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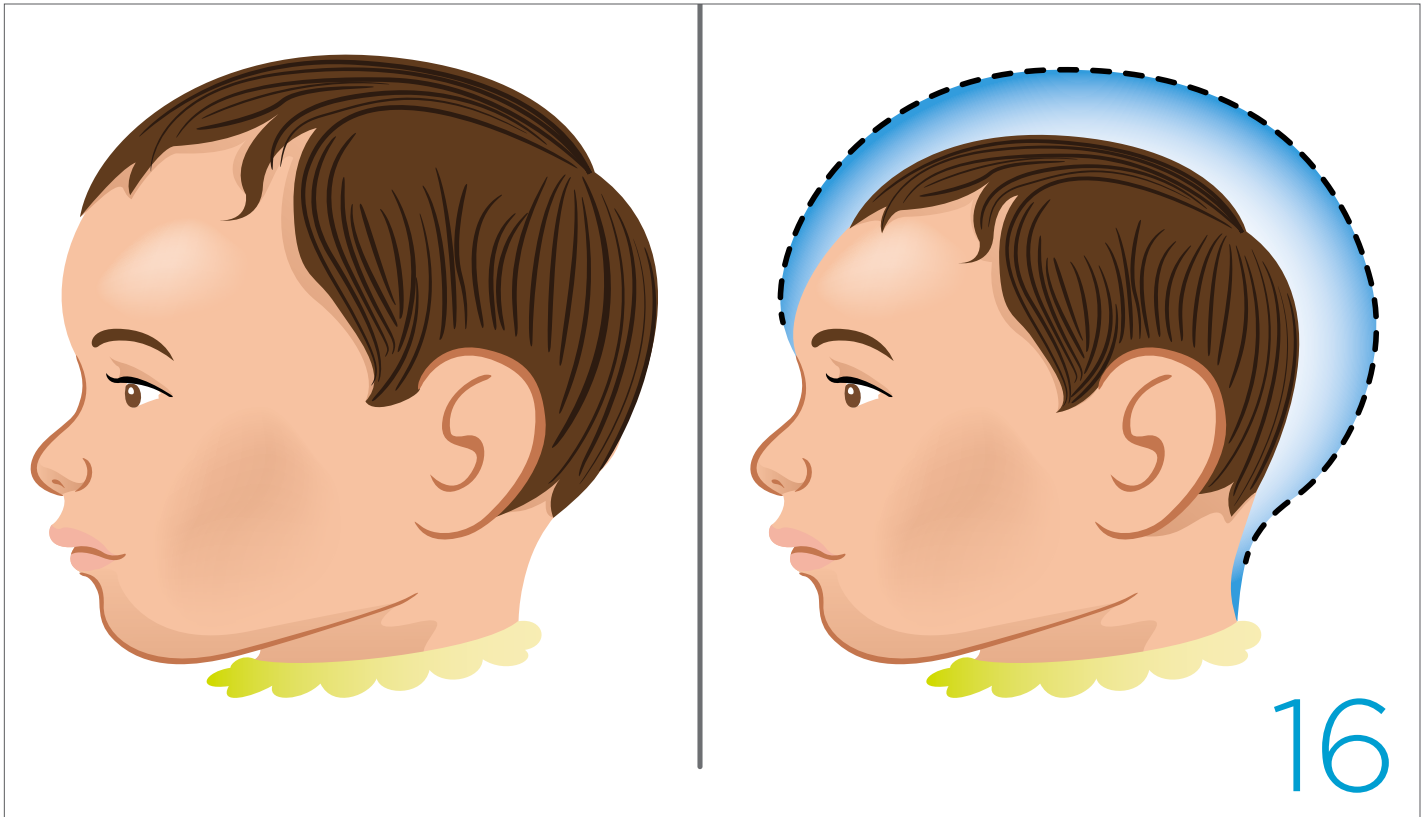
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Family physician Michael Hanak, MD, is among the 60% of employed physicians in the United States. But he credits his job at Rush University Medical Center for allowing him to be fully engaged in many other medical endeavors.

Giving Voice to Millennials



RECENTLY ATTENDED the inaugural Educational Policy Series presentation organized by Christiana Shoushtari and Anna Zelivianskaia of our CMS Medical Student Section. The purpose of the meeting was to educate physicians-in-training on the importance of advocacy and how to approach it. The turnout was much larger than anticipated, at over 90 students from all seven medical schools in Cook County. Even after a change of venue to accommodate the crowd, we were scrambling to set up more tables.

We heard from Scott Ziomek, Director of External Affairs at Northwestern Memorial Hospital, who gave a talk about Northwestern's approach to advocacy, and gave an example of an effort they led to preserve tax exempt status for non-profit academic medical centers in Illinois. He also spoke about the potential reduction in funding for graduate medical education. The audience was highly attentive, asked some clearly pointed and informed questions, and many stayed late. I was struck by one question in particular: "What are physicians doing about this problem?" I came away from this meeting with two distinct impressions: 1) While the work we are doing is important, it has not been widely perceived as such by our peers; and 2) The next generation of physicians is highly knowledgeable and engaged in public policy, which gives me hope about #1.

Millennials are the generation born between 1980 and 1995. They entered the workforce during the worst recession since the Great Depression. They are graduating from medical school with an unprecedented average debt of \$176,000. They are technologically savvy and maintain extensive connections through social media. All these factors add up to a group that is highly motivated and capable of organizing for change. You can see this in the success that political campaigns have had recently when they are able to connect with and mobilize millennials.

The AMA's Medical Student Advocacy Conference has seen over double the number of registrations from last year. We've seen it in increased student and resident participation in our CMS Council meetings. Millennials are informed, articulate and passionate. We need to harness their energy and talent. For that reason, I strongly support increasing resident and student representation at the ISMS House of Delegates meeting, making it proportional to their membership and on a par with other districts. It's time that we gave full voice to the future generation of physicians.

It raises the question: What role should physicians have in shaping public policy? Is it an obligation we have as citizens who are privileged to witness the effects of public policy on our patients' health and lives? Do our responsibilities end with the role of agency, which is acting within the system to facilitate the needs of individual patients? Or do our responsibilities extend to advocacy, which is changing the system so that it works better for all of our patients?

Kathy M. Tynus, MD
President, Chicago Medical Society

Chicago

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High Price of Health Care

Trade agreement could be a bad deal for medicine **By Anna Zelivianskaia**

IN THE MIDDLE of a busy emergency room, a resident tells me, “I just found out how much a brand-name proton pump inhibitor costs—a 400% markup from generic and a few pills cost over \$200!” Unfortunately, this is nothing new. And, in my opinion, the problem will only worsen under what’s known as the Trans-Pacific Partnership (TPP) trade agreement.

The TPP was negotiated between the United States and 11 Pacific Rim countries, and now awaits congressional approval. Based on the final text, which was released in November 2015, the TPP will negatively impact public health in the signatory countries, including the U.S.

Harmful provisions in the TPP would loosen patent requirements, prolong pharmaceutical monopolies, and tighten intellectual property regulations. Longer brand-name monopolies translate into limited generic usage. This is particularly worrisome for developing countries with less access to generics drugs.

According to Public Citizen’s Global Trade Watch, “The TPP would set the parameters” for future efforts by national and state legislatures to reduce the cost of medicines, protect public health and the nation’s fiscal health. Just one critical example: The TPP’s limits on future policy could shut down high-profile reform efforts, first and foremost, for Medicare Part D price negotiation.

Impact on Biologic Medicines

The most controversial TPP medicine-related provision concerns biotech drugs, or biologics – medical products derived from living organisms, Public Citizen states on its website. “Biologics include many new cancer treatments, now averaging around \$190,000 per person per year. Most health systems cannot pay such prices without compromising other health care priorities. In the TPP, the pharmaceutical industry achieved its goal that every TPP country must provide new exclusivity periods for biologics.”

Provisions like these are particularly dangerous in a time when the face of poverty is changing and health care is becoming less affordable. Médecins sans Frontières (MSF) translated as “Doctors Without Borders,” relies mostly on generic drugs to treat many diseases—80% of antiretroviral medicines used by the organization are generics.

In its early years, MSF worked mostly in low-income developing countries. However, poverty now exists and grows in countries with greater overall wealth. MSF today works in over 30 countries with incomes that are categorized as “middle” or “high” by the World Bank. Millions of people will be considered poor in TPP-participating countries once their country reaches middle-or high-income status.

For countries participating in the TPP, patent laws would be relaxed; it would be possible to patent a newer version of an existing medicine even though it has no new therapeutic benefit. The TPP would also extend current patent terms, which are usually 20 years, by five years if the company faces loosely defined “regulatory delays” during the patent process. In certain cases, individual governments can make medicines more affordable in their countries through price controls or reimbursement policies, but the TPP would also restrict the participating countries’ ability to alleviate health care costs using these techniques.


“Harmful provisions in the TPP would loosen patent requirements, prolong pharmaceutical monopolies, and tighten intellectual property regulations.”

According to an MSF spokesman, “Data exclusivity blocks competing firms from using previously generated clinical trial data to gain approval for generic versions of these drugs and vaccines. If pharmaceutical companies have their way, the TPP will block generic producers of biologics from entering the market for at least 12 years.”

The argument for such regulations is that pharmaceutical companies need time to recoup costs lost during the development process; profit promotes innovation. However, the Federal Trade Commission found no evidence to support this and concluded that no years of exclusivity were necessary to promote innovation in biologic drugs. These regulations limit access to life-saving medications for the most underserved patients.

The TPP was negotiated using “fast-track” authority, which means that the final agreement is subject to a straight up-or-down vote by Congress, with little opportunity for debate or amendment. Most trade negotiations require this “fast-track” approach because other countries are unlikely to participate in negotiations if the final deal could have substantial changes or stall during the approval process.

As health care professionals, we have a responsibility to advocate on behalf of our patients. I believe that our efforts across the world will be severely limited if there are restrictions on affordable medications. And because of these threats to public health, I have written to Congress and President Obama to let them know I oppose the TPP.

Anna Zelivianskaia is a fourth-year medical student at the University of Illinois at Chicago. She may be reached at azeliv2@uic.edu. 

Finality on Medicare Overpayment

CMS final rule relaxes the overpayment look-back period **By Clay J. Countryman, Esq.**

“A provider will generally have no more than eight months total to report and return overpayments.”

ON FEB. 12, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to adopt federal regulations regarding Section 6402(a) of the Affordable Care Act that requires health care providers to report and return overpayments within 60 days of identifying an overpayment. These regulations are important to physicians because of the significant liability that providers could be subject to under the False Claims Act and the Civil Monetary Penalties for failure to report and return overpayments to the Medicare and Medicaid programs. CMS had previously issued a proposed rule in February 2012 containing regulations to implement the requirements of Section 6402(a) to report and return overpayments. These proposed regulations had raised several questions and compliance challenges for physicians and other health care providers.

This Final Rule is only applicable to Medicare Parts A and B overpayments, and does not address Medicaid overpayments. CMS has adopted separate regulations for Medicare Parts C and D overpayments, and has not proposed or finalized a rule containing regulations for Medicaid overpayments. Because the requirement to report and return overpayments in Section 6402(a) of the ACA applies to all Medicare and Medicaid payments, providers must determine the requirements that apply to reporting and returning each type of overpayment.

CMS also emphasized that the obligation to report and return overpayments was effective prior to the issuance of this final rule, and providers could face potential FCA and Civil Monetary Penalties liability for failure to report and return Medicare Parts A and B overpayments. The message seems to be that providers should already be in compliance with the overpayment requirements in Section 6402(a) of the ACA.

Questions were submitted to CMS regarding when an overpayment has been “identified” to begin the 60-day clock within which an overpayment must be reported and returned. CMS clarified in this final rule that an overpayment is considered “identified” when a provider “has, or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.”

In regard to “quantification of overpayments,” CMS clarified that a provider is entitled to the opportunity to conduct the auditing work necessary to quantify the overpayment amount before the 60-day clock begins. Specifically, CMS stated that “the 60-day time period begins when either the reasonable diligence is completed or on the day the person received credible information of


a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment.” CMS explained that the identification standard in the final rule is intended to apply to different circumstances that providers may encounter.

The challenge for providers going forward will continue to be to determine quantifying overpayments with regard to a single claim as compared to quantifying other affected claims by the same issue. CMS commented that providers should not report and return overpayments on specific claims from a probe sample in an audit conducted to quantify potential overpayments until the full overpayment from a particular issue is identified. However, physicians should keep in mind that the OIG and other agencies have historically taken the position that overpayments should be returned as they are identified on particular issues.

CMS appears to use the term reasonable diligence to address both “proactive compliance activities” and “reactive investigative activities” by providers in determining if they have received an overpayment. CMS commented that “undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider’s Medicare claims would expose a provider to liability under the identification standard in the final rule for failing to exercise reasonable diligence if the provider received an overpayment.

CMS established a six-month benchmark for the time period of a “reasonably diligent investigation.” The federal agency commented that absent “extraordinary circumstances,” a timely, good faith investigation of credible information about an overpayment will last at most six months from the receipt of credible information. Thus, a provider will generally have no more than eight months total to report and return Medicare Parts A and B overpayments under the final rule (six months for investigation and two months to report and return any overpayments).

CMS also addressed questions about the look-back period that providers should use when conducting internal reviews to quantify overpayment amounts. The final rule states that Medicare Parts A and B overpayments must be reported and returned “only if a person identifies the overpayment within six years of the date the overpayment was received.” CMS had originally proposed a ten-year look-back period for Medicare Parts A and B overpayments.

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Evolving Roles for Physician Leaders

The chief medical officer as a partner for the chief of staff **By Susan Reynolds, MD, PhD**

THE ROLE of Chief Medical Officer in a hospital or health system has evolved. Originally, the CMO primarily served as a liaison between hospital administration and the medical staff. Now the CMO is a vital part of the executive suite, overseeing quality, patient safety, and medical staff affairs. With payment reform now linking reimbursement to quality, the CMO can have a major impact on revenue and often has line item authority over budgetary matters.

The Chief of Staff is elected by the medical staff to represent its members to the hospital board and administration. A Chief of Staff reports to the board. However, the CMO is hired by the hospital and reports to the CEO, and gives input to the board and the C-suite from a physician executive's perspective.

There aren't enough hours in a day for a Chief of Staff to handle all the challenges that medical staff members face. The medical staff oversees credentialing and privileging as well as peer review. A CMO usually oversees Medical Staff Services and therefore can assist the Chief of Staff by making sure credentials files are complete before they are presented to the Credentials Committee. The CMO can also make

sure the medical staff bylaws are followed and legal input is obtained if quality concerns are raised.

Stress and burnout among physicians is on the rise. Disruptive behavior is becoming more apparent, in spite of the Joint Commission's "Zero Tolerance" standard. Such behavior must be dealt with appropriately, and CMOs have time and experience to provide such support to the Chief of Staff.

More than half of CMOs now hold advanced degrees, which include education about quality metrics, patient safety, finance and budgeting, and population health management. Not only can such CMOs support the Chief of Staff and the Medical Executive Committee, but they can also assure that hospital goals pertaining to the medical staff are met.

An effective leader removes obstacles so that followers can succeed. The CMO can often be an obstacle remover for the hospital's elected physician leaders. Collaboration is essential so that physician leaders who are either elected or hired achieve their objectives together.

Susan Reynolds, MD, PhD, is president and CEO, The Institute for Medical Leadership. [C](#)

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Physician Stress and Burnout: A Growing Epidemic

Your Society will create programs to help

PHYSICIANS DON'T need a study to tell them that stress and burnout in their professional ranks is increasing as health care system demands become increasingly more complex and intrusive. But in December 2015, an update from a three-year study evaluating burnout and work-life balance from the Mayo Clinic and the American Medical Association shows that American physicians are worse off today than they were three years earlier. Meanwhile, these factors remained largely unchanged among U.S. workers in general, resulting in a widening gap between physicians and workers in other fields. The study compared data from 2014 to metrics they collected in 2011 and found that now more than half of U.S. physicians are experiencing professional burnout.

In addition, an article in the Dec. 8, 2015, issue of *JAMA Network* revealed that 28.8% of resident physicians report depression or depressive symptoms, and therefore, are entering their careers depressed. Stress was better treated in the past, and physicians could take a day off each week, for example, to unwind. Residents worked longer hours but they were able to reap the rewards by staying connected with cases through their duration. At all levels, physicians and residents fear admitting to being

stressed, an ingrained form of thinking in which one must never fail the patient, show weakness, and seem unaccustomed to hard work.

To actively address these concerns, the Chicago Medical Society (CMS) recently approved the outline for an educational series. As recommended by the Public Health Committee, in a resolution, CMS will involve psychiatrist members in planning the comprehensive member benefit to be offered through the Society.

Specifically, the resolution calls for CMS to develop a series of programs, which may include continuing medical education credit, to assist physicians in the early identification and management of stress. The programs will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, as well as help physicians recognize when to seek professional assistance for stress-related difficulties. Your Society feels that these programs are needed more than ever to help member physicians find ways to relieve stress and burnout so they can continue to provide high-quality care to their patients. The resolution was adopted in February 2016. [C](#)

Equitable Costs for the Uninsured

Resolution calls for greater transparency in hospital health care costs

WHEN IT COMES to health care, it is no secret that uninsured patients usually get the raw end of the deal—and that's especially so when it comes time to pay their hospital bills. Generally, uninsured patients in Illinois are charged the full amount for hospital services while insurance companies pay a lower amount for their clients. That's where a resolution submitted by Linda F. Gruenberg, DO, a psychiatrist, comes in.

In her resolution, Dr. Gruenberg calls for greater transparency and disclosure of the cost of hospital health care services. Specifically, the resolution led the Chicago Medical Society to adopt policy that self-pay and uninsured patients should not be billed higher charges for hospital services than the maximum amount the hospital is reimbursed by a third-party insurer. In addition, the resolution calls for the Illinois State Medical Society to work with the Illinois Attorney General to create an agreement that prevents hospitals from charging uninsured patients more than insured ones.

The step is not without precedent. In Minnesota,

the Attorney General and Minnesota hospitals have entered into an agreement relating to hospital billing and collection practices. Among the items in the agreement is a provision that a hospital may not charge an uninsured patient more than the hospital would be reimbursed by its largest insurer for those with health insurance—in other words, reimbursement for treatment costs for uninsured and insured patients should be equitable.

Wisconsin, too, has been a leader in creating transparency in the cost of hospital health care services. The state's hospitals share cost-related information online. Patients can compare hospital prices for a variety of services, locations and types of services (such as inpatient, outpatient surgery or emergency services) as well as other financial information.

With this resolution, Dr. Gruenberg hopes to make costs more equitable between uninsured and insured patients who visit a hospital for health care services, thus continuing CMS' role at the forefront of patient advocacy. The resolution was adopted by the CMS Governing Council in February 2016. [C](#)

2016 Medicare Physician Fee Schedule

CMS releases the Final Rule


By Nicole Channell

THE CENTERS for Medicare and Medicaid Services (CMS) has released the revised 2016 final Physician Fee Schedule. When Congress repealed the sustainable growth rate (SGR) formula, it called for an annual raise of .5% from 2016 through 2019 as a part of a transition to value-based reimbursement. But this has evolved into a .3% pay cut in the final rule this year.

CMS lowered the conversion factor (CF) by .02% to reflect an RVU budget neutrality adjustment. CMS also tacked on an additional .77% decrease to meet cost-savings targets. CMS only corrected enough misvalued codes for a savings of .23%. Because it fell short of the 1% mark, CMS is obligated to reduce total fee-for-service spending on physicians by .77% to make up the difference.

Here is a snapshot of the combined estimated impact (work, MP and PE RVU changes) for select specialties from CMS. The impact illustrated here only reflects the change in RVUs; it does not include the CF calculation for 2016.

Specialty	Combined Impact
Cardiac Surgery	0%
Clinical Psychologist	0%
Dermatology	-1%
Diagnostic Testing Facility	0%
Emergency Medicine	0%
Gastroenterology	-4%
Hematology/Oncology	0%
Independent Laboratory	9%
Interventional Pain Management	0%
Interventional Radiology	1%
Nurse Anesthesiologist	0%
OB/GYN	0%
Ophthalmology	-1%
Orthopedic Surgery	0%
Otolaryngology	0%
Pathology	8%
Plastic Surgery	1%
Psychiatry	0%
Radiation Oncology	-2%
Radiology	0%
Rheumatology	0%
Urology	0%
Vascular Surgery	-1%

Nicole Channell is a health care consultant with PBC Advisors, LLC, in Oak Brook. The company provides business and management consulting and accounting services to physician practices and hospital systems. Visit www.pbcgroup.com. 



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Helping Physicians With Opioid Management

Your Society will create specialized programs

IT'S NO SECRET that opioid abuse is on the rise. According to a 2015 study by the Centers for Disease Control and Prevention (CDC), drug overdose is the leading cause of accidental death in the United States, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.

As a result, many local, state and federal agencies have begun to demand more education for physicians on dispensing opioid prescriptions as well as recognizing and preventing addiction in their patients. The American Medical Association now has a task force to reduce opioid addiction abuse, which includes members of 25 state, specialty and other health care associations. The task force encourages physicians across the nation to educate themselves on managing their patients' pain and promoting safe, responsible opioid prescribing.

Similarly, the Chicago Medical Society is

concerned about the rise in prescription opioid abuse. As a result, CMS approved a resolution aimed at helping member physicians more safely manage pain and opioid prescribing.

The measure was adopted by the Governing Council in February 2016. Basically, it calls for CMS to develop continuing medical education courses on pain management and opioid prescribing for member physicians. It also specifies the type of education the CME courses should contain.

According to the resolution, CMS-developed content should educate member physicians on how to address proper drug disposal with their patients. It should also address the role of physicians in increasing access for their patients to substance abuse treatment. And finally, the content should educate physicians on how to incorporate risk management strategies into their practices in order to reduce the number of opioids prescribed and related opioid abuse, addiction and deaths. All are excellent and necessary goals. **C**

Safe Drug Substitutions

New patient safety law amends the Pharmacy Practice Act

WHEN A PHYSICIAN indicates on the original prescription "Do Not Substitute," it clearly prohibits a pharmacist from switching a brand name drug for a generic. Nonetheless, patients report instances where pharmacies make a substitution without notifying the doctor or patient. Patients may not realize the error until they get home and find their insurer won't cover another 30-day supply.

Now, with the proliferation of biological medicines and biosimilars, the State of Illinois has a new law regulating these products' substitution. SB 455 amends the Pharmacy Practice Act, and spells out the conditions under which a pharmacist in Illinois may substitute a prescription interchangeable product for a prescribed biological product. The law, which went into effect Jan. 4, 2016, creates a framework for substitutions and defines "biological product" and "interchangeable biological product." The Chicago Medical Society will push for strict enforcement of the law's provisions to ensure the safety of patients.

The need for oversight was the subject of a resolution brought by psychiatrist Linda Gruenberg, DO, to the CMS Governing Council. The measure, which was adopted in November 2015, drew attention to the risks for patients.

Under the law, substitutions are permitted

only when the following conditions are met: the prescribing physician does not designate that substitution of an interchangeable biological product is prohibited; the FDA has determined the substitute product is interchangeable with the prescribed biological product; and the pharmacy informs the patient of the substitution.

Dispensing pharmacists are to report the substitution within five business days after the dispensation of any biological product. Such a report must be entered into an electronic record the prescriber can access via one of the following means: an interoperable electronic medical records system; or electronic prescribing technology; or pharmacy benefit management system; or a pharmacy record. If these options cannot be accomplished, the pharmacist is required to communicate via fax, or telephone, or electronic transmission.

Of course, when there is no FDA-approved interchangeable biological product for the medication prescribed, or a refill prescription has not changed from the product dispensed on the prior filling of the prescription, such communication is not required.

Entry into an electronic records system is presumed to provide notice to the prescriber. Active, or prior notification, to the physician of a dispensation is not required under the law. **C**

Exciting New Program from the Medical Student Section of the The Chicago Medical Society (CMS)

Health experts from diverse professional backgrounds will address medical students about timely, important topics...

Don't miss your chance to participate in this intimate, engaging, and fun development forum about organized medicine, health policy, and the tools you'll need to become an effective, confident and knowledgeable health advocate!

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- *How medical students can create change in their school and/or community?*
- *How to educate elected officials?*

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Sessions & Speakers

March 8 – April 12

Tues, March 8th, 7:00 P.M. at CMS headquarters (515 N. Dearborn St.)

Dr. Stephen Ondra, SrVP & CMO, HCSC (Blue Cross/Blue Shield of IL parent company)

Previously Senior VP & CMO of Northwestern Memorial Hospital, Interim Chair of Neurosurgery, and Senior Health Policy Advisor to President Obama's Administration, Dr. Ondra will share his professional experiences and how each of his roles has impacted patients, health policy, and the field of medicine. [Dr. Ondra information.](#)

Tues, April 12th, 6:00 P.M. at CMS headquarters (515 N. Dearborn St.)

Dr. Kathy Tynus, President, Chicago Medical Society

Dr. Tynus cover organized medicine, what it does, how she got involved in it, and the positive impact she has made in medicine throughout her training and career. She has had various committee and leadership roles at CMS and the Illinois State Medical Society on issues including public health, continuing medical education, the health workforce, and healthcare finance. [Dr. Tynus information.](#)

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CMS medical students* who attends two of these three sessions will obtain a **Certificate of Completion** and become a Fellow of The Chicago Medical Society (great for your resume!). You will also be eligible to apply for a **PAID trip to Washington, D.C.** to advocate alongside other CMS physicians! Plus, enjoy a **free dinner** at these talks!

RSVP (*Space is limited to a first-come-first-served basis.*)

Online RSVP here: <http://goo.gl/forms/J5QX2MU0qw>

Questions? Contact CMS Medical Student Trustee, Christiana Shoushtari (students@cmsdocs.org)

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Preventing Gunshot Wounds

Three CMS resolutions target the epidemic of firearm injuries and fatalities in Chicago

“In the first ten days of January this year, at least 120 people in the city had suffered gunshot wounds.”

GUN VIOLENCE in Chicago is reaching epic proportions. In the first ten days of January this year, at least 120 people in the city had suffered gunshot wounds, including 19 fatalities according to Chicago police. During the same time frame a year ago, 40 people had suffered gunshot wounds, including nine fatalities, according to statistics kept by the *Chicago Tribune*. If the trend keeps up, this year Chicago will top its 2,986 gunshot wound victims in 2015.

The solutions to the problem are by no means easy or obvious. But the Chicago Medical Society (CMS) is throwing its weight into the issue by backing three resolutions that support research into firearm safety, stricter requirements for criminal background checks for people purchasing guns and reworking the term “gun control” so that it takes on a meaning of “gun violence mitigation” rather than being seen as an infringement on Second Amendment rights. The three resolutions are meant to strengthen current CMS positions or throw support behind efforts by the Centers for Disease Control and Prevention (CDC). All of them were adopted by the CMS Governing Body in February 2016.

Research on Firearm Safety

This resolution from CMS’ Public Health Committee supports funding for Centers for Disease Control research on firearm safety and gun violence prevention in the United States. Legislative attempts to authorize the appropriation of funding failed this past summer in Congress since current federal law states that, “None of the funds made available for injury prevention and control at the CDC may be used to advocate or promote gun control.” Similar language was added to the National Institutes of Health budget.

Yet the CDC continues to issue regular reports on incidents of gun violence in the U.S. without advocating for gun control. CMS’ support for CDC research is an extension of its overall public health approach to gun violence, which is concerned with prevention that does not conflict with Second Amendment rights. In addition to encouraging and supporting CDC research, this resolution also calls for a combination of public and private funding sources.

Specifically, the resolution directs CMS to support legislation that would appropriate funding for CDC research on firearm safety or gun violence prevention. Currently, for example, there is legislation in Congress (HR 2612) that would appropriate funds to the CDC for the purpose of conducting or supporting research on firearm safety or gun violence.

The resolution also requires that CMS join with all major national medical societies to work together toward achieving increased public and private funding for the development, evaluation, and implementation of evidence-based programs and policies to reduce firearm-related injury and death. And finally, the resolution calls for CMS to condemn the daily firearm violence throughout our city and nation.

Gun Violence


This resolution builds on CMS’ longtime existing policies opposing the ready accessibility of handguns without evidence of responsibility on the part of the possessor; stricter enforcement of local and state and federal laws; imposition of maximum penalties on offenders; and the right of counties and municipalities to enact ordinances governing ownership, sale, and transport of firearms.

CMS has previously advocated against gun violence as a public health problem and formed policy regarding firearm safety, criminal background checks for all gun sales, including gun shows both public and private. These positions have been affirmed by not only CMS but also by the Illinois State Medical Society (ISMS) and the American Medical Association (AMA).

In this resolution, CMS will request ISMS to support legislation that requires criminal background checks for all gun sales, public, private and Internet-based. Your Society will also request that ISMS support legislation that would restrict the sale of military style assault weapons and large capacity magazines for civilian use.

Gun Control Terminology

This Public Health Resolution basically advocates for the use of less controversial language when describing efforts to mitigate gun violence. Currently, the term “gun control” has negative connotations that seemingly restrict Second Amendment rights of U.S. citizens to bear arms. It also reinforces that previous CMS resolutions and resulting policies have focused on efforts to prevent death and injury from gun violence, rather than control actual gun use.

As a result, this resolution calls for using the term “Gun Violence Mitigation Law/Legislation,” or “GVML,” or “Gun Violence Mitigation,” or “GVM,” in future resolutions and policies as an alternative to “Gun Control Law/Legislation” or “Gun Control” language. It also requests that the ISMS adopt such language and further relay this resolution to the AMA House of Delegates to enact into national policy. 

Protecting Kids from Loud Toys

CMS joins groups calling for better testing and labeling of products

IT'S WELL KNOWN that loud or prolonged elevated levels of sound can produce long-term hearing loss. But children, due to their immaturity, may be more susceptible to damage to the nerve fibers in the inner ear. They also have the most to lose: when hearing loss occurs at a young age, the repercussions can be most profound—academically, socially and professionally.

An estimated one in five U.S. children will have some degree of hearing loss by the time they reach age 12, according to the Third National Health and Nutrition Examination Survey. This could stem from the number of children playing with toys and other products that emit loud sounds.

To help parents and prod manufacturers toward greater safety, the Chicago Medical Society (CMS) recently approved recommendations to guide both state and national efforts. Laying this foundation, CMS' Governing body, which voted in February 2016, said that children should avoid toys that produce sound greater than 85 dB of SPL (sound pressure level) or greater than 90 dB SPL for more than one hour. The author of this measure, Ajay Chauhan, DO, also calls for setting audible toy sounds at 40-50 dB SPL.

An otolaryngologist, Dr. Chauhan wants the Illinois State Medical Society and American Medical Association to adopt these recommendations as a springboard for further action. Neither organization currently has specific policy in this area. Once the language is in place, the measure would then seek to require manufacturers to label toys with the level of sound produced or with a warning that sound production exceeds safety standards.

Many toys exceed 65 decibels, and even 85 decibels, when measured at 2.5 centimeters; children often hold toys pressed up against the ear. Noise-induced hearing loss can result from a one-time exposure to a very loud sound (at or above 120 decibels), blast, impulse, or by listening to loud sounds (at or above 85 decibels) over an extended period. The louder the sound, the shorter the time period before hearing damage occurs, the CDC states. Listening to portable media devices such as compact disc and MP3 players at high-volume levels (above 85 decibels) for long periods of time can cause similar damage.

PIRG: Tougher Standards

Over time, noise standards have been put in place. In 2009, federal law gave the Consumer Product Safety Commission authority to enforce voluntary standards contained in the comprehensive ASTM


F963 toy standard.

Under the American Society of Testing and Materials standard, the sound-pressure level produced by toys should not exceed 85 dB at 50 cm from the surface of the toy. However, children play with toys at much closer range. The ASTM standard states that hand-held, floor, crib and tabletop toys should not produce continuous sound above 85 decibels when measured from 25 centimeters (about 10 inches). Close to the ear toys should not produce continuous sounds that exceed 65 decibels when measured from 2.5 centimeters (about 1 inch). Toys with impact-type impulsive sounds should not produce a peak sound in excess of 115 decibels when measured from 25 centimeters; and toys with an explosive-type sound should not produce a peak sound in excess of 125 decibels when measured from 25 centimeters.

Yet even with these improvements, the current standards do not take into account how children play with toys. The Public Interest Research Group (PIRG) Education Fund, in its 2015 report, "30th Annual Survey of Toy Safety: Trouble in Toyland," found that some products marketed to kids under age three, while not exceeding the federal requirement, remain too loud and dangerous. PIRG argues that the current standards should undergo further review by the CPSC. For instance, the distance at which toy volumes are tested for compliance with federal standards are longer than a child's reach, not taking into account the child's shorter arms.

PIRG measured the loudness of toys using a hand-held digital sound-meter, taking the readings from 20 inches away, as well as right up against the toy, to determine the range of noise exposure for a child playing with these toys. The results of the survey can be found in the 2015 report. PIRG's review followed the Occupational Safety and Health Administration standard of 85 decibels as the lower limit for possible hearing damage.

Advocates for children's hearing encourage parents to download a smartphone app that can measure sound levels and use it to test the sound level of toys in the store. A simple rule is that if the toy sounds too loud for the parent, then it is too loud for a child. If a child has a loud toy at home or is given one as a gift, the parent can place clear packing tape over the speaker to reduce the noise level. Finally, parents should look for toys that have volume controls.

Lifelong consequences of hearing loss include impaired learning and memory, occupational and social functioning, and psychological and physiological harm. 

"An estimated one in five U.S. children will have some degree of hearing loss by the time they reach age 12."

Managed Care Litigation

As networks narrow, U.S. District Court case filings are on the upswing

By Jonathan M. Herman, Esq.

“The root cause of these trends appear to be based on issues pertaining to the network relationship between payors and providers, particularly the “narrowing” of networks.”

IN THE TRIPARTITE relationship among payors (insurers and self-funded plans), providers (physicians, hospitals, and other medical service providers), and patients (members of individual or group health plans), not a day passes without palpable tension among them. Payors strive to adhere to their committed risk set forth in their health benefit plans, providers demand fair payment for services rendered, and patients simply want coverage for their medical expenses. This is the world of “Managed Care Litigation.”

Put another way, the payor-provider-patient relationship is a tug of war that is “all about the money,” frequently having little to do with patient care because when litigation is initiated by an out-of-network provider, it is usually an attempt to recover the difference between a perceived underpayment and billed charges. By definition, there is not a contract between the parties which would speak to amounts of payment and patient care. Conversely, a member seeking coverage for a procedure invariably contends that the procedure is “medically necessary,” indirectly implicating a desire for the best possible care. Then the question is whether the policy language affords coverage for the desired service, or an alternative service.

This article discusses some of the empirical data attendant to managed care cases filed since January 2014, comparing the first nine months of 2014 to the first nine months of 2015. It also discusses some recurring subject matter themes.

The Numbers Behind the Filings

In the first nine months of 2014, there were 312 managed-care related lawsuits, involving Blue Cross Blue Shield Plans (109 cases), Aetna (82 cases), United Healthcare (47 cases), Humana (41 cases), and CIGNA (33 cases). Of all those cases, 104 were filed on behalf of members, 75 on behalf of physicians, 75 on behalf of other service providers, and 36 on behalf of facilities. There were 14 cases on behalf of plan sponsors (employers offering a group health plan for the benefit of their employees), six cases involving a plan’s subrogation rights, and two cases filed by health insurers seeking repayment from a provider. During this period, the greatest concentration of cases was filed in the U.S. Eleventh Circuit (75), followed by the U.S. Ninth Circuit (46), and the U.S. Fifth and Sixth Circuits (42 each).

In the first nine months of 2015, there were 362 managed-care related disputes, filed against Blue Cross Blue Shield Plans (159 cases), Aetna (86 cases), United Healthcare (55 cases), Humana (16 cases), and CIGNA (46 cases). Of all those cases, 153 were filed on behalf of members, 35 on

behalf of physicians, 20 on behalf of other service providers, and 89 on behalf of facilities. There were 50 cases on behalf of plan sponsors, seven cases involving a plan’s subrogation rights, and eight cases filed by health insurers seeking repayment from a provider. During this period, the greatest concentration of cases was filed in the U.S. Sixth Circuit (74), followed by the U.S. Ninth Circuit (64), and the U.S. Tenth Circuit (42).

The number of newly filed cases increased by about 16% from the first nine months of 2014 and the same time period in 2015. The number of cases filed on behalf of members seeking coverage of a disputed claim increased by 47%. While cases filed on behalf of physicians and other service providers have decreased, cases filed by facilities have more than doubled. Cases filed by health insurers seeking recovery of overpayments have quadrupled. The U.S. Sixth Circuit has replaced the U.S. Eleventh Circuit as the hotbed of newly filed cases, although new case filings in the U.S. Ninth Circuit have remained high in both periods. (The Ninth Circuit encompasses California which, given its large population, invariably sees a lot of claims. There does not appear to be any pattern of cases originating within other Circuits.)

The root cause of these trends appears to be based on issues pertaining to the network relationship between payors and providers, particularly the “narrowing” of networks. As physicians and other service providers go in-network, their disputes become governed by a contract or an arbitration clause. Facilities which choose to remain out-of-network may find that their charges are subject to a high patient responsibility, where the patient lacks the ability to pay.

Emergent Case Themes

The impetus behind an increasing number of cases from 2014 to 2015 appears to be the providers’ revenue compression, frequently as a reduction in out-of-network payments by payors and increased patient responsibility. Payors often cite increased costs to treat sick individuals, citing the Patient Protection and Affordable Care Act (PPACA), which likely also prompts a more proactive effort to recover alleged overpayments from providers. The following specific themes have emerged:

- Efforts to obtain coverage for mental health benefits represent the largest subject matter of new cases filed in 2015 (29 new cases in 2015 versus 16 cases in 2014). Many of those efforts seek recovery of benefits for treatment received by adolescents at residential treatment centers (19 cases in 2015). Frequently, plaintiffs allege

that coverage was denied on the basis that the patient could be treated on an outpatient basis and/or with a less restrictive level of care. There have been 10 filed cases alleging violations of the Federal Mental Health Parity Act and/or its state law equivalent. The increase in cases seeking coverage for mental health benefits is apparently due to an increased awareness of mental health parity laws. Prior to the passage of such laws, benefits were often limited, if at all available. Yet even though mental health benefits must be “on par” with other plan benefits, many mental health benefit providers remain out-of-network, leaving members with high patient financial responsibility.

- Class action filings almost doubled in 2015, with 24 new cases filed in 2015 versus 14 in 2014. The subject matter of the 2015 class actions include efforts to obtain coverage of Harvoni, alleged to be a breakthrough, lifesaving treatment for Hepatitis C; efforts to obtain coverage for applied behavior analysis therapy for the treatment of autism; coverage for cervical artificial disc replacement; and a challenge to an insurer’s requirement that plan enrollees with HIV/AIDS obtain specialty medications from a mail order pharmacy instead of a local pharmacy, which would be out-of-network and therefore result in pricing discrimination.
- Payors are taking significant, proactive efforts to recover alleged overpayments from providers, typically alleging that the providers are engaging in “fee forgiveness,” namely forgiving the out-of-pocket amounts that patients would otherwise have to pay under their health benefit plan to out-of-network providers. Conversely, providers frequently allege that payors are improperly offsetting and/or withholding amounts properly payable under claim submissions on behalf of other, unrelated patients.

In one case directly asserted under the PPACA, an in-network diagnostic laboratory alleged that the payor’s unilateral 60% reduction in reimbursement rates violates Section 2706 of the PPACA (no discrimination against a provider acting within the scope of its license, with differences in reimbursement rates based only on quality or performance measures).


Additional types of managed care litigation can be

expected. For instance, provider revenue compression will likely drive additional litigation. In-network providers are pursuing litigation under state law prompt pay statutes, alleging that such laws require higher reimbursement than that ordinarily due under the contract. Moreover, certain types of cases will become more common. Citing the PPACA, payors are seeking premium growth and certainly do not appear to be shy about pursuing recovery of overpayments made to providers. Patients will continue to demand coverage for their claims, especially given the emergence of mental health parity laws.

No Sign of Abatement

Managed care case filings are up from 2014 through 2015 and show no sign of abating. The class action will likely remain the procedural vehicle of choice for patients and providers, and may prove to be a two-edged sword: an action finding coverage across the class unquestionably benefits patients and providers, but a successful defense by the payor may bar all such efforts at coverage. Finally, payors will continue to mine their claims data looking for outliers and have every incentive to recover overpayments, especially when acting as an Employee Retirement Income Security Act of 1974 (ERISA) plan fiduciary.

(The case statistics discussed in this article are derived from cases filed in the U.S. District Courts, as original proceedings or removed from state court. Insofar as the health plans at issue are invariably provided as employer group health benefits, the predicate for removal to federal court is usually ERISA, which additionally governs the evidentiary burdens of the parties to the litigation. Cases pending in state court rest exclusively upon state law theories of recovery (the provider’s claim that the payor negligently misrepresented benefits, for example). The case statistics cited in this article would likely be higher if the state court population of cases were included.

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“Payors will continue to mine their claims data looking for outliers and have every incentive to recover overpayments.”

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.

Medicare and Telemedicine

New federal payments models on the horizon to accelerate acceptance, widespread use

By Adam Romney, Esq., and Michaela Andrawis, Esq.

TELEMEDICINE—the use of video and Internet technology as a health care delivery tool—is going viral. It has the potential to transform health care by allowing facilities and practitioners to diagnose and treat individuals from practically any location. Telemedicine could improve patient access to services, lower costs and create better patient experiences. Despite this potential, Medicare coverage and payment for telemedicine has been extremely limited.

Generally, Medicare fee-for-service reimbursement of telemedicine requires real-time, interactive audio and video telecommunications between the provider and beneficiary. The beneficiary must: 1) be geographically located in a rural area; 2) be located at an approved “originating site” (physician offices, hospitals, or skilled nursing facilities); 3) be seen by an approved provider-type (physicians, nurse practitioners, clinical psychologists); and 4) receive one of an approved list of services (certain consultations, assessments, office visits, therapies, and health-management training). Services delivered via telemedicine that do not meet these criteria are not entitled to Medicare payment. Medicare’s restrictive policy on telemedicine has arguably caused deceleration in the development and implementation of telemedicine technologies by providers.

health care organizations to participate in the Bundled Payments for Care Improvement-Model 2 (BPCI-Model 2), which involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. BPCI-Model 2 episodes of care include a beneficiary’s inpatient stay in an acute care hospital, post-acute care and all related services during the episode of care, which ends either 30, 60, or 90 days after hospital discharge.

Under BPCI-Model 2, Medicare continues to make fee-for-service payments to providers and suppliers furnishing services to beneficiaries in Model 2 episodes. The total expenditures for a beneficiary’s episode of care is later reconciled against a bundled payment amount, determined by CMS to be the target price. A payment or recoupment amount is then made by Medicare reflecting the aggregate performance compared to the target price.

CMS has waived certain conditions of payment for telemedicine services under BPCI-Model 2. For instance, it waives the geographic area requirement for telemedicine services furnished to beneficiaries during a BPCI-Model 2 episode, as long as the services are furnished in accordance with all other Medicare coverage and payment criteria. However, patients must

“The Comprehensive Care for Joint Replacement (CJR) Model will test bundled payment and quality measurement for an episode of care associated with hip and knee replacements.”

Medicare may be changing its tune. Several new programs suggest that the Centers for Medicare and Medicaid Services (CMS) is experimenting with broadening its restrictive telemedicine policies. For example, the Affordable Care Act (ACA) allows CMS to explore new payment models to improve quality and lower costs, and encourages the use of telemedicine technologies. Accordingly, the federal CMS has developed innovative payment models that include increased opportunity for telemedicine reimbursement from Medicare.

Bundled Payments for Care Improvement

In October 2013, CMS began testing selected

still be located in an approved “originating site” (physician offices, hospitals, or skilled nursing facilities).

The geographic area requirement waiver would allow participants to receive Medicare reimbursement for telemedicine services provided to a much larger patient population. Under BPCI-Model 2, participants may be reimbursed for tapping into the large population of Medicare beneficiaries in major U.S. cities.

Medicare Shared Savings Program

In June 2015, CMS released the Final Rule for the Medicare Shared Savings Program (MSSP). The MSSP was established by the ACA and is intended

to create a new approach to the delivery of health care by facilitating coordination and cooperation among providers. Providers may participate in the MSSP by creating or participating in an Accountable Care Organization (ACO).

The ACA requires ACOs to “define processes to...coordinate care, such as through the use of telemedicine, remote patient monitoring, and other enabling technologies.” The Final Rule for the MSSP addressed this statutory language by adding a requirement that ACOs describe in the MSSP participation application how it will encourage and promote telemedicine technologies for improving care coordination.

CMS has also indicated it will consider waivers of telemedicine payment rules proposed by individual MSSP participants on a case-by-case basis.

Next Generation ACOs

In March 2015, CMS announced the Next Generation ACO Model, an initiative that will allow participating ACOs to assume higher levels of financial risk and reward than are available under the MSSP. The goal is to test whether strong financial incentives for ACOs, coupled with tools to support better engagement and care management, can improve health outcomes and lower costs.

For Next Generation ACOs, CMS indicated it will waive the geographic area requirement and the originating site requirement to receive Medicare reimbursement for telemedicine services. These waivers will allow for payment of claims for telemedicine services delivered to beneficiaries in specified facilities or at their home, regardless of the beneficiary's geographical location, including those in large U.S. cities.

In spite of these waivers, telemedicine services must comply with all other Medicare coverage and payment criteria, and no additional reimbursement will be made for set-up costs, technology purchases, training, or other costs. In particular, services are limited to professional consultations, office visits, office psychiatry services, and additional services specified through regulation. CMS also specified certain telemedicine claims would not be allowed if service is rendered to beneficiaries at their residence, including: 1) follow-up inpatient telemedicine consultations for beneficiaries in hospitals or skilled nursing facilities; 2) subsequent hospital care services, with the limitation of one telemedicine visit every three days; and 3) subsequent nursing facility care services, with the limitation of one telemedicine visit every 30 days.

Comprehensive Care for Joint Replacement

In November 2015, CMS released the Final Rule for a new model to support improved and efficient care for beneficiaries undergoing hip

and knee replacements. The Comprehensive Care for Joint Replacement (CJR) Model will test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

CMS recognized the overall benefit of telemedicine technologies and expects the CJR model design features to build interest in furnishing telemedicine services to beneficiaries in their place of residence. Accordingly, for the CJR model, CMS will waive the requirement that beneficiaries be located in a rural location. This waiver will allow providers and suppliers furnishing services to utilize telemedicine for CJR beneficiaries beyond those located in rural areas.


Under appropriate circumstances and in order to test the CJR model, CMS will waive the originating site rule—requiring the beneficiary to present from a clinical location such as a hospital, physician office, or skilled nursing facility—only when telemedicine services are being furnished in the CJR beneficiary's place of residence during the episode.

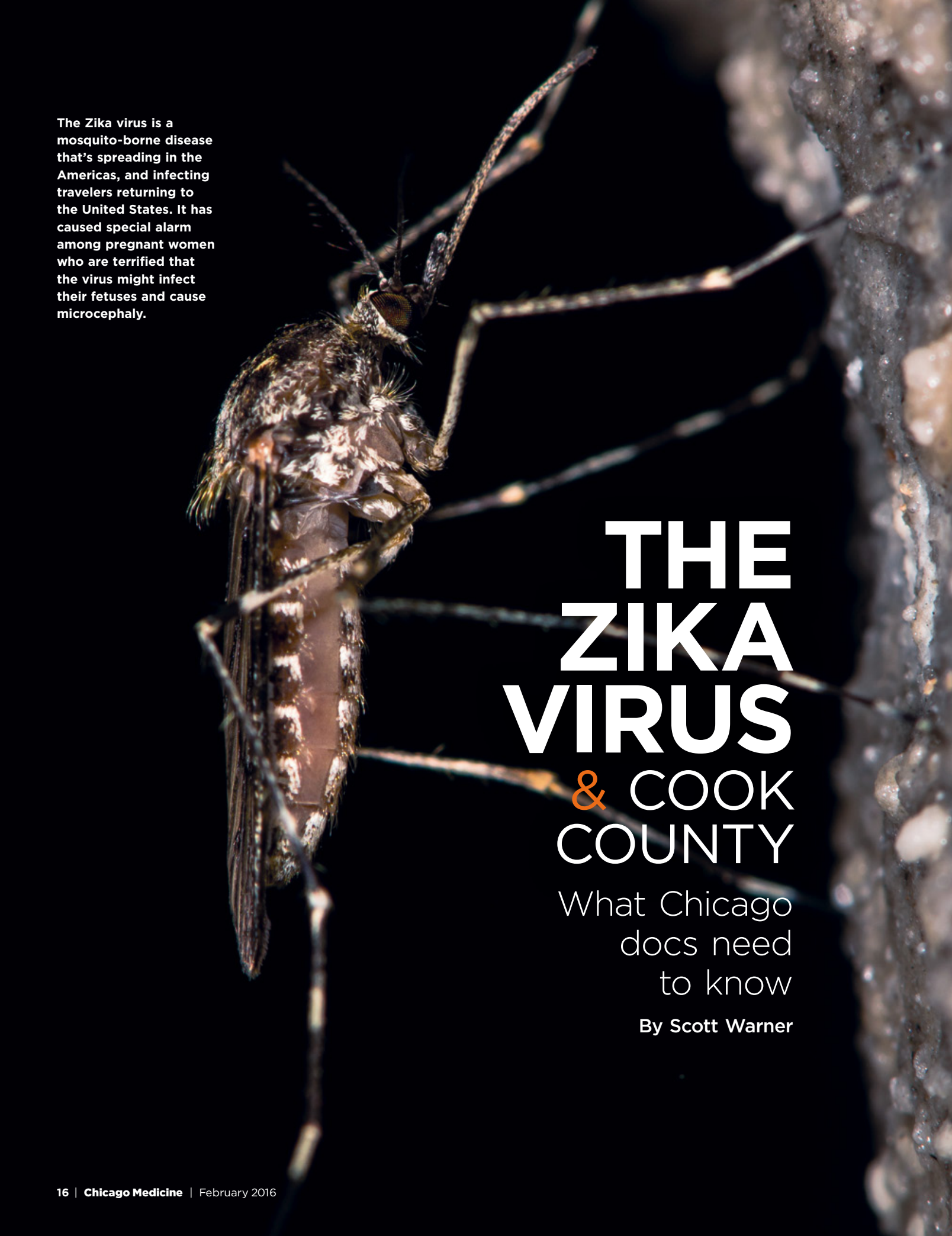
With these two CJR waivers, Medicare-covered telemedicine services may be furnished to a beneficiary in his or her place of residence, unless the service is not appropriate for the beneficiary's place of residence (subsequent hospital care services). Otherwise, telemedicine services must be furnished in accordance with all Medicare coverage and payment criteria.

CMS will monitor patterns of utilization of telemedicine services under the CJR model to monitor for overutilization or reductions in medically necessary care, and significant reductions in face-to-face visits with physicians and nurse-practitioners. In the Final Rule, CMS declined any waiver to permit payment of telemedicine services for home health services or social work related to the CJR model. Such services must still be provided in-person to be eligible for Medicare payment.

Telemedicine to Grow

These recent innovative models suggest that coverage and payment for telemedicine under traditional Medicare Part A and Part B is likely to grow. As Medicare expands coverage and relaxes its conditions of payment for telemedicine, wider acceptance and implementation of telemedicine services and technologies is likely to follow suit.

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The Zika virus is a mosquito-borne disease that's spreading in the Americas, and infecting travelers returning to the United States. It has caused special alarm among pregnant women who are terrified that the virus might infect their fetuses and cause microcephaly.

THE ZIKA VIRUS & COOK COUNTY

What Chicago
docs need
to know

By Scott Warner

IT'S NOWHERE NEAR as horrifying as the Ebola virus, but news about the mysterious Zika virus has stirred up fear among the public. People want to know how likely they are to get this mosquito-borne virus that's spreading in the Americas, and infecting travelers returning to the United States, including Illinois. They want to know how sick they can become and pregnant women, or those who might become pregnant, are expressing terror that their fetus will develop microcephaly, for which there is no known cure or standard treatment.

"We wouldn't even be talking about the Zika virus if it weren't for the headlines about pregnancy outcomes," says Allison Arwady, MD, chief medical officer, Chicago Department of Public Health (CDPH). Dr. Arwady is referring to reports, like those from Brazil, where since last November, there have been 404 confirmed cases of microcephaly in newborns, 17 of which were confirmed to have the Zika virus. Links between the virus and poor pregnancy outcomes are still under investigation but public health officials are concerned.

All told, Brazil had an epidemic of an estimated one million cases of the virus in 2015. And a growing number of countries are reporting presence of the virus. While no mosquito-borne Zika virus cases have yet been reported in the United States, there have been travel-associated cases, and reports of sexually transmitted Zika in Texas. In Illinois, three travel-related cases have been reported to date.

Understanding the Zika Virus

The Zika virus is a mosquito-borne flavivirus transmitted primarily by *Aedes aegypti* mosquitoes. *Aedes aegypti* mosquitoes are not endemic to Illinois.

Zika virus infection should be considered in patients with acute onset of fever, maculopapular rash, arthralgia or conjunctivitis, who traveled to areas with ongoing transmission in the two weeks prior to illness onset. The illness is usually mild with symptoms lasting from several days to a week. Severe disease requiring hospitalization is uncommon. Because of possible associations with poor pregnancy outcomes, until more is known, the Centers for Disease Control and Prevention (CDC) recommends that pregnant women in any trimester and women trying to become pregnant consider postponing travel to areas with active Zika transmission.

Outbreaks of Zika have occurred in parts of Africa, Southeast Asia, the Pacific Islands, and the Americas. Currently, active transmission is occurring in areas of Central America, South America, the Caribbean, Mexico and Puerto Rico. Because the *Aedes* species of mosquitoes that spread Zika virus are found throughout the world, it is likely that outbreaks will spread to new countries; see www.cdc.gov/zika for updated travel information.

In December 2015, Puerto Rico reported its first confirmed Zika virus case. Spread of the virus through blood transfusion and sexual contact has been reported.

There is no vaccine to prevent or medicine to treat Zika. Travelers can protect themselves from this disease by taking steps to prevent mosquito bites. When traveling to countries where Zika virus or other viruses spread by mosquitoes have been reported, they are advised to use insect repellent, wear long sleeves and pants, and stay in places with air conditioning or that use window and door screens.

What Physicians Can Do

To help Chicago-area physicians reassure their patients, and help allay their concerns, Dr. Arwady offered several insights. These include:

- The species of mosquito that most easily carries the Zika virus (*Aedes aegypti*) is not native to Illinois. In order for a mosquito to transmit the virus, it must first bite someone who already has it. Dr. Arwady says the CDC is studying the reported cases of sexually transmitted Zika, but these cases are rare. If patients have not traveled to countries where Zika is present, and have not had sex with someone who has the virus, there is virtually no risk of contracting the disease.
- The CDPH already has a major mosquito monitoring and abatement program in place in Chicago to halt West Nile virus, and will be monitoring this summer for mosquitoes that could carry Zika. The program places larvicide in more than 100,000 locations and provides targeted spraying as needed.
- While the Zika virus is a concern for pregnant women, it should be of little worry for practically everyone else; 80% percent of those who contract the virus don't even know they have it, and those who do become ill generally don't suffer long-term consequences, rarely need hospitalization, and don't die from it.

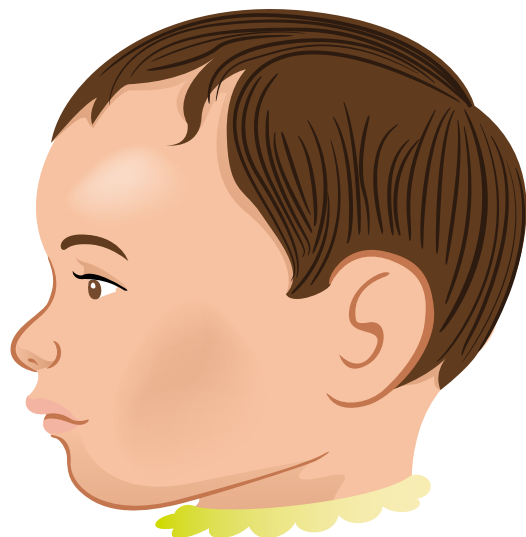
"While the Zika virus is a concern for pregnant women, it should be of little worry for practically everyone else; 80 percent of those who contract the virus don't even know they have it, and those who do become ill don't suffer long-term consequences..."

Dr. Arwady urges Chicago health care providers to sign up for the CDPH Health Alert Network (HAN). She points out that the CDPH has worked closely with the CDC and the Illinois Department of Public Health (IDPH) to send providers alerts on all kinds of public health issues, including the Zika virus. "We won't flood you with emails, we'll

THE ZIKA VIRUS

Since November 2015, Brazil has recorded 404 cases of microcephaly in newborns, 17 of whom were confirmed to have the Zika virus. Microcephaly causes an abnormal smallness of the head, a condition associated with incomplete brain development.

Child with normal head size




Child with microcephaly



only send important notices, and we can tailor the information to your specialty,” she said. To sign up, go to: www.chicagohan.org.

The Chicago Medical Society (CMS) is also actively working to increase awareness of the Zika virus. This month, CMS approved a resolution that authorizes the organization to educate physician members and the public

about resources available to help avoid and prevent infection and transmission of the Zika virus. Authored by Jim Curry, a student at the University of Illinois at Chicago College of Medicine, School of Public Health, the resolution is en route to the Illinois State Medical Society for consideration at its House of Delegates Meeting in April. 

Resources for Physicians

SO WHERE DO physicians go for help? As always, the Centers for Disease Control and Prevention (CDC) has a wealth of current information on the Zika virus on its website at www.cdc.gov/zika. It has recently issued updated guidance on the care of pregnant women and the prevention of sexual transmission of Zika virus.

The Chicago Department of Public Health (CDPH) is also a good resource and currently advises:

- Pregnant women or those trying to become pregnant should consider postponing travel to affected countries.
- Pregnant women with partners who have traveled to affected countries should consider using condoms or abstaining from sex throughout the

pregnancy.

- Pregnant women who have traveled to affected areas during their pregnancy may pursue Zika testing, regardless of symptoms, two to 12 weeks after return from travel.
- Alerts will be issued as new information becomes available.

Chicago-area physicians can call 312-746-4835 from 8 a.m. to 4 p.m. weekdays to request lab testing for Zika. Currently, testing for the Zika virus is prioritized to include:

- Pregnant women with a history of travel to an area with active Zika virus transmission (parts of South/Central America, Mexico, Caribbean, Puerto Rico), with or without symptoms, if they are within 12 weeks of

travel. Check for up-to-date information about affected regions at <http://wwwnc.cdc.gov/travel/notices>.

- Men or women with a history of travel to an area with active Zika virus transmission and symptom onset (fever, rash, arthralgias, conjunctivitis) during travel or within two weeks of return.

Testing is not indicated for pregnant women without a travel history to an area with Zika virus transmission. It is also not indicated for men and non-pregnant women who have traveled to affected areas but do not have compatible symptoms within two weeks of return. Testing of Chicago residents requires collaboration with the CDPH.



MORE INSIGHT

helps you make the most of your
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Looking Ahead:

Midwest Clinical Conference

The 69th annual conference focuses on innovations in health care that you can use today

YOU WON'T want to miss out on this year's clinical conference. Hosted by the Chicago Medical Society, the conference focuses on the hottest topics in medicine with presentations from leading experts in a variety of fields. You'll learn about integrating genetics into your practice, advances in telemedicine, innovations in pediatrics and dermatology, and more.

The two-day conference runs May 20-21 at the Westin Chicago-River North. This educational conference offers five concurrent course tracks, 20 CME sessions, over 60 speakers and over 50 different topics including cutting-edge clinical advances, medical-legal updates, physician leadership issues, and technology. And, you'll have the opportunity to earn up to 14.5 CME credits.

MCC engages physicians at every career stage. Students, residents and fellows will be competing in the Research Poster Symposium. Papers address basic science issues; health policy and medical education; or clinical medicine. Authors will display and present their work to MCC participants.

Included in your registration—other than the top-notch seminars—are breakfast, lunch; two general luncheon sessions; a keynote address by a nationally recognized speaker; exhibits; networking; and a resident and student poster board competition. What are you waiting for? To register, visit www.cmsdocs.org.

Friday, May 20: 8:00 a.m.-11:30 a.m. Concurrent Sessions

A-01: Innovations in Health Care and Practical Implications for Physicians' Practice

DESCRIPTION: The health care landscape is rapidly changing. This session will focus on top areas of innovation and the practical implications of these transformative changes for your practice, including the following: alternative payment models, data aggregation and analytics, precision medicine, social media, health care technology, and mobile health.

Innovation in the Health Care Transformation

FACULTY: Sidney Welch, JD, Chair, Health Care Innovation, Polsinelli, Atlanta, GA

Legal Implications Associated with Digital Health and EMRs

FACULTY: Steven B. Bender, Partner, Health Law Partners

DESIRED LEARNING OUTCOMES: At the conclusion of this

session, participants should be able to: understand the role of technology in new health care delivery and alternative payment models; recognize and operationalize cutting-edge technology issues in health care delivery, including mHealth, eHealth, precision medicine, data aggregation and analytics; understand the details of electronic health records and how to make your practice technically and practically compliant; discuss the current legal status of the electronic health record donation rule; understand the legal risks of using an electronic health record; recognize the must haves and must avoid issues when negotiating an electronic health record license agreement.

CO-SPONSORED BY THE AMERICAN BAR
ASSOCIATION-HEALTH LAW SECTION

B-01: Neurology

DESCRIPTION: Members of the Chicago Neurological Society will discuss the steps in prevention, recognition, and management of patients who present with stroke or transient ischemic attack symptoms in office and outpatient settings. This course will focus on the importance of interpreting findings of stroke and when to intervene in the prevention of first or recurring strokes.

Case Studies in the Diagnosis and Evaluation of Patients Who Present with Stroke or TIA in the Outpatient Setting

FACULTY: Camilo R. Gomez, MD, MBA, Loyola University Medical Center

Interactive Review: The Complexity Surrounding Anticoagulation for Prevention of First Ever and Recurrent Stroke

FACULTY: Jose Biller, MD, Professor and Chair, Department of Neurology, Loyola University Medical Center

Carotid Artery Disease

FACULTY: Michael Schneck, MD, Professor of Neurology and Neurosurgery, Loyola University Medical Center

DESIRED LEARNING OUTCOMES: At the completion of this learning activity, participants should be able to: recognize how to evaluate patients with possible stroke-like symptoms or imaging findings in the office setting; understand the bleed risk and benefits of anticoagulation for stroke prevention, and the choice of anticoagulant and timing of anticoagulation; understand how to evaluate patients with atherosclerotic and non-atherosclerotic carotid artery disease (carotid disease) and when to intervene

procedurally and when to treat with non-invasive therapies.

CO-SPONSORED BY THE CHICAGO
NEUROLOGICAL SOCIETY

C-01: Success Factors for Physician Leaders

DESCRIPTION: This program will present key success factors and leadership skills that will help physicians to succeed and prosper in a rapidly changing health care environment. Emerging roles for physician leaders, strategies to motivate others, effective meeting management techniques, and building a diverse organization will be covered.

FACULTY: Susan F. Reynolds, MD, PhD, President and CEO, The Institute for Medical Leadership

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: discuss new roles for physician leaders and new leadership skills that will help them to succeed.

CO-SPONSORED BY THE INSTITUTE
FOR MEDICAL LEADERSHIP

D-01: Dermatology

DESCRIPTION: After completion of this session, participants will be able to recognize the basic elements seen in dermatoscopy, understand how these elements make a pattern, and begin to apply the Chaos and Clues method of pattern analysis.

Blistering Skin Diseases

FACULTY: Julie Anne Moore, MD, Assistant Clinical Professor, Department of Dermatology, Rush University Medical Center, Private Practice Physician in Melrose Park and Lombard

Evaluation of Hair Loss

FACULTY: Lady C. Dy, MD, Assistant Professor and Director of Dermatopathology, Department of Dermatology, Rush University Medical Center

Introduction of Dermoscopy: Skin Surface Microscopy

FACULTY: John Kalis, MD, Assistant Clinical Professor, Department of Dermatology, Rush University Medical Center, Private Practice Physician in Oak Brook, with the Illinois Dermatology Institute

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: discuss pattern recognition of blistering conditions that will aid in disease diagnosis, diagnostic studies to establish diagnosis, and treatment of blistering conditions that will aid in disease diagnosis; recognize different patterns of hair loss, diagnostic studies to establish types of hair loss, and treatment of different types of hair loss; understand the basics of dermoscopy to assist the clinician in determining if the skin lesion is suspicious or has obvious benign features under the handheld dermatoscope.

CO-SPONSORED BY THE CHICAGO DERMATOLOGY
SOCIETY

E-01 Cyber Security: Protecting Your Data in the 21st Century

DESCRIPTION: This session will discuss the various aspects of cyber security that impact health care. Some of the topics that will be discussed include: the changing landscape of external threats and the steps you can take to protect yourself; why firewalls, anti-virus and backups aren't enough; "Ransomware" and how

encryption is being used as a weapon by today's viruses. Questions are encouraged to make this an interactive session, with dedicated Q&A time at the end of the presentation.

FACULTY: Eric Rieger, President, WEBIT Services, Inc.

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should have a better understanding of: cyber security for their organization; the different types of threats, and how to better protect their data; and the importance of business continuity in securing data.

F-01: Emergency Medicine

DESCRIPTION: Experts from the Illinois College of Emergency Physicians will discuss the latest technology and ideas to improve emergency medicine practice. Emphasis will be placed on currently evolving advances that promote quality patient care.

Patient Satisfaction – EDPEC is Coming!

FACULTY: Helen Straus, MD, MS, Assistant Professor, Rush Medical College, Attending Physician, Department of Emergency Medicine, John H. Stroger, Jr., Hospital of Cook County

FACULTY: Pilar Guerrero, MD, Assistant Professor, Rush

Medical College, Attending Physician, Department of Emergency Medicine, John H. Stroger, Jr., Hospital of Cook County

Electronic Medical Records – A Look Ahead

FACULTY: Helen Straus, MD, MS, Assistant Professor, Rush Medical College, Attending Physician, Department of Emergency Medicine, John H. Stroger, Jr., Hospital of Cook County

Simulation Lab – State of the Art 2016

FACULTY: Michelle Sergel, MD, Assistant Professor, Rush Medical College, Attending Physician, Department of Emergency Medicine, John H. Stroger, Jr., Hospital of Cook County

Unique Clinical Settings—What Is New in Detainee Medical Practice?

FACULTY: Eileen Couture, DO, MS, RN, Attending Physician, Illinois and Michigan (locum tenens); Chair-elect (2016-2017), National Commission of Correctional Medicine; Member, Board of Directors, South Suburban Drug and Alcohol Counsel

New Learning Strategies in Emergency Medicine

FACULTY: Tarlan Hedayati, MD, Assistant Professor, Rush Medical College, Attending Physician, Department of Emergency Medicine, John H. Stroger, Jr., Hospital of Cook County

Resiliency for the ED Physician

FACULTY: Janet Lin, MD, MPH, Associate Professor, Department of Emergency Medicine, Emergency Medicine Director, International Emergency Medicine and Global Health Fellowship Program, University of Illinois at Chicago

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: obtain knowledge and tools to provide quality emergency care in clinical settings; identify emerging ideas and technologies applicable in day-to-day emergency medicine practice; discuss challenges that arise during implementation of new strategies, technologies, and skills; discuss current concepts as well updates on development of ED-based patient satisfaction assessment tools; review the American Medical Informatics Association (AMIA) 2020 goals; discuss current devices, designs, and techniques that facilitate modern clinical training by maximizing learner exposure

while minimizing patient risk; have a focused look at the challenges and innovations in medical management of the U.S. jail population; incorporate rapid-fire teaching and social media opportunities into formal learning pathways for clinicians; share current concepts in resiliency; provide tools for physicians to adapt and bounce back from clinical environmental stressors to limit/ avoid burnout; recognize stressors and identify strategies to promote well-being in order to reduce medical errors and improve clinical practice overall.

CO-SPONSORED BY THE ILLINOIS COLLEGE
OF EMERGENCY PHYSICIANS

L-01: General Luncheon Keynote Session: 12 p.m.-1:00 p.m.—Residency Training in the United States: Past, Present, Future

DESCRIPTION: This presentation will discuss the evolution and current status of the residency system for training doctors in the United States. Emphasis will be placed on the underlying educational principles, moral values, cultural context, and internal and external tensions of the system. There will be an opportunity for the audience to engage in questions and commentaries.

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: understand the evolution of the American residency system including current challenges and opportunities in residency training, and potential solutions and future directions.

KEYNOTE SPEAKER: Kenneth Ludmerer, MD, Professor, Washington University Department of Medicine, St. Louis, MO, and author of the bestselling book, *Let Me Heal*. Dr. Ludmerer has disclosed that he does not have any relevant financial relationships with any commercial interests.

Friday, May 20: 1:00 p.m.-5:00 p.m. Concurrent Sessions

A-02: Cardiovascular Health

DESCRIPTION: This conference track sponsored by the American Heart Association and the American Stroke Association will highlight current guideline recommendations, population health strategies and innovative programs and services in cardiology. Participants will learn about programs and resources impacting patient satisfaction and outcomes.

Chronic Care Management and Population Health

FACULTY: Vincent Bufalino, MD, Advocate Heart Institute

Get Pumped: An Overview of AHA/ASA Innovations in Practice, Locally & Nationally

FACULTY: Marc Silver, MD, Advocate Christ Medical Center, Clinical Professor, University of Illinois College of Medicine

Programs That Work: Controlling High Blood Pressure

FACULTY: Sarah Song, MD, Assistant Professor, Rush University Medical Center, Department of Neurology

Patient Support Network

FACULTY: Amanda Kelly, Senior Director, Community Health, American Heart Association

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: identify gaps in chronic

care by using data from ambulatory EHRs for population health; gain knowledge of AHA innovative national programs and local initiatives promoting the development and integration of technologies into patient care; review the AHA HBP guideline recommendations & algorithm and identify opportunities to implement into practice impacting behavioral change and patient outcomes; gain knowledge of AHA/ASA online resources for patients and caregivers and identify opportunities to incorporate them into practice.

CO-SPONSORED BY THE AMERICAN HEART
ASSOCIATION

B-02: Updates in Family Medicine

DESCRIPTION: This course will discuss various topics relevant to the practicing primary care provider. The content and instruction are focused on providing new abilities and strategies in primary care, assisting in modifying practice, and ultimately improving patient outcomes.

PURLs: Priority Updates from the Research Literature for Primary Care

FACULTY: Kate Rowland, MD, MS, Assistant Professor, Rush University Editor-in-Chief, PURLs

Adult Immunizations: What You Need to Know

FACULTY: Michael Hanak, MD, Assistant Professor, Rush University Medical Center

Perioperative Overview for the Primary Care Provider

FACULTY: Suparna Dutta, MD, Assistant Professor, Rush University Medical Center

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: briefly define PURL (Priority Updates from the Research Literature) and where it comes from, explain several examples of articles from the research literature and how they pertain to primary care practice, identify sources of bias introduced by external funders, describe the motivation to change practice based on new valid research; understand the current ACIP recommendations and immunization schedules for adults, educate adult patients about the importance of immunization, develop an office wide strategy to improve the immunization rate with adult patients (patient recall and reminder systems, standing orders); apply a systemic approach to guide preoperative assessment, recommend the appropriate continuation and discontinuation of medications and nutraceuticals in the perioperative setting; assess, optimize and manage a variety of medical comorbidities in the perioperative setting.

CO-SPONSORED BY THE ILLINOIS ACADEMY OF
FAMILY PHYSICIANS

C-02: Telehealth Patient Care Delivery Challenges and Solutions

DESCRIPTION: Telemedicine has become a vibrant tool for health care providers to engage patients. The demand for telemedicine has never been stronger and the predictions for its growth are significant. This course will address the current telemedicine platforms, reimbursement, security, and compliance issues.

FACULTY: Julian Rivera, JD, Husch Blackwell, LLP, Austin, TX

FACULTY: Kristin Schleiter, JD, LLM, Senior Legislative Attorney, American Medical Association

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to understand the challenges

and opportunities for engaging patients through telehealth and identify and address telehealth regulatory and business solutions.

D-02: Transitioning Youth to Adult Health Care: Training and Resources from the Illinois Transition Care Project

DESCRIPTION: This training is focused on improving the ability of adult providers and subspecialists to accept and treat transitioning and recently transitioned young adult patients. The training has a special emphasis on treating patients with childhood onset conditions. Presenters will focus on the following topics: introduction to transition from pediatric care; developing and maintaining patient registries; assessing health care skills; creating/reviewing individualized health care skills goals; coordinating care with other providers; applying examination strategies for patients with special health care needs; discussing benefits, services, and guardianship; coding and reimbursement for transition activities; and conclusion.

Define Transition and Describe Why Transition Care is Important

FACULTY: Miriam Kalichman, MD, Neurodevelopmental Pediatrician, Transition Course Lead Pediatrician, Retired Associate Medical Director, Division of Specialized Care for Children, Habilitation Clinic at the University of Illinois at Chicago

Perform Key Clinical Activities to Facilitate Successful Transition

FACULTY: Rachel N. Caskey, MD, Associate Professor of Internal Medicine and Pediatrics, University of Illinois College of Medicine and School of Public Health

Coordinate Care, Utilize Portable Medical Summary, and Explain Benefits Eligibility and Guardianship

FACULTY: Mary Keen, MD, Medical Director, Pediatric Program, Marianjoy, Rehabilitation Hospital and Clinics

Apply Quality Improvement Strategies and Access Free Transition Resources

FACULTY: Kathy Sanabria, MBA, Transition Training Course Director, ICAAP Associate Executive Director

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: define the concept of transition, identify guidelines that direct transition care, explain its importance, and implement exam strategies for patients with special needs; apply new skills to perform key clinical activities for newly transitioned young adults; apply coding and billing strategies to facilitate reimbursement; apply exam strategies for patients with special health care needs; effectively coordinate care using a portable medical summary; discuss benefits eligibility and guardianship; implement quality improvement strategies, tools, and resources to facilitate successful transition to adult care.

CO-SPONSORED BY THE ILLINOIS CHAPTER,
AMERICAN ACADEMY OF PEDIATRICS

E-02: Midwest Ophthalmology Update

DESCRIPTION: This course will provide an update on areas of ophthalmology that are of interest to ophthalmologists and practitioners of all specialties. Areas of focus for 2016 include: thyroid eye disease, graft versus host disease, diagnosis and management of uveitis, identification, diagnosis and management of GCA,

diagnosis and management of red eye.

Thyroid Eye Disease

FACULTY: Vinay Aakalu, MD, Assistant Professor, Ophthalmology and Oculofacial Plastic Surgery, University of Illinois at Chicago, Director, Lacrimal Cell Biology Laboratory

Giant Cell Arteritis (GCA): Systemic and Ophthalmic Manifestations, Diagnosis, and Treatment

FACULTY: Adam Breunig, MD, Associate, Chicago Glaucoma Consultants, Associate Professor Ophthalmology, Rush University Medical Center

Ocular Manifestations of Systemic Disease, Common Etiologies, and Treatment of the Red Eye

FACULTY: Anjali Tannan, MD, Assistant Professor of Ophthalmology, Rush University Medical Center

Graft Versus Host Disease: Ocular Surface Manifestations and Treatment

FACULTY: Sandeep Jain, MD, Associate Professor of Ophthalmology, University of Illinois at Chicago, Director, Corneal Neurobiology Laboratory

Diagnosis and Management of Uveitis

FACULTY: Debra Goldstein, MD, Professor of Ophthalmology, Director, Uveitis Service, Northwestern University

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: understand diagnosis, clarification, and management of Thyroid Eye Disease; understand identification, diagnosis, and management of GCA; understand identification, diagnosis, and management of common causes of red eye and gain knowledge of ocular manifestations of systemic diseases; understand diagnosis, management, and treatment of Ocular Surface GVHD; understand diagnosis and management of selected uveitic conditions.

CO-SPONSORED BY THE CHICAGO
OPHTHALMOLOGICAL SOCIETY

Saturday, May 21: 8:00 a.m.-11:30 a.m. Concurrent Sessions

G-01: Psychiatric

DESCRIPTION: The first part of this educational session will focus on the different aspects of neurocognitive disorders and different diagnostic methods and treatment options. Based on recent research, the speakers will also share their extensive experience on the importance of lifestyle and maintaining cognitive vitality. This panel will also discuss best practices when prescribing opioids and address the tension between patients demanding pain relief and the regulatory scrutiny that surrounds opioid prescribing. Finally, this activity will teach how to identify patients who may be suffering from anxiety and/or depression and the best available treatment options. There will be dedicated Q&A time at the end of the presentation.

Substance Abuse—Opioid Analgesic Prescribing

FACULTY: Lekshmi Venugopal, MD, Medical Director, Linden Oaks Medical Group, St. Charles

Diagnosis and Treatment of Neurocognitive Disorders

FACULTY: Sandra Swantek, MD, Rush University Medical Center

Update on the Diagnosis and Treatment of Depression and Anxiety-Related Disorders

FACULTY: Philip Janicek, MD, Linden Oaks Medical Group, Naperville

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: understand opioid prescribing patterns; understand data on opioid-related overdoses and other harm; recognize high-risk patients and be able to identify risk-reduction strategies; review recent diagnostic changes for depression and anxiety-related disorders in the DSM- 5; review newer antidepressants recently approved; review newer anxiolytic and sedative-hypnotic agents; understand standard diagnostic criteria for common neurocognitive disorders; discuss the importance of screening and performing a neuropsychological assessment on patients who are believed to have a disorder; discuss pathophysiology and treatment options for those patients who are diagnosed.

CO-SPONSORED BY THE ILLINOIS
PSYCHIATRIC SOCIETY

H-01: Women's Healthcare Today

DESCRIPTION: This course will explore various practices in women's health care for obstetrics and gynecology. From navigating the changes in surgical approaches to various procedures to understanding and approaching infertility and fertility preservation, this course will help you understand basic practices and the new wave of contemporary medicine. Join us as we examine options in minimally invasive surgery, management of cervical neoplasia screening and patient care fertility challenges.

Today's Minimally Invasive Surgical Options in Gynecology

FACULTY: Teresa Tam, MD, Associate Director of Obstetrics and Gynecology, Past President, Chicago Gynecological Society

Current Management for Cervical Neoplasia Screening ("Pap Smear")

FACULTY: Elliot M. Levine, MD, President, Chicago Gynecological Society, Advocate Illinois Masonic Medical Center

The Issues Involving Endometriosis and Infertility

FACULTY: W. Paul Dmowski, MD, PhD, Founding Member, Reproductive Medicine Institute

Stopping the Biological Clock: Reproductive Aging and Fertility Preservation

FACULTY: Shweta Nayak, MD, Reproductive Medicine Institute

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: understand the change in surgical approaches for various procedures in OB-GYN, appreciate the value of the described changes to patients, understand the overall contemporary surgical treatments now available in GYN; understand the principles for optimal screening intervals, recognize the recommendations from various specialty organizations, understand the value of coincident HPV screening, and understand the available therapies for abnormalities that are found; be familiar with the pathogenesis of endometriosis, associated infertility, how to approach the infertile patient with endometriosis in terms of surgical treatment, and treatment success with assisted reproductive technology; be familiar with natural reproductive aging, how to utilize and interpret measures of reproductive potential, and the risks and benefits of fertility preservation.

CO-SPONSORED BY THE CHICAGO
GYNECOLOGICAL SOCIETY

I-01: Improving the Care of Surgical Patients in Illinois

DESCRIPTION: Surgeons from around the state have joined to improve the care of surgical patients through the Illinois Surgical Quality Improvement Collaborative. Through this collaborative, hospitals have focused efforts on using risk-adjusted data to identify opportunities to improve patient care. In addition to individual hospital quality improvement efforts, member institutions have participated in collaborative quality improvement efforts. This session will provide an overview of the Illinois collaborative and discuss several topics related to the care of surgical patients that are areas of focus within the collaborative. Faculty will discuss strategies to optimize patients prior to surgery as well as the use of standardized postoperative protocols to decrease venous thromboembolism and guidelines for the appropriate use of blood transfusions. Faculty will also discuss the role of early resumption of postoperative diet and activity to optimize the postoperative course.

Perioperative Venous Thromboembolism Prophylaxis

FACULTY: Anthony Yang, MD, Northwestern University

Surgical Quality Improvement

FACULTY: Jonah Stulberg, MD, Northwestern University

Preoperative Optimization of the Surgical Patient

FACULTY: Amy L. Halverson, MD, Associate Professor, Northwestern University

Enhanced Recovery After Surgery

FACULTY: Michael F. McGee, MD, Assistant Professor, Northwestern University

Optimal Management of Perioperative Blood Transfusion

FACULTY: David Odell, MD, Assistant Professor

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: describe current recommendations for the perioperative prophylaxis for venous thromboembolism; understand how process and outcome measures are used to assess surgical quality; understand how optimization of medications, smoking cessation and optimal glycemic control may improve postoperative outcomes; describe the components of enhanced recovery after surgery; explain appropriate criteria for perioperative blood transfusion.

CO-SPONSORED BY THE METROPOLITAN CHICAGO
CHAPTER OF THE AMERICAN COLLEGE OF
SURGEONS

J-01: Gene: Genomic Explorations in the New Era: Updates in Genetic Medicine and Integrating Genetics into Your Practice

DESCRIPTION: The world of genetics is constantly evolving and changing the future of medicine. This program aims to expand physician knowledge and familiarity with family history collection & interpretation, criteria for genetic evaluation/referral, benefits and limitations of genetic testing, and implications of test results on patient management so physicians are able to integrate new technologies,

genetic testing, and research into medical or clinical practice.

Family History and Ethnicity

FACULTY: Brad Tinkle, MD, PhD, Director of Clinical Genetics, Advocate Medical Group

Carrier Screening: Who Needs It and Why

FACULTY: Aishwarya Arjunan, MS, MPH

Prenatal Genetics: Overview of Current Screening and Testing Options

FACULTY: Melissa Vandenberg, MS

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: obtain a minimum family history and recognize when a genetics referral is warranted, recognize ethnic backgrounds with increased risk of certain genetic disorders; recognize the benefits and limitations of carrier screening and identify individuals for whom carrier screening should be offered; review current screening and testing options available in the prenatal setting, recognize benefits and limitations between screening tests, identify appropriate times to offer prenatal genetic testing.

CO-SPONSORED BY THE CENTER FOR JEWISH GENETICS & GENETIC TASK FORCE OF ILLINOIS

K-01: Orthopedic Emergencies: Guidelines for the Primary Care Physician on Injuries and Disorders that Require Urgent or Emergent Orthopedic Evaluation

DESCRIPTION: Musculoskeletal injuries and disorders are a common reason for patients to present for care and evaluation. Many patients initially present to primary care physicians rather than to specialists for musculoskeletal complaints. The sheer range of disorders confront the initial treating primary care physician with the complex tasks of identifying what is occurring in the patient, sorting through many choices for initial workup, and understanding how quickly the patient must be seen to facilitate optimal care. Some emergent or urgent injuries and conditions may become more difficult to treat if not seen by the specialist in a timely manner while others may suffer irreversible adverse outcomes due to the delay in treatment. This symposium will identify key orthopedic injuries and conditions that the primary care physician should be able to identify and it will also outline best first steps in imaging and workup and the proper time sequence for follow-up care. Since the field of orthopedics is broad, this symposium will focus on conditions of the hand, spine, adult trauma, sports injuries, and total joint replacement.

Hand Surgery Emergency and Urgent Conditions for the Primary Care Physician: How to Know When Your Patient Must Be Seen Right Away

FACULTY: Alfonso Mejia, MD, MPH

Pre- and Post-Operative Emergent and Urgent Complications of Total Joint Surgery

FACULTY: Mark Gonzales, MD, PhD

The Injured Patient: When Is a Trauma Center the Best Setting for Treatment?

FACULTY: Matthew Jimenez, MD

Sports Injuries You Don't Want to Play Around With

FACULTY: Mark Hutchinson, MD, Matthew Marcus, MD

Bumps, Lumps, and Masses: Identifying Characteristics

that Should Raise Some Alarms

FACULTY: Yasser Farid, MD, PhD

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: define the clinical presentation of emergent hand injuries; explain the time course of individual disorders required to optimize care; illustrate clinical management of hand injuries; organize principles of care into initial treatment, studies needed, and hand-off to specialty care; define the clinical presentation of emergent complications of total joint surgery; explain the differing complication categories of total joint surgery; illustrate the danger of deep venous thrombosis and outline the appropriate precautions; describe the factors that statically lead to emergent and urgent complications when performing total joint surgery; define the difference between an emergency room and a trauma center, and outline the trauma center's specialized requirements; explain the differences between the different levels and trauma center verification; describe the factors that should determine whether a patient should be transferred to an emergency room setting; define the clinical differences between an acute and a chronic injury, and their warning signs; explain the different complication categories of total joint surgery; illustrate the dangers and complications of fractured vertebrae; describe the common complications resulting from deep muscle contusion; discuss the complications resulting from traumatic spinal cord injury; define the clinical presentation of the four most common types of primary bone cancer; explain when to be suspicious of malignant masses; illustrate clinical management of common soft tissue masses, and evaluate when surgery is necessary; outline the principles of site workup.

CO-SPONSORED BY THE ILLINOIS ASSOCIATION OF ORTHOPAEDIC SURGEONS

L-02: General Luncheon and Technology Workshop: 12 p.m.-1:00 p.m.

DESCRIPTION: The Chicago Medical Society will collaborate with targeted vendors to host three concurrent hands-on workshops during a boxed luncheon session.

Saturday, May 21: 1:00 p.m.-5:00 p.m. Concurrent Sessions

G-02: Ultrasound

DESCRIPTION: This session will provide practitioners a unique forum to improve their competence in ultrasound for diagnostic and interventional procedures. Emphasis will be placed on learning basic terminology of ultrasound technology and providing physicians of different specialties with increased knowledge of organ evaluation and ultrasound uses in everyday medical practice.

FACULTY: Michael Woo, MD, Assistant Professor, University of Chicago Medicine

FACULTY: Carlos Fernandez, MD, Director of Gynecological Ultrasound, Advocate Illinois Masonic Medical Center

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should: have a better understanding of the use of ultrasound in everyday medical practice; have the knowledge to perform and/or interpret regional ultrasound scans on models and ultrasound simulators; explain the benefits of using ultrasound as a diagnostic measure; have knowledge of new advances in ultrasound technology and 4D ultrasound.

H-02: Advanced Technologies for Rehabilitation of Neurological Disorders

DESCRIPTION: There have been many technical advances in rehabilitation linked primarily to the application of advanced engineering technologies. These are used as part of rehabilitation training, or as part of the preparation for use of advanced assistive devices. In addition there is now increasing use of sensors as a tool to provide quantitative assessments of patient progress. This session will present an overview of a number of advanced technologies now in use in advanced neurorehabilitation practice.

Advanced Technologies for Rehabilitation of Neurological Disorders

FACULTY: William Z. Rymer, MD, PhD, Director of Sensory Motor Performance Program, Rehabilitation Institute of Chicago, Professor, Departments of Physical Medicine & Rehabilitation, Physiology, and Biomedical Engineering, Northwestern University

Advanced Technologies for Rehabilitation of Neurological Disorders: Exoskeletons

FACULTY: Arun Jayaraman, PT, PhD, Director, Max Nader Center for Rehabilitation Technologies and Outcomes Research, Rehabilitation Institute of Chicago, Assistant Professor, Departments of Physical Medicine & Rehabilitation, Physical Therapy & Human Movement Sciences, and Medical Social Sciences, Northwestern University

Upper Extremity Robotic Therapy

FACULTY: James L. Patton, PhD, Director, MARS National Center for Rehabilitation Robotics, Rehabilitation Institute of Chicago, Professor, Bioengineering, University of Illinois at Chicago, Affiliate Professor, Physical Medicine and Rehabilitation, Northwestern University

Phone Based Diagnostics

FACULTY: Konrad Kording, PhD, Research Scientist and CI Chair, Rehabilitation Institute of Chicago, Associate Professor of Physical Medicine & Rehabilitation, Physiology, and Applied Mathematics, Northwestern University

Mechatronic Devices for Hand Rehabilitation


FACULTY: Derek G. Kamper, PhD, Associate Professor of Biomedical Engineering, Armour College of Engineering, Illinois Institute of Technology

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should have a better understanding of rehabilitation robotics for retraining of patients with stroke and spinal cord injury; be able to discuss wearable robots for use in people who are likely to recover walking or assistive devices for those whose injuries are such that they will not walk independently again; discuss advanced devices for retraining upper extremity and hand functions after stroke; understand how the use of wearable sensors to track compliance, daily levels of activity, and progress following therapeutic intervention can improve the patient's condition.

I-02: Mobile Health Apps

DESCRIPTION: Given the expansion of cutting-edge technology and the use of mobile devices, it is crucial to keep up with changes so your practice will survive. By using software applications (apps) you can streamline your workflow. This program will address challenges along with corresponding mobile apps to address these problems.

FACULTY: Pardeep Athwal, MD, CEO of Orunje, Chicago.

DESIRED LEARNING OUTCOMES: At the conclusion of this session, participants should be able to: explain how smart phone apps can help them improve their practice; discuss the various advances in mobile health apps; gain knowledge of strategies to fully integrate these apps into their practices. 

Target Audience

All physicians, residents, medical students and practice managers

Conference Location

Westin Chicago—River North
320 N. Dearborn, Chicago, IL 60654
www.westinchicago.com

Accommodations

Reservations: 866-716-8104
Note: Please mention the discount code
SET #343362 when calling in.
Book online: www.westinchicago.com/catering-20

CME Disclosures

Planning member and faculty member disclosures of all financial relationships will be provided to MCC participants in the conference guide that is distributed on the day of and prior

to the start of the conference. *Program and Speakers are subject to change.

ACCREDITATION STATEMENT

The Chicago Medical Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

DESIGNATION STATEMENT

The Chicago Medical Society designates this live activity for a maximum of 14.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. EARN UP TO 14.5 CME CREDITS.

REGISTRATION

www.cmsdocs.org/events/69thMCC

WESTIN CHICAGO RIVER NORTH, CHICAGO

MAY 20–21 ■ 2016

CHICAGO MEDICAL SOCIETY'S 69TH ANNUAL Midwest Clinical Conference

THRIVE *IN A DYNAMIC HEALTH CARE ENVIRONMENT*

PARTICIPATING ORGANIZATIONS:

- Illinois Psychiatric Society
- Chicago Dermatological Society
- Chicago Gynecological Society
- Genetics Task Force of Illinois
- Ukrainian Medical Association of North America—Illinois Branch
- Chicago Neurological Society
- Illinois Association of Orthopedic Surgeons
- Illinois Academy of Family Physicians
- American Academy of Pediatrics—Illinois Chapter
- Chicago Ophthalmological Society
- Argentine American Medical Society
- American Heart Association
- Chicago Pathology Society
- Polish American Medical Society
- Philippine Medical Association of Chicago
- Reproductive Medical Institute
- Metropolitan Chapter of the Chicago College of Surgeons
- Illinois College of Emergency Physicians
- The Institute for Medical Leadership
- American Bar Association—Health Law Section

EVENT FEATURES:

- **KEYNOTE SPEAKER: Kenneth M. Ludmerer, MD**
Distinguished Professor in the History of Medicine at Washington University
- A Two Day educational conference providing 5 concurrent Tracks, over 30 sessions and up to 56 different topics including clinical sessions planned in conjunction with our specialty society co-hosts
- Physician Leadership Session presented by former White House Advisor Susan Reynolds, MD, PhD from The Institute for Medical Leadership
- MCC will incorporate tracks on medical-legal strategies, cybercrimes and hands-on workshops highlighting cutting edge technology
- Designated Exhibitor Space and Excellent Sponsorship Opportunities
- Poster Board Competition Reception

INFORMATION

Haydee Nascimento
312.670.2550

Hnascimento@cmsdocs.org



Come to Springfield

CMS members needed to shape legislation at House of Delegates

The Capitol Building in Springfield symbolizes the legislative advocacy that will take place during the ISMS House of Delegates, April 15-17. CMS members can make their voices heard in this lively forum.

WOULD YOU LIKE to influence health policy? Serve your profession? The 2016 Illinois State Medical Society House of Delegates (HOD) will take place April 15-17, at the Springfield Wyndham City Centre. (For registration details, see page 30.) Physicians can help the Chicago Medical Society maintain its strong statewide impact by volunteering to serve as a delegate or alternate.

Many powerful resolutions come from CMS members participating in the HOD meeting. And at

least 20 of their resolutions will be deliberated this April. They cover such issues as narrow networks, hospital charges for uninsured patients, medical research funding, Zika virus awareness, medical cannabis packaging, and firearm violence.

Chicago physicians can shape the debate and direction of ISMS legislative advocacy. Now more than ever we need a full slate to press our agenda. For information about serving as a CMS representative, please call 312-670-2550. [C](#)

Leadership Nominations

YOUR CMS colleagues nominated the following physicians for leadership positions in 2016-2017:

President-elect

Clarence W. Brown, Jr., MD

Secretary

Dimitri Azar, MD

Council Chair

Vemuri S. Murthy, MD

Council Vice Chair

Tina Shah, MD

Trustees-at-Large

Anne Szpindor, MD
Niva Lubin-Johnson, MD

Councilors-at-Large

Neelum T. Aggarwal, MD
E. Boone Brackett, MD
Lance Wallace, MD
Earl E. Fredrick, Jr., MD
Makis G. Limperis, MD
James G. MacKenzie, DO
Gerald E. Silverstein, MD
Usharani Nimmagada, MD

Alternate Councilors-at-Large

Anne Hong, MD
Ghassan D. Aswad, MD
Brian Farrell, MD
Zahurul Huq, MD
Kimberly E. Merenkov, MD
William G. Troyer, Jr., MD
Michael Wasserman, MD

Judicial Panel

Kenneth G. Busch, MD

WESTIN RIVER NORTH, CHICAGO

MAY 20-21, 2016

The Chicago Medical Society

Presents The 69th Annual

MIDWEST CLINICAL CONFERENCE

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Register today! <http://www.cmsdocs.org/events/69thMCC>

Questions? Contact Haydee Nascimento: 312-670-2550 or hnascimento@cmsdocs.org

Calendar of Events

MARCH

16 Chicago Gynecological Society

The CGS presents a dinner and CME-accredited lecture by Norman Ginsberg, MD, titled "From Mendel 'til Now: An Interesting Journey." 6:00-9:00 p.m., *Maggiano's Banquets Chicago*, 111 W. Grand Ave. To RSVP, please contact Abbey 312-670-2550, ext. 326; or agalvin@cmsdocs.org. CGS Members and affiliates—one dinner credit. All guests and non-members \$75.00.

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. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

16 CMS Public Health Committee Open to all members, this committee studies and responds to local public health concerns, developing policy and working with outside public health organizations and agencies. 6:00-7:00 p.m. Teleconference. For information, contact Rachel 312-670-2550, ext. 338, or rburns@cmsdocs.org.

28 Resolutions Reference Committee

Open to all members, this committee shapes CMS, ISMS, and AMA policy by studying member resolutions, hearing testimony, and making recommendations to the Council. 7:00-8:30 p.m. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Rachel 312-670-2550, ext. 338, or rburns@cmsdocs.org.

APRIL

15-17 ISMS House of Delegates The policymaking body of the Illinois State Medical Society meets this year in Springfield to deliberate and set policy and legislative agendas. Wyndham Springfield City Centre; 700 E Adams St., Springfield, Ill. Or call 217-789-1530. Also, please contact www.hod@isms.org or call 312-853-4745 or 800-782-4767, ext. 4745.

15-17 Illinois Medical Directors

Association The IMDA is hosting a bi-state conference on long-term care

in St. Louis. Nationally known speakers will address attendees for a total of 11.25 CME, CMD and CEU credits over two days. Come join us for live lectures, group workshops and a baseball game. Contact Abbey at 312-670-2550, ext. 326; or agalvin@cmsdocs.org for information and RSVP.

20 Chicago Gynecological Society

The CGS presents a dinner and CME-accredited lecture by Jacques Abramowicz, MD, titled "3D-4D Ultrasound in OB-GYN Not Reimbursed. Should We Do It Anyway?" 6:00-9:00 p.m., *Maggiano's Banquets Chicago*, 111 W. Grand Ave. To RSVP, please contact Abbey 312-670-2550, ext. 326; or agalvin@cmsdocs.org. CGS Members and affiliates—one dinner credit. All guests and non-members \$75.00.

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

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25 Resolutions Reference Committee

Open to all members, this committee shapes CMS, ISMS, and AMA policy by reviewing member resolutions, hearing testimony, and making recommendations to the Council. 7:00-8:30 p.m. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Rachel 312-670-2550, ext. 338, or rburns@cmsdocs.org.

30 Midwestern Association of Plastic Surgeons

The MAPS is hosting its Annual Scientific Meeting, where participants may earn up to 8.5 CME credit hours. Following the conference, MAPS will host a social event and award ceremony at the University of Chicago's Gleacher Center. Live entertainment will be provided by renowned cabaret singer Nan Mason. Contact Abbey at 312-670-2550, ext. 326; or agalvin@cmsdocs.org for information and RSVP. Or visit our Eventbrite registration site: <http://maps2016.eventbrite.com>.


MAY

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. 8:00-9:00 a.m. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

18 CMS Public Health Committee Open to all members, this committee studies and responds to local public health concerns, developing policy and working with outside public health organizations. 6:00-7:00 p.m. Teleconference. For information, contact Rachel 312-670-2550, ext. 338, or rburns@cmsdocs.org.

20-21 Midwest Clinical Conference

The Chicago Medical Society's 69th Annual MCC offers cutting-edge content for physicians in primary care and in the specialties. Sessions will review the medical-legal landscape, physician leadership issues, and technology. Highlights include a nationally recognized keynote speaker; resident-student poster competition; networking; and exhibits. For details, see page 20 of this issue. Location: Westin River North Hotel, 320 N. Dearborn St., Chicago. Up to 14.5 CME credits; \$325 for CMS members; \$425 for CMS members on-site; \$525 for non-members; \$620 for non-members on site; free for CMS Students; \$25 for CMS residents/fellows; \$30 for non-member students; \$50 for non-member resident/fellows. Register online at: <http://www.cmsdocs.org/events/69thMCC>; or contact Rachel at rburns@cmsdocs.org; or call 312-670-2550, ext. 338. 

classifieds

Personnel Wanted

(Board-certified or board-eligible) anesthesiology, urology, gynecology, gastroenterology, ophthalmology, family medicine, pain management, ENT, urogynecology, plastic surgery, orthopedics, ENT & general surgery for multi-specialty surgical out-patient centers located in northwest and west suburban Chicagoland. Active part-time physicians wanted (not semi-retired). Please send resumes by fax to 847-398-4585 or to kimberleeo@officegci.com and vino878@aol.com.

Medical director needed for patient home visit program. Participates in the development of quality improvement processes; makes medical policy decisions regarding development and implementation of policies and procedures; assists in strategic planning and promotion of patient home visit program; works in collaborative practice with APNs to achieve established goals and clinical outcomes; provides clinical supervision, education and orientation of APNs. Provides clinical direction to mobile medical team through active leadership and participation in meetings, patient visits and review of records. Applicants can send their resume to: Classified Ad Department, Box #1, Chicago Medicine Magazine, 515 N. Dearborn St., Chicago 60654.

Internist and psychiatrist needed to perform Social Security disability evaluations in the Downtown Loop and southwest suburbs. No malpractice insurance is required. Flexible schedule. Call Julie 312-922-3666.

Office/Building for Sale/Rent/Lease

For sale: Freestanding multi-specialty surgery center in Wood Dale, Ill., with ample parking. State-licensed ASC with one larger and one smaller operating room, 3,800-4,000 sq. ft. Asking \$4.75 million, not including real estate. Email Administration@officegci.com and vg1028@aol.com with serious inquiries.

For sale: medical office at 6151 W. Belmont Ave., Chicago; four exam rooms and three administrative rooms on ground floor; three rental apartments, garage in back. Doctor retiring. \$339,000. Call Janina 773-909-0890.

Medical office space in Justice, Ill., on busy 79th Street location; three exam rooms, reception office, reception area and storage building shared with dentist on the other side. \$1600.00 per month, heating included. Building possibly for sale if interested in income apartments upstairs. Call 708-594-1988, leave message.

For sale: Single specialty surgical center near Glen Ellyn, Ill., This free-standing state licensed Ambulatory Surgical Center has 3,780 sq. ft. with two ORs, two labs, and one exam room with lots of parking. Could easily be converted to a multi-specialty center. Asking \$2.3 million, not including real estate. Sale can include business or business with building. Please email kimberleeo@officegci.com and vino878@aol.com for more information.

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Gainfully Employed

Physician finds time for patients, practice issues **By Scott Warner**

"If physicians aren't at the table at every level, we risk not only a loss of influence, but the quality of care we provide to our patients," says Michael Hanak, MD, on being an employed physician.

MICHAEL HANAK, MD, is among the estimated 60% of fully employed physicians. And he's making the most of it. The 35-year-old board-certified family physician sees patients at Rush University Medical Center where he is one of more than 500 physician employees. Dr. Hanak also serves as an assistant professor at Rush Medical College, mentors students, and is a board member of the Illinois Academy of Family Physicians. These are only a few of the endeavors he has committed himself to, and he credits his role as an employed physician in allowing him the time to be so usefully engaged. "Thirty years ago physicians worked 80-90 hours a week as private practitioners. Now, many employed physicians can work 30-40 hours a week and have more time to be involved in other health-care related activities, and spend more time with their family."

He also praises employed physician status for offering doctors a steady salary and not having to deal with some of the more tedious and unsteady business aspects of medicine. But Dr. Hanak points out that there is a price for being employed. In return for security, physicians give up a level of autonomy. "They may have to see a certain number of patients, spend hours on electronic health records, have their practice patterns monitored, and be unable to hire their own staff," he says. "The 'art' of medicine sometimes fades in an effort to check boxes and get through payor and government-driven quality initiatives," he adds.

And, he says, more employed physicians are experiencing burnout. While he commends his Rush practice for being physician administered and sensitive to physicians' needs ("No one is telling me I can't order another test"), he is concerned about the growing number of employed physician practices that are administered by non-physicians. "There's no question that there will be ongoing scope of practice concerns." He urges his colleagues to contact the Chicago Medical Society and the Illinois State Medical Society for guidance if such issues arise.


Despite the pressures, Dr. Hanak says he loves being a doctor and comforting his patients. He says that even as a child, he knew he wanted to become



a doctor. Growing up in the blue-collar town of Linden, Michigan, near Flint, he was encouraged to follow his dream. His mother Teresa taught kindergarten, and his father Al sold automotive parts. He has a brother involved in the family business and another brother and sister who work in marketing in Chicago. When he was in high school, he did volunteer work at his local hospital, and shadowed his beloved family physician.

When he enrolled in college, it was a straight trajectory to medical school. He was admitted into the Medical Scholars Program at Michigan State University, which would automatically enroll him in the school's College of Human Medicine upon earning his BS in human biology. This select undergraduate process also gave him the chance to study the humanities, and do more than "just keeping my nose in a book." He minored in music therapy, and spent a semester in London.

Today, one way he facilitates his caring relationship with patients is by being involved with hospital leadership. He currently co-chairs the quality committee of the employed medical group at Rush, which reviews standardized processes for care.

On a personal note, Dr. Hanak is in a happy "medical marriage." His wife of two years, Neive, is a fertility nurse at Northwestern, and the couple dote on their 6-month old daughter, Sloane. 

Career Highlights

AFTER GRADUATING from medical school at Michigan State University in East Lansing, Dr. Michael Hanak served his residency in family medicine at Advocate Illinois Masonic Medical Center, through the University of Illinois at Chicago. He is an assistant professor at Rush Medical College, and last year served as the national chair of the AMA Young Physicians Section. Currently he serves on the ISMS Council on Membership and Advocacy, and is chair of the CMS Continuing Medical Education Committee.

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