for Medicare and Medicaid Services.

Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (Adopted)
Original Sponsor: Robert Sobel, MD

CMS’ resolution targets the process by which pharmaceutical companies create perverse price discrepancies between the newest agents and popular generics; incentivize “me-too” drug development and patent-extending alterations; and create a generic market with uneven competition under the Hatch-Waxman Act. The measure supports federal legislation to modify the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) so that time-specific patent protections are replaced with negotiated payment schedules and indefinite exclusivity for FDA-approved drugs in the Medicare Part D Program.

ISMS adopted the resolution and will transmit it to the AMA.

Mandatory Influenza Vaccination for Healthcare Workers (Substitute Adopted)
Original Sponsor: Jerrold B. Leikin, MD

Although healthcare workers are urged to protect patient safety by being immunized against vaccine-preventable illnesses, new policy advanced by CMS says that healthcare workers should not be terminated from employment due solely to their refusal to get the influenza vaccine. The resolution requests similar policy adoption by the AMA while still recommending that healthcare workers get immunized.

Prescription Drug Importation (Adopted as Amended)
Original Sponsor: A. Jay Chauhan, DO

This CMS measure supports the FDA allowing

Chicago Physician Installed as ISMS President

FORMER CHICAGO Medical Society President Kathy M. Tynus, MD, was inaugurated as president of the Illinois State Medical Society during the 2018 House of Delegates and Annual Meeting. Dr. Tynus, a board-certified internal medicine specialist, was president of CMS from 2015-2016. She practices with Northwestern Medical Group in Chicago, in addition to serving on the medical staff at Northwestern Memorial Hospital, and as clinical associate professor at the Feinberg School of Medicine. Dr. Tynus also serves on the Accreditation Council for Graduate Medical Education Transitional Year Review Committee and previously served on the American Board of Internal Medicine Test Writing Committee.
MEMBER BENEFITS

patients to purchase prescription medications from Canada. As such, ISMS will urge the AMA to work with the U.S. Congress and the FDA to establish oversight of any imported Canadian prescription medications to protect consumers from counterfeit, contaminated, and harmful drugs.

Trauma-Informed Care and Services for Victims of Human Trafficking (Adopted as Amended)

Original Sponsor: Traci A. Kurtzer, MD

CMS’ resolution to ISMS encourages physicians to take the lead in their institutions to ensure hospitals and clinics have policies and procedures in place to provide affordable, trauma-informed medical care to victim-survivors of human trafficking. Therefore, as per the CMS measure, ISMS will educate clinics, hospitals and physicians about the new Illinois State Law PA 99-870: Illinois Department of Healthcare and Family Services Medical Benefits for Non-citizen Victims of Trafficking, Torture or Other Serious Crimes, which became effective Jan. 1, 2018, and which amends the Public Aid Code to cover healthcare services for eligible non-citizens.

The Illinois Cranial Anticoagulation Reversal ICARE Initiative (Adopted)

Original Sponsors: Darian Esfahani, MD; Scott Leikin, DO; Joseph Lee, MD; Nikesh Bajaj, DO

CMS’ resolution to ISMS urges support for initiatives that reduce barriers to the use of anticoagulation reversal agents that are up to date with contemporary guidelines in emergency settings for hemorrhagic stroke and other life-threatening clinical indications, including the Illinois Cranial Anticoagulation Reversal (ICARE) Initiative or subsequent iterations for the benefit of Illinois stroke patients.

Engage and Collaborate with the Joint Commission (Referred for Decision)

Original Sponsor: Jerrold B. Leikin, MD

This resolution calls upon ISMS and AMA to engage and collaborate with the Joint Commission’s Board and Leadership to provide and survey appropriate medical standards, as per its mission statement.

Abused and Neglected Child Reporting Act (Adopted)

Original Sponsor: Linda F. Gruenberg, DO

Per this resolution, ISMS will research the process for reporting cases of alleged child abuse as provided under the Abused and Neglected Child Reporting Act (325 ILCS 5/). It further calls for an amendment to the Illinois State Statute so that the Department of Children and Family Services (DCFS) and other agencies investigate any and all reported and alleged cases of abuse to a minor regardless of the alleged perpetrator’s relation to the child, lack of responsibility for the child, or the alleged perpetrator’s residence. Currently, those investigations do not extend to distant family members who have only occasional contact with the child or who live outside Illinois, or to adult friends and acquaintances of the family who do not reside in Illinois. Such individuals fall outside the definition of persons whom the DCFS will investigate for reported alleged child abuse.
Advancing Scientific Knowledge

CMS is helping other associations bring specialized knowledge to members

The day-long annual scientific meeting of the Midwestern Association of Plastic Surgeons featured speakers, panels, and presentations on clinical and research topics related to all aspects of plastic and reconstructive surgery.

THE MIDWESTERN Association of Plastic Surgeons (MAPS) held its annual scientific meeting on April 14 at Northwestern Memorial Hospital. In this photo, keynote speaker (left) Rodrick J. Rohrich, MD, clinical professor at the University of Texas, Southwestern Medical Center, was awarded a plaque by (center) Mohammed Alghoul, MD, vice president of MAPS and program chair, and (right) Wei F. Chen, MD, president of MAPS. Dr. Rohrich spoke on “Advances and Innovations–Becoming an Expert in Rhinoplasty.” CMS is proud to manage this high-profile organization.

Safety in the Workplace

Your CMS hosts educational events such as OSHA training

At this OSHA training update, participants review steps to minimize exposure to bloodborne pathogens, such as use of personal protective equipment and hazard communication.

THE CHICAGO Medical Society hosts training updates for clinicians and their staff on healthcare worker safety and health. In this photo, industrial hygienist Robert P. Leonard of the U.S. Department of Labor, Occupational Safety & Health Administration, leads the two-hour session “OSHA 2018: Bloodborne Pathogens and Beyond.” The event took place on April 18 at Advocate Christ Medical Center in Oak Lawn. Sessions are repeated throughout the year. For more information, see page 25.
Welcome New Members

The Chicago Medical Society greets its newest members. We are now 29 voices stronger!

Resident District
Mena W. Megelie, MD
Brooke E. Vasichek, MD

District 3
Maria S. Khan, MD
Mark Kraus, MD
Veeda O. Landeras, MD

District 4
Juliana L. Basko-Plluska, MD

District 7
Vivek Iyengar, MD

Student District
Cyrus Alavi
Alexander E. Ayala
Kristin M. Bala

Brett Curran
Adam A. Douglas
Jeffrey W. Fuchs
Leah C. Getsov
Philip G. Ghobrial
Jennings Hernandez
Abigail Z. Huntley
Sara A. Khan
Simon P. Lalehzarian
Sherin M. Mahrat
William M. Norkett
Daniel P. O’Brien
Cecily E. Ober
Srinivas Panchamukhi
Kelsey Romatoski
Joshua A. Smith
Rachel M. Suen
Margaret Van Der Bosch

and insight on employer and hospital relationships; contracting and negotiation; consolidation and merger of health systems and payers; regulatory changes; private equity opportunities, and physician unions. Experts will share everyday “survival” techniques for both employed physicians and those in private practice settings. Physicians may earn up to 21.5 CME credit hours.

9-13 AMA Annual House of Delegates
CMS actively participates in the American Medical Association’s policymaking meetings, advocating for both members and their patients. Resolutions adopted at the CMS Council frequently advance 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 outstanding membership privilege, ensuring that their voice is heard at the highest levels of organized medicine and well beyond.

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

18 CMS Executive Committee Meeting
(TBA) 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. CMS Building, 33 W. Grand Ave., Chicago.
For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

18 CMS Board of Trustees Meeting
(TBA) Meets every other month to make financial decisions on behalf of the Society.
9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago.
For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

5 OSHA Training: Bloodborne Pathogens and Beyond 10:00 a.m.-12:00 p.m.; NorthShore University HealthSystem; 2650 Ridge Ave., Room 1711, Evanston. For more information, contact Candice 312-670-2550, ext. 338, or ccole@cmsdocs.org.

18 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.
10:00 a.m.-12:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

AUGUST

SEPTEMBER
Personnel Wanted

- **ANESTHESIOLOGIST** for D & C
- **OB-GYN** for D & C and Tubal Sterilization
- **UROLOGY** primarily for Vasectomy
- **FAMILY** Medicine Physician for D & C and Birth Control

**FAMILY PLANNING** and Birth Control Centers, 1-3 days per week in Wood Dale, Downers Grove, Glen Ellyn and Chicago (Motor Row District). Please send CV and salary requirements by fax to 847-398-4585 or send CV via email to administration@officegci.com and vino878@aol.com.

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Looking for an exit strategy? Possibly sell your practice? I’m a professional practice broker and the only doctor who owns and operates a local brokerage. I’ve sold dozens of practices and can help you as well because I’ve walked in your shoes. Complimentary consultations. Please call Dr. Uhland 224-458-9388, or email Chicagolandbusinessbroker@gmail.com.

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IN HER day-to-day position as president of the medical staff at Advocate Lutheran General Hospital, Lisa Laurent, MD, MBA, MS, acts as an ambassador between the medical staff and the administration. Her role includes chairing the cabinet and the medical executive committee. Her position is especially key since Advocate Health Care recently finalized its merger with Wisconsin's Aurora Health Care, creating the 10th largest U.S. not-for-profit hospital system. “I’m excited about the merger,” she says. “I feel privileged that it is occurring during my tenure and feel that the disruptive innovation the new organization promotes will have a positive impact on our patients and community.”

Since assuming the presidency on January 1, Dr. Laurent has teamed up with other physicians to create several successful programs. One of which she is especially proud is the physician resilience committee that she chairs. “We created the committee to address the growing dilemma of physician burnout,” she says. “Not only do we identify opportunities to educate and support physicians, but we also make relevant changes in the environment to enhance how physicians practice. We are committed to improving personal and professional fulfillment among medical staff. This in turn affects clinical outcomes, the performance of the entire care team, and the culture at the workplace. Our committee is aligned with the system-wide Advocate physician wellness committee that I co-chair.”

As part of the strategic imperative of the resilience committee, physicians now engage in an interactive education series called “Wellness Wednesdays: Hot Topic, Hot Lunch.” Dr. Laurent says: “We address a variety of topics hosted by guest speakers who are experts in the space. We’ve received very positive feedback about how this transparent reciprocal face-to-face communication helps physicians feel valued and part of the team.”

Another accomplishment is the Fighting Cancer is Always in Fashion! fundraising fashion show Dr. Laurent founded and co-chaired. The event was wildly successful, both from the financial and engagement perspectives. Dr. Laurent got 19 male physicians to serve as models. The highlight of this feel-good event was the grand finale when 19 cancer survivors walked the runway. “We netted an astonishing $130,000, all of which went directly to the cancer survivorship center on campus,” she says.

One of Dr. Laurent’s biggest influences in her decision to specialize in diagnostic radiology came during her residency at The University of Texas Health Science Center at Houston/MD Anderson Cancer Center. “I was an on-call first-year radiology resident working at the trauma center when a severely injured patient with a complex cervical spine injury was flown from Mexico at 2 a.m.” she recalls. “Dr. John Harris, our radiology department chairman, had encouraged the residents to call him 24/7 and he would help. After I finally got up the nerve to call him, Dr. Harris was there in 30 minutes. He wasn't critical or judgmental—he just walked me through the case with encouragement and a warm smile. Every day, I try to model that attitude and to empathize with others.”

Dr. Laurent’s Career Highlights

**Dr. Laurent** is a full-time practicing radiologist and also serves on the board of directors and executive committee of the American Association for Physician Leadership, the largest international professional organization focused on the growth and development of physician leaders. She received her BA from Smith College in Northampton, MA, and her MD from Drexel University in Philadelphia. She did a medical and surgical internship at Chestnut Hill Hospital in Philadelphia and a fellowship at the Brigham and Women’s Hospital in Boston. She also received an MBA from the University of Wisconsin in Madison and a master’s in science in healthcare quality and safety management from the Thomas Jefferson Medical College in Philadelphia. She has received numerous awards and is an accomplished researcher, author, and guest speaker.
healthy vitals

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