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chicago medicine

Newsletter, 2011, Vol. 114, No. 2

SAVE THE DATE!
CMS QUARTERLY MIDWEST CLINICAL CONFERENCE,
JUNE 8, OAK BROOK...See pages 20-21

PRESIDENT'S MESSAGE

CMS testifies before City Council on "hands-only" CPR campaign



CMS President Dr. David A. Loiterman discussed the "hands-only" CPR campaign before aldermen at City Hall on March 8. *From left:* Dr. George Chiampas, director CCARES, Dr. Loiterman; Marc Levison, assistant deputy fire commissioner for EMS services, Ald. Margaret Laurino (39th Ward), and Ald. Michelle Harris (8th Ward).

*Empowering bystanders
to help save lives*

Founded in 1850 to promote public health, your CMS is leading a modern-day campaign to in-

struct adults on giving "hands-only" CPR to victims of sudden cardiac arrest that occurs outside the hospital setting.

The hands-only CPR campaign operates under the aegis of Project SMILE

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PRESIDENT'S MESSAGE *(continued from first page)*

(Saving More Illinois Lives through Education), a growing coalition of health-related organizations and medical professionals.

Our efforts have sparked the interest of the Chicago City Council's Committee on Police and Fire. At the Committee's invitation, we gave testimony and showed aldermen how this simple tool empowers citizens to help save lives.

Joining me at City Hall were Marc Levison, assistant deputy fire commissioner for EMS services, and George Chiampas, DO, director of CCARES (Chicago Cardiac Arrest Resuscitation Educational Service).

Dr. Chiampas, who is also assistant professor of emergency and sports medicine, Northwestern University, and medical director for the Bank of America Chicago Marathon, gave aldermen a live hands-only demonstration. (For a video demo

and comprehensive information, please go to www.handsonlycpr.org.)

To further dramatize our testimony, we relayed an amazing survival story from Minnesota. As recounted in numerous news stories, a man received 96 minutes of both hands-only and conventional CPR from more than two dozen different responders after he collapsed on the sidewalk.

The obvious lesson here is that all adults should be able to recognize the warning signs of sudden cardiac arrest, and be ready to administer good, hard, fast CPR.

It can be a lifesaver.



David A. Loiterman, MD, FACS
President,
Chicago Medical Society

NEWS FOR CHICAGO PHYSICIANS



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Call to physicians: Spread word about hands-only CPR



Dr. Chiampas

DR. GEORGE CHIAMPAS has a request for his fellow physicians: "Help get the word out to your patients, your community organizations, your school systems, about hands-only CPR." As director of CCARES (Chicago Cardiac Arrest Resuscitation Education Service), Dr.

Chiampas calls the hands-only technique a life skill that is as easy for lay people to perform in an emergency as calling 911, or applying the Heimlich maneuver. He sees many more lives being saved as the public learns this new technique and can jump in to help a stricken person before the paramedics arrive.

Dr. Chiampas suggests physicians provide patients the following link to as many resources as possible: www.handsonlycpr.org.

A skill everyone can use



Dr. Murthy

NATIONALLY, FEWER THAN 33% of victims of sudden cardiac arrest occurring outside the hospital setting receive bystander CPR, and fewer than 8% of victims live to be discharged from the hospital. Death rates remain high mostly because bystanders hesitate to give CPR. Many don't feel comfortable giving

mouth breaths, while others worry about germs and transmitting disease.

Hands-only CPR is simpler and safer to perform than conventional CPR, or mouth-to-mouth resuscitation, and can be just as effective. When given within three to five minutes of collapse, CPR can "buy time" as the bystander calls 911. When combined with early defibrillation, plus early advanced care, long-term survival rates can exceed 50%, according to the American Hospital Association (AHA) website.

As George Chiampas, DO, emphasized to aldermen at City Hall on March 8: "CPR is a life skill everyone in the community can use."

For a demonstration, go to www.handsonlycpr.org.

As Project SMILE enlists other state and county medical societies, the CPR campaign will reach citizens through hospitals, clinics, houses of worship, schools, stores, and other public venues. Physicians and other health professionals can partake of online courses and live programs covering basic and advanced cardiovascular life support, including the use of AEDs.

The Project SMILE coalition exists today because of Chairman Vemuri Murthy, MD. A member of CMS' District 5, Dr. Murthy is active in the American Heart Association, teaching AHA courses on advanced cardiovascular life support. He is also chairman of the Department of Anesthesiology at West Suburban Medical Center. Troubled by needless deaths every year, often resulting from lack of training, Dr. Murthy approached CMS last year to lead the Project SMILE coalition, complementing efforts by the AHA and Red Cross.

Please consider asking your hospital to become a partner. For information, please contact Ashley Robbins (312) 670-2550, ext. 326, arobbins@cmsdocs.org.



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Next step—CPR ordinance

THE PROJECT SMILE COALITION IS WORKING with members of the Chicago City Council to draft an ordinance requiring signs in public areas that demonstrate how to give hands-only CPR. Aldermen are also considering a pilot hands-only program in the Chicago public schools. The Chicago Police Department has also expressed interest in basic training for the 11,000-member police force.

What is optimal hands-only CPR?

STUDIES HAVE SHOWN THAT 100 CHEST compressions per minute provide the most effective CPR. Listening to the Bee Gees' song, "Stayin' Alive," helped researchers perfect their rhythm because the music contains 103 beats per minute.

Project SMILE coalition members

PLEASE CONSIDER JOINING OUR GROWING community of hands-only CPR partners. For more information, contact Ashley Robbins (312) 670-2550, ext. 326.

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Alderman Laurino paves way for hands-only testimony

The Project SMILE coalition is grateful to Ald. Margaret Laurino (39th Ward) for inviting members of the coalition to give testimony on March 8 before the Police and Fire Committee, and to Committee Chair Ald. Michelle Harris, for presiding over the meeting. We've reprinted Alderman Laurino's resolution below.



Following testimony on hands-only CPR, members of the Project SMILE coalition joined Ald Margaret Laurino outside the City Council Chamber (from left): Amer Z. Aldeen, MD, Dept. of Emergency Medicine, Northwestern; George Chiampas, DO, director CCARES (Chicago Cardiac Arrest Resuscitation Education Service); David A. Loiterman, MD, FACS, President, CMS; Ald. Laurino; and Robert Herskovitz, JD, Deputy Regional Health Administrator, Region V, U.S. Dept. of HHS.

RESOLUTION

Sponsored by Ald. Margaret Laurino (39th Ward)

WHEREAS, sudden cardiac arrest claims hundreds of thousands of lives each year. And failure to provide effective CPR is one of the primary reasons for the high death rate. Indeed, American Heart Association (AHA) statistics show that less

than one-third of victims receive life-saving CPR. However, when provided correctly and immediately after a sudden cardiac arrest, CPR can more than double a victim's chance of survival; and

WHEREAS, the AHA announced a new technique everyone can use to help victims of sudden cardiac arrest—hands-only CPR, or chest compressions, instead of mouth-to-mouth rescue breaths. Since 2005, several studies have shown that hands-only CPR can be as effective as conventional CPR (mouth-to-mouth rescue breaths) in the out-of-hospital setting. And so on March 31, 2008, scientists at the AHA authored an advisory statement for the public encouraging the use of hands-only CPR by untrained bystanders and trained bystanders who are not confident they can perform conventional CPR; and

WHEREAS, some surveys suggest people are reluctant to perform conventional CPR (mouth-to-mouth breaths) due to fear of infection and disease. Hands-only CPR could eliminate that risk and fear, and potentially lead to increased survival rates for victims of sudden cardiac arrest; and therefore be it

RESOLVED, that representatives of the Chicago Fire Department and American Heart Association be invited to provide testimony before the Committee on Police and Fire on public outreach and education pertaining to hands-only CPR.

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CMS Council backs public health resolutions



Susan B. Kern, MD, chair of the CMS Resolutions Reference Committee, comments on a resolution during the Council meeting.

THE CMS COUNCIL, THE POLICY-MAKING body of the Chicago Medical Society, met on Feb. 8, 2011, to hear updates and plan the 2011-2012 agenda. In addition to the elections reported in the last newsletter issue, the Council adopted two resolutions for passage to the ISMS House.

• Indoor Tanning Restrictions (Sponsor—Howard Axe, MD, Trustee, District 4)

CMS will introduce and promote legislation barring all minors from using indoor tanning parlors in Cook County. The language further requests CMS to forward the resolution to ISMS to introduce legislation at the state level, and for ISMS to consider submitting the resolution to the American Medical Association for national action.

This resolution is based on the same public health considerations that led to bans on the sale of cigarettes and alcohol to minors in the U.S., the sponsor testified. According to the American Academy of Dermatology Advisory Board, “people receive most of their lifetime carcinogenic exposure to UV radiation during their most vulnerable years, which are 17 years of age and younger.”

• Creating an Official CMS Position on Calorie Counts (Sponsor—Joshua T.B. Williams, MS3, Co-chair, Medical Student Section)

CMS will adopt an official position on posting calorie counts by supporting federal legislation under the Patient Protection and Affordable Care Act (PPACA). The resolution further requests CMS to forward the resolution to ISMS for reaffirmation of existing policy on posting calorie counts in restaurants.

(The PPACA requires restaurants to begin posting calorie counts in 2011, but the law applies only to chains with 20 or more restaurants. Two-thirds of Illinois adults are obese, according to the sponsor, and the state should enact a labeling law as part of a multi-pronged attack against obesity.



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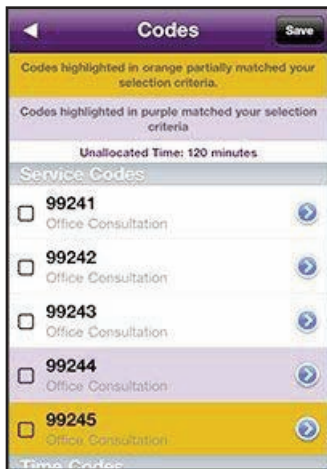
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New AMA physician app streamlines CPT coding



Sample page from AMA's new physician CPT app.

PHYSICIANS CAN quickly and easily find CPT (Current Procedural Terminology) billing codes through the AMA's first app designed specifically for physicians

The new app features both decision-tree logic and quick search options, allowing physicians to digitally track CPT codes and email them anywhere. Physicians

can also save their most frequently used codes by location or type of service to allow for even more ease of use.

The CPT evaluation and management quick refer-


ence app is available for free through the iTunes store and is compatible with Apple iPhone, iPod Touch and the iPad. Go to: (<http://www.apple.com/itunes/affiliates/download/>)

In other news, the AMA is seeking ideas for the next great medical app idea. All U.S. physicians, residents and medical students are invited to participate in the 2011 AMA App Challenge: (<http://www.amaidealab.org/>).

Participants can submit their app ideas online. Submissions will be accepted through June 30, 2011.

Two winners will be selected, one from the resident/fellow or medical student category, and one from the physician category. The winners will each receive \$2,500 in cash and prizes, plus a trip for two to New Orleans for the grand unveiling of their winning idea at the AMA's meeting in November.

Source: American Medical Association



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Understanding Accountable Care Organizations

By Terrell J. Isselhard and Kimberly T. Boike

Introduction

SIGNED INTO LAW BY PRESIDENT OBAMA ON March 23, 2010, The Patient Protection and Affordable Care Act (PPACA) will dramatically overhaul the U.S. healthcare system. It also creates various challenges for solo medical practitioners and small medical practices. However, by participating in larger business models or joining larger medical groups, those physicians can alleviate some pressures from high overhead expense, medical liability premiums, litigation awards, as well as the cost of adopting EHR systems.

ACO participants

The PPACA requires that ACOs be made up of physicians, physician networks, partnerships, or joint venture arrangements between hospitals and physicians, or hospitals employing physicians. The key word in all of these options is “physicians.” The federal government finally recognizes that unless physicians are made an integral part of the healthcare delivery system, the cost of care will not be reduced. Therefore, physicians should seriously consider establishing business models that provide high-quality coordinated care in cost-efficient delivery systems. Such systems should financially reward participants through shared cost savings. The goal is for patients to receive high-quality care as service providers become more efficient in providing that care.

Realistic expectations or a dream?

Both the federal government and healthcare community recognize the current system is unsustainable. While no one can predict whether this laudable goal of reducing costs can be achieved, the federal government has determined that incentives to practice “smart” medical care will encourage cost-efficiency, while also improving care for patients in both the public and private sectors.

Fundamental requirements of an ACO

The seven requirements entities must meet to qualify as an ACO organization are as follows:

- Three-year agreement with CMS (Centers for Medicare and Medicaid Services).
- Legal structure to receive and distribute shared saving to participating providers.
- Include primary care providers.
- Serve at least 5,000 Medicare fee-for-service beneficiaries.
- Leadership and management structure that includes clinical and administrative systems.
- Processes to promote evidence-based medicine and patient engagement; measure quality and cost; and coordinate and monitor care (through tele-health and remote patient systems).
- Patient and caregiver assessments or use of individualized care plans.

Essentially, an ACO must have primary care providers who can bring in at least 5,000 Medicare fee-for-service patients for treatment and a business model that promotes quantitative evidence-based statistics for measuring quality and cost.

Use of technology

To accumulate the data necessary to fulfill these goals and criteria, ACOs must invest significant time and resources into electronic systems that monitor and measure all aspects of care and related costs. Who will pay for this? Most solo practitioners and small medical groups lack the resources to invest in electronic medical care delivery systems. Many hope the federal government will continue to provide financial incentives and authorize new incentives. In addition, a number of private insurance companies monitor cost and quality of care. Insurance companies, therefore, may help physicians establish their own in-office electronic monitoring programs.

Payment mechanisms

Medicare fee-for-service payments will continue to be made to healthcare providers. If, however, physicians belong to an ACO, the PPACA will allow shared savings only if (1) quality performance standards are achieved; and (2) estimated average per capita Medicare expenditures are less than the CMS benchmarks. The government is

preparing rules and regulations that define these benchmarks. There is debate over how aggressive the benchmarks should be in the initial years.

As in private insurance carrier agreements, there can be various levels of savings and risk between Medicare and the ACO. For example:

Level I – The ACO bears no financial risk and simply shares in any savings or bonuses for meeting quality requirements.

Level II – The ACO is eligible for a larger share of savings, but would also be liable if costs rise above predetermined targets.

Level III – The ACO is paid through full or partial capitations.

Significant advantages over other business models

It is extremely important to recognize that the PPACA specifically authorizes CMS to waive requirements of certain statutes (Stark, Fraud and Abuse, and Civil Monetary) for ACOs.

Because final rules governing ACOs are not

complete, the breadth of waivers should be reviewed to insure the ACO remains in compliance. Why are waivers so important? First, all other healthcare delivery business models are still required to conform to onerous, unrealistic statutes that promote inefficiency and make it difficult to create coordinated, cost-efficient healthcare delivery systems. Under current statutes, there is no incentive to provide care in a cost-efficient manner. In addition, restrictions on owning multiple entities that provide a continuum of care create unnecessary overhead and administrative costs. All these costs can be avoided under one business model with common ownership, where the healthcare provider monitors quality and cost, and rewards participants with savings achieved under the model.

Forming ACOs

There are various ways solo practitioners and small medical groups can create an ACO or other business model that will achieve the same goals of

(continues on next page)

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HEALTHCARE OVERHAUL *(continued)*

an ACO: 1) Merge or consolidate their practices with other practitioners; (2) Join or merge with larger medical groups; (3) Join ACO organizations created by hospitals or other healthcare providers; or (4) Create a larger patient pool to achieve Medicare's 5,000 patient requirement, and assume responsibility for monitoring and measuring quality and associated costs.

Healthcare industry with or without ACOs

Regardless of whether the PPACA is finally determined to be constitutional, the U.S. healthcare industry is forging ahead to create the same business model for all patients (not just Medicare patients). For the first time, technology and software programs have been developed to monitor and measure quality and cost. It is also indisputable that providing a continuum of preventive care, cost-efficient treatment during acute and terminal illness, and post-hospital care, including home care, reduces costs and improves the quality of treatment.

All physicians are urged to embrace this golden opportunity. The federal government, insurance carriers, hospitals and other healthcare providers, finally recognize that physicians are the true gatekeepers of cost-efficient quality care. Your decisions and how you treat patients ultimately affect cost and quality of care.

Mark Twain said it best: "Even if you are on the right track, you will get run over if you just sit there." Good luck on your journey!

Mr. Isselhard is a principal in the Chicago-based health law firm of Chuhak & Tecson, PC, where Ms. Boike is an associate. Inquiries or suggestions should be emailed to Mr. Isselhard at tisselhard@chuhak.com or to Ms. Boike at kboike@chuhak.com.

(On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS), proposed new rules under the Affordable Care Act for accountable care organizations (ACOs). There is a 60-day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program.)

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we have so
many unknowns
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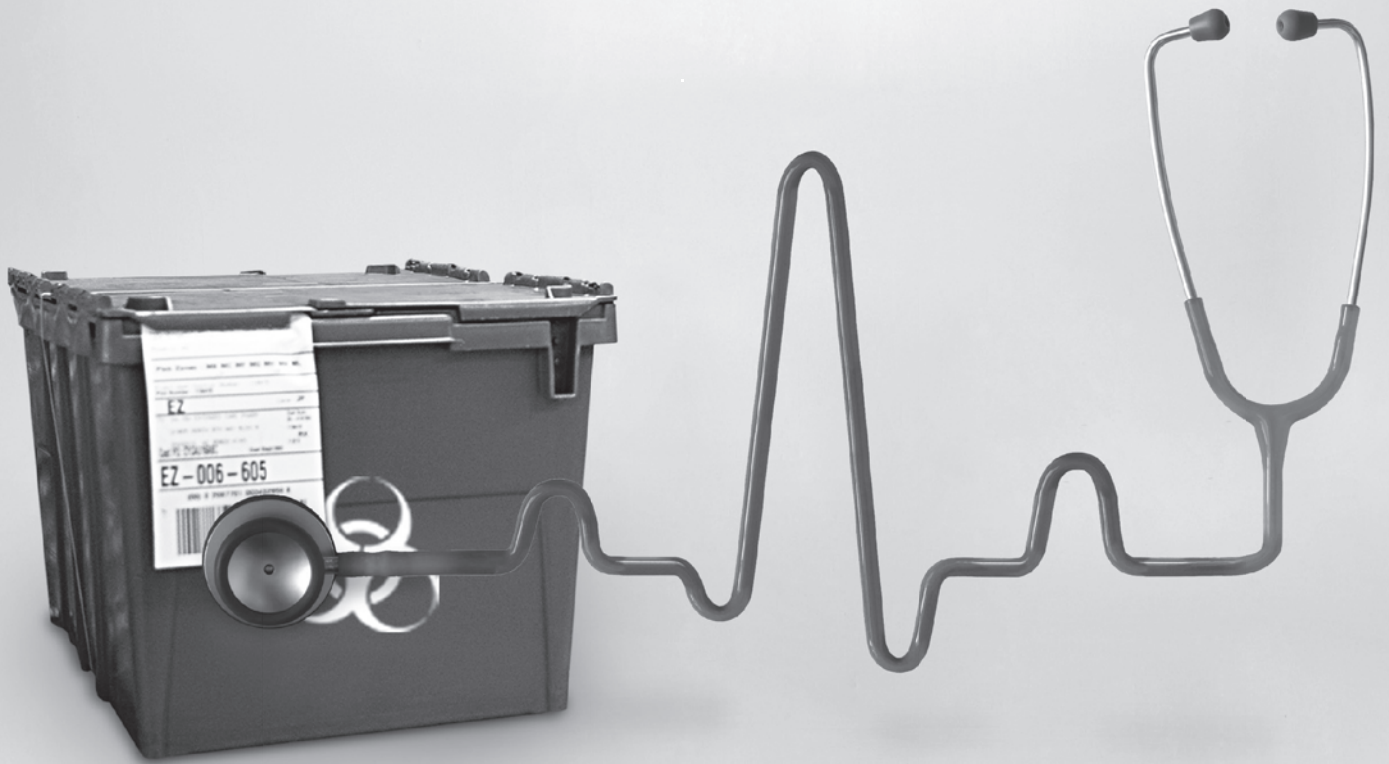
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Why back-to-basics may be best

By John Cercone,

CMS Relationship Manager

Healthcare Business Banker, PNC



Cercone

THERE'S SOMETHING IN THE massive healthcare reform legislation for everyone to love and hate.

To be sure, change of this scale evokes strong feelings on both sides. There has been much prognosticating and handwringing over the impact of healthcare reform on the day-to-day operations of healthcare practices.

But, in reality, succeeding in this post-reform era might simply require a re-focus on the best practices that better-performing physicians have implemented for years.

Best practice: promote primary care

Under healthcare reform, physicians will see incentives to provide basic care. In fact, Medicaid payments for primary care services will increase to 100% of the Medicare payment rates for 2013 and 2014. In addition, for 2011 through 2016, primary care providers qualify for a 10% bonus payment if they charge at least 60% of their total allowed Medicare charges as office, nursing facility, or home visits.

- **Action: adjust your panel.** Evaluate the financial impact of increases in Medicaid payments for primary care service and whether it would justify increasing the number of Medicaid patients you see.

- **Action: consider additional covered services.** Also consider whether your practice can provide additional covered services. Tobacco cessation for pregnant women, for example, will now be covered under Medicaid, and Medicare patients will have access to a comprehensive health risk assessment as of 2011.

Best practice: verify eligibility

The Medical Group Management Association's *Performance and Practices of Successful Medical Groups* (aka "The Gold Book"), which outlines best practices of better performing medical offices, notes that better performing practices consistently take these steps:

- They validate insurance and address information.
- They verify insurance and benefits eligibility.
- They provide new patients with a written financial policy.
- They have a written policy for when co-payment must be paid and the few times when co-payment can be deferred.
- They collect all payments at time of service.

- **Action: streamline the verification process.** Seek to highly automate the verification process for both new and established patients (e.g., by using Internet-based tools that enable real-time insurance verification). Look also for practice management software that offers so-called "eEligibility" functions that pre-check insurance eligibility.

- **Action: take advantage of administrative simplification.** Long-promised standards and operating rules for claims, enrollment, premium payments, claims attachments and referral certification/authorization are all slated for implementation between 2013 and 2016. Prepare your internal systems to implement the new standards and provide billing staff with the training they need.

Best practice: mine your data

As both commercial insurance and Medicaid expand to cover substantially more Americans, physicians may find that lucrative self-pay patients are now covered by lower-reimbursing commercial insurance. At the same time, they may find that the low-income patients they once provided charity care for now have coverage through Medicaid.

- **Action: crunch the numbers.** Evaluate your existing systems to uncover some basic yet critical data. Do you know how much you are being paid? Which insurance pays better? Which payers abide by the terms of their contract? Once you have identified your preferred payers, you can look at how you want to shift your reimbursement mix of commercial and federal payers.

- **Action: get the mix right.** Be selective and evaluate which payers you want to accept patients from. Compare what private payers are paying for your top billing codes. For example, if ABC Health Plan consistently pays 130% of the Medicare allowable while XYZ Health Plan is paying 105% for the same code, you may want to close the practice to XYZ members.

A final thought: Keep it simple. Change is certainly in the air. But one thing will remain constant: Success in this changing landscape will go to those physicians who provide quality care while focusing on sound principles of practice management.

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COURSE TOPICS: Health Care Worker Safety and Health, Common Hazards from Bloodborne Pathogens Associated with Medical & Dental Offices, Compliance with OSHA Regulations, Emerging Infectious Diseases and Q & A.

LEARNING OBJECTIVES: 1) Implement a training program for healthcare employees who may be exposed to blood-borne pathogens. 2) Identify appropriate personal protective equipment (PPE). 3) Develop an emergency response plan. 4) Create a written exposure control plan for healthcare workers assigned as first-aid providers. 5) Develop a strategy to prevent the spread of pandemic flu within a practice.

2011 WORKSHOPS:

- Wednesday, May 25:** Advocate Christ Medical Center (Oak Lawn, IL) 2 p.m. to 4 p.m.
- Wednesday, June 8:** Embassy Suites (Downtown Chicago) at 10 a.m. to 12N
- Friday, August 5:** Advocate Lutheran General Hospital (Park Ridge, IL) 2 p.m. to 4 p.m.
- Friday, Sept. 2:** Hilton Oak Lawn Hotel (Oak Lawn, IL) 2 p.m. to 4 p.m.
- Wednesday, Sept. 21:** Embassy Suites (Downtown Chicago) 10 a.m. to 12N
- Wednesday, Oct. 19:** Advocate Christ Medical Center (Oak Lawn, IL) 2 p.m. to 4 p.m.
- Friday, Oct. 21:** Doubletree Hotel-Chicago (Oak Brook, IL) 9:30 a.m. to 11:30 a.m.
- Friday, Nov. 4:** Advocate Lutheran General Hospital (Park Ridge, IL) 2 p.m. to 4 p.m.

SPEAKER: Sukhvir Kaur, MPH, Compliance Assistance Specialist, OSHA-Chicago North Office. *Ms. Kaur has disclosed that she has no relevant financial relationships with commercial interests.*

The following planning members of the Chicago Medical Society's CME Subcommittee on Joint Sponsorship and staff have disclosed the following: Vickie Becker, MD, Chairman, Roger L. Rodrigues, MD, Planning Member, Babu P. Arekapudi, MD, Planning Member, Marella L. Hanumadass, MD, Planning Member, Vijay Yeldandi, MD, Course Director, and Cecilia Merino, Director of Education, have no relevant financial relationships with commercial interests.

ACCREDITATION AND DESIGNATION STATEMENTS:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME). The Chicago Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

The Chicago Medical Society designates this educational activity for a maximum of 2.0 **AMA PRA Category 1 Credits™**. Physicians should only claim credit commensurate with the extent of their participation in the activity.

REGISTRATION: Register Online at www.cmsdocs.org or contact Elvia Medrano at (312) 670-2550, ext. 338, or emedrano@cmsdocs.org

DR. YESH NAVALGUND / OWNER
DNA ADVANCED PAIN TREATMENT CENTER
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CALENDAR OF EVENTS

May 10

District 5 Meeting
Allscripts & Healthdirections.com
6:00-8:30 p.m.
Location TBD

May 18

CMS Executive Committee Meeting
8:00-9:00 a.m.
Online

May 18

ISMS Executive Committee Meeting
12:00-1:00 p.m.
ISMS Headquarters

May 18

Chicago Gynecological Society Meeting
6:00-8:30 p.m.
Maggiano's Banquets, Chicago

May 25

OSHA Workshop
2:00-4:00 p.m.
Advocate Christ Medical Center, Oak Lawn

June 8

CMS Council Meeting
4:30-9:00 p.m.
Maggiano's Banquets, Oak Brook

June 8

CMS Annual Dinner
4:30-9:00 p.m.
Maggiano's Banquets, Oak Brook

June 11

ISMS Board Meeting
9:00 a.m.
ISMS Headquarters

Join us June 8 for CME at Midwest Clinical Conference in Oak Brook



Accountable care organizations, anti-trust issues, EMRs, and balance billing are among the topics at CMS' upcoming conference at the Doubletree in Oak Brook.

LEARN ABOUT THE LATEST TRENDS IN healthcare reform at the CMS Midwest Clinical Conference, scheduled for June 8 at the Doubletree Hotel in Oak Brook.

CMS' restructured MCC is being held on a quarterly basis this year, with each one-day conference offering up to seven hours of high-quality CME credit.

Sessions in June will focus on accountable care organizations and anti-trust issues, EMRs and meaningful use, patient safety and full disclosure, payment reform and balance billing. Trends in the Chicago market will be highlighted.

Physicians can also learn about the VA's virtual lifetime electronic record (VLER), a seamless EMR shared by the VA and Defense Department.

MCC participants can unwind during a cocktail reception, attend the CMS Council Meeting and Annual Dinner, and installation of officers.

For more information on MCC, please contact CMS (312) 670-2550; or visit: www.cmsdocs.org.

Save-the-Date

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Date:

Wednesday, June 8th

Location:

Doubletree Hotel - Oak Brook

Audience:

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More details to follow! For more
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