



DUPAGE COUNTY
MEDICAL SOCIETY

IN BRIEF

APRIL 2010

VOLUME 31, ISSUE 4

LINKING DOMESTIC VIOLENCE TO HEALTHCARE – FREE SYMPOSIUM

Jacquelyn Campbell, PhD, RN, will lead a symposium for medical providers titled, “Linking Domestic Violence to Healthcare” on Friday, May 7, at Advocate Good Samaritan Hospital.

Doctor Campbell will speak on recognizing, understanding and assessing domestic violence. The keynote address will be followed by a panel discussion featuring local experts who will speak to the flow of services for a victim from the time she is first seen by a clinician, to her work with a domestic violence agency, to her experience with the criminal justice system.



Jacquelyn Campbell, PhD, RN

Registration for this free educational opportunity will begin at 7:30 a.m., and refreshments will be served. The symposium will run from 8 a.m. to 12 noon, with an optional light lunch and networking hour taking place immediately after the program, from noon to 1 p.m.

Doctor Campbell is a nationally recognized expert and researcher on the impact of domestic violence and the issues it presents in healthcare. She is also the co-creator of the Danger Assessment Tool, a series of questions designed to measure a woman’s risks in an abusive relationship.

Continuing education credit for physicians has been applied for through the American Medical Association and the American Academy of Family Physicians. CEUs for nurses have been applied for through the Illinois Nurses Association and availability of education credit is also anticipated for social workers, counselors, domestic violence professionals and chaplains.

“Linking Domestic Violence to Healthcare” is presented by Family Shelter Service, through its Illinois Health Cares funding, and Advocate Good Samaritan Hospital. To register or learn more about this free symposium, contact Jamie Edwards, prevention educator and Illinois Health Cares coordinator for Family Shelter Service, at 630.221.8290, extension 7133. You can also email her at jamiee@familyshelterservice.net.

THIRD WAVE OF H1N1 IN AMERICA APPEARS LESS LIKELY, CDC SAYS

The likelihood of a third wave of pandemic H1N1 influenza appears to be declining as all indicators of swine flu activity remain low throughout the bulk of the country, according to data released in March by the U.S. Centers for Disease Control and Prevention (CDC).

“Nobody can say for sure that we are totally out of the woods, but the further we go into spring and summer, the less likely we are to see another wave,” said CDC spokesman Tom Skinner. The agency does warn that some local activity of the virus is likely to “continue to percolate along.”

Currently, only the southeast United States is seeing any significant H1N1 activity. Although the nation’s second wave of swine flu emerged there last fall, experts attributed that to the region’s early opening of schools. There is nothing to point at now as a cause of the increased activity, the CDC said.

Attention is now turning to the Southern Hemisphere, where the beginning of fall marks the onset of the traditional flu season.

(CONTINUED ON PAGE 2)

IN BRIEF

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INSIDE THIS ISSUE

Courts Endorsed.....	Page 5
Overtreated.....	Page 6
Uninsured.....	Page 7
Financial Column.....	Page 9
Medical Identity Theft....	Page 10
Overweight Kids.....	Page 11
Chlamydia.....	Page 13

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DuPage County Medical Society
498 Hillside Avenue
Glen Ellyn, Illinois 60137
Phone 630/858-9603
Fax 630/858-9512
dcms@dcmsdocs.org
www.dcmsdocs.org

DCMS EXPANDING USE OF ELECTRONIC COMMUNICATIONS

Like many organizations, DCMS is increasingly using electronic communications to share information with members in a timely, cost-effective and environmentally friendly manner. Meeting materials for all DCMS Committees and the Board, for example, are now being distributed only electronically in advance of meetings. And DCMS is relying on email and the Society's website to promptly communicate information alerts.

Soon DCMS members will have the chance to opt out of receiving mailed copies of the In Brief newsletter, instead choosing to receive it electronically only.

Members are also urged to visit the DCMS web site at www.dcmsdocs.org for regularly updated news. The newsticker on the homepage always offers quick reference briefings on important developments with links to more detailed information. The site also contains archived issues of the In Brief newsletter.

As a physician member on Facebook, you can get automatic Society updates through the social networking site. Just search for "DuPage County Medical Society" and then become a fan.

As always, please keep the Society office informed when any of your contact information changes – address, phone, fax, email, etc. We also send occasional alerts to office managers, but again only if the appropriate contact information is available.

To assure that you receive all the important DCMS communications, please confirm that the Society has your email address. DCMS does not share, print or sell email contact information. Update or confirm your information by calling 630.858.9603, faxing it to 630.858.9512, or emailing it to dcms@dcmsdocs.org.

(H1N1, CONTINUED FROM PAGE 1)

Most authorities believe that swine flu will be the predominant form of seasonal flu there this year, and the vaccine against it is being incorporated in seasonal flu vaccines.

While the swine flu virus continues to be the primary circulating influenza virus in most of the world, influenza B -- one of the seasonal flu viruses -- is spreading more rapidly in Asia, the World Health Organization reported. It is also beginning to circulate more widely in Russia and Sweden.

PRESIDENT'S MESSAGE



Rashmi K. Chugh, MD
DCMS President

Doctor Chugh has invited Margaret A. Kirkegaard, MD, MPH, a family medicine physician, medical director of Illinois Health Connect, and a member of the DCMS Executive Committee, to provide a guest perspective this month for the President's Message. Following is Doctor Kirkegaard's column:

IT HAS TO BE US

As I write this, health system reform is stalled in Washington. President Obama is wringing his party to get the necessary votes to pass the Senate version of the health reform package through reconciliation. Those on the right are feeling relieved that they have successfully blocked what they deem a potentially disastrous reform package. Those on the left are wondering how the process can be salvaged. But the bottom line is that there is a very real chance that nothing will happen. Like every other attempt at health reform in the past three decades, this one might well result in the *status quo*.

Is the *status quo* truly a better alternative to health reform?

The *status quo* is financially unsustainable. A study published in *Health Affairs* in October 2009 examined the two percentage point differential between health care inflation and inflation in the GDP. The researchers concluded that by the year 2085, 118 percent of the real increase in per capita income would be devoted to health care. In other words, all consumption and production would be devoted entirely to healthcare spending.

More important to physicians, however, is the impact that insurance has on the health and well-being of our patients. In 2002, the Institute of Medicine (IOM) estimated that 18,000 patients die annually due to lack of insurance. A more recent study, published in the *American Journal of Public Health* in December 2009, found that annual deaths attributable to uninsurance to be two and a half times the IOM estimate at 45,000 annual deaths.

Many physicians develop a "heart" for diseases which have afflicted their patients. Oncologists advocate for improved cancer screening. Cardiologists support the "Go Red for Women" campaign. Throughout the debate filled with "cost curves," "public options," and "budget deficits," the impact of the *status quo* in terms of human lives has been lost. Most of the patients who do not have insurance also do not have a voice in the political process.

I recently attended a conference in Washington where Susan Dentzer, the editor-in-chief, of *Health Affairs* offered three possible views of the future of health reform. One was a quote from Winston Churchill who said, "Americans can always be counted on to do the right thing, after they have exhausted all other alternatives," suggesting that health reform may yet happen this year.

For the second opinion she quoted George Carlin who said, "I don't believe there's any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can't completely ignore." Maybe we will just kick the can down the road a bit and defer health care reform for another Congressional session, for another Administration or until health care inflation creates another financial crisis.

Her final viewpoint was expressed by the late Jerry Garcia of the Grateful Dead who said, "Somebody has to do something, and it's just incredibly pathetic that it has to be us." Derailing current health reform without offering an option to the *status quo* is not sufficient. Physicians need to ensure that patients have a voice in the political process. It doesn't have to be pathetic but it does have to be us. ☐

DCMS MISSION STATEMENT

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PRESIDENT OBAMA ENDORSES HEALTH COURTS

In a letter to Congressional leaders in early March, President Barack Obama endorsed health courts specifically and proposed an appropriation of \$50 million for additional demonstration grants including health courts.

The presidential endorsement represents a major breakthrough for the creation of health courts - a concept developed by Common Good in partnership with the Harvard School of Public Health, with funding from The Robert Wood Johnson Foundation. Health court pilot projects have been endorsed by virtually all leading health care participants as well as patient safety experts and consumer groups such as AARP. The DuPage County Medical Society has championed efforts to advance the concept in Illinois.

Philip K. Howard, Chair of Common Good, and a leading proponent of health courts, called President Obama's support a huge breakthrough. "Reliable health courts hold the key to eliminating the billions of dollars wasted each year in defensive medicine, as well as rebuilding a culture of openness needed for safe medicine," he said. "Special health courts should provide quicker justice to patients injured by mistakes and give physicians confidence that they will not be dragged through years of litigation when they did nothing wrong." ■■

QUOTABLE

Newt Gingrich, former speaker of the U.S. House of Representatives and founder of the Center for Health Transformation, a health-care policy consulting firm, said the following in a New York Times op-ed that asked conservative thinkers for their best health system reform idea, February 21, 2010.

"CAT scans, blood tests, ultrasounds, Caesarean sections – in many instances, these diagnostic tools and procedures are vital for treating patients. Too often, however, such procedures are ordered unnecessarily and drive up the cost of medicine for patients, taxpayers and insurance carriers.

"A new Gallup poll, commissioned by Jackson Healthcare, indicates that doctors believe an astounding one in four health care dollars is now spent on unnecessary care.

"Doctors order these procedures to protect against frivolous suits filed by trial lawyers seeking an easy payout, particularly after a doctor makes a simple mistake. Seventy-three percent of the doctors surveyed said they had practiced defensive medicine in the past year. As a result, American patients not only endure extra hours of tests and treatments but also pay more for health care.

"If President Obama and Congress are serious about reducing health care costs, then the more than \$600 billion a year in unnecessary care should be at the top of the list. Congress must give states the incentive to reform their civil justice systems so that lawyers will think twice before suing doctors for frivolous cases. There is a place for health courts that address only medical malpractice cases, and a need for caps on damages for "pain and suffering" that have nothing to do with lost wages or actual damages. Doctors who incorporate best medical practices should be protected from lawsuits altogether.

"These reforms would allow doctors to stop playing defense, and make it possible for patients and taxpayers to better afford health care." ■■

ACCESS TO CARE REDUCED AS LIABILITY RISK INCREASES

A new study conducted at Brigham Young University demonstrates that as medical liability reform is curtailed and risk increases, physicians respond by lightening their workload.

The study notes that when the expected liability risk increases by 10 percent, the decline in hours worked add up to the equivalent of one of every 35 physicians retiring without a replacement. The effect is much larger for physicians aged 55 and older.

The national study, published late last year in the *Journal of Law and Economics*, combined physicians' responses to surveys about workload and income with data from insurers about medical liability risks in each medical specialty and state. ■■

REPORTS SUGGEST MANY PATIENTS ARE OVERTREATED

According to many recently published reports, it appears many American patients are being overtreated with far too much routine screening.

Is it doctors practicing defensive medicine? Or are patients so accustomed to a culture of medical technology that they insist on extensive tests and treatments?

A combination of both is at work, experts agree, but new evidence and updated guidelines are recommending a step back and more thorough doctor-patient talks about risks and benefits of screening tests.

Americans need to realize that “more care is not necessarily better care,” says cardiologist Rita Redberg, MD, editor of the *Archives of Internal Medicine*. Much of the screening patients and doctors now regard as routine provides no benefit to care.

“People have come to equate tests with good care and prevention,” said Redberg. “Prevention is all the things your mother told you – eat right, exercise, get enough sleep, don’t smoke – and we’ve made it into getting a new test.”

Not all doctors and advocacy groups agree with the criticism of screening. Many argue that it can improve survival chances and that saving even a few lives is worth the cost of routinely testing tens of thousands of people.

While some patients clearly do benefit from screening, others clearly do not, said Richard Wender, MD, former president of the American Cancer Society. “Sometimes it’s kind of the path of least resistance just to order the test.”

Doctors also often order tests or procedures to protect themselves against lawsuits – so-called defensive medicine – and also because the fee-for-service system compensates them for it, said Gilbert Welch, MD, a Dartmouth University internist and health outcomes researcher. “We’ve systematically exaggerated the benefits of early diagnosis,” which does not always improve survival. ■■

CAP ON AWARDS STRUCK DOWN IN GEORGIA

Coming on the heels of the Illinois Supreme Court ruling that the state’s cap on non-economic damages was unconstitutional, a unanimous Georgia Supreme Court has struck down limits on jury awards in medical liability cases.

The Georgia court ruled that the \$350,000 cap on non-economic damages violated the right to a jury trial guaranteed by the Georgia Constitution. The cap “clearly nullifies the jury’s findings of fact regarding damages and thereby undermines the jury’s basic function,” Chief Justice Carol Hunstein wrote for the court.

As was the case in Illinois, the ruling was praised by victims’ rights groups and plaintiffs’ lawyers and was condemned by physicians. American Medical Association President, Doctor James Rohack, said in a written statement that the ruling, “is a step backward for the state’s patients and physicians as Georgia once again allows a broken legal system to jeopardize access to healthcare.” ■■

NUMBER OF UNINSURED MIDDLE-CLASS AMERICANS RISING EVEN BEFORE RECESSION HIT

The economic turmoil that Americans have weathered in the first decade of the 21st century have taken a tremendous toll on people's ability to afford health insurance – and employers' capacity to offer it – according to a new report from the Robert Wood Johnson Foundation (RWJF).

The new report, *Barely Hanging On: Middle-Class and Uninsured*, offers a state-by-state analysis that documents that while the situation has been tough for everyone, it is America's middle class that has been hardest hit.

The report shows that the number of middle-income earners who obtained health insurance from their employers dropped by 3 million people from 2000 to 2008. Just 66 percent of people in families earning roughly \$45,000 to \$85,000 annually are now insured through their employer – a drop of seven percentage points from 2000 to 2008.

Employer-sponsored insurance (ESI) has long been the mainstay of health coverage for middle-class families, who typically do not qualify for government insurance programs. Among middle-income Americans, only about half of the decline in employer-sponsored coverage from 2000 to 2008 was offset by government insurance programs. For people who earned less money, declines in ESI were even steeper, but those numbers were mostly offset by increases in coverage through government insurance programs like Medicaid.■

Nuts & Bolts of the Patient Centered Medical Home June 25-26 Marriott Oak Brook Hotel

Presented by the Illinois Academy of Family Physicians (IAFP) and TransforMED, this conference will bring together the various components of the Patient-Centered Medical Home – tailored to your practice size and readiness level.

Whether you are on your way to NCQA recognition, or not even sure what PCMH stands for, this conference will meet your needs. Attendees can take choose an education track and also choose from a wide range of breakout sessions on technology topics and practice innovations.

This conference is targeted to primary care physicians and their leadership team interested in implementing the medical home. Bring your office manager, practice partners, whoever is vital to your transformation team! Contact IAFP at 630.435.0257 or iafp@iafp.com with questions.

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Register online at www.iafp.com by May 31 and save \$50.

Group discounts available for multiple attendees from the same practice.

AMA TOOL HELPS PHYSICIANS CORRECT UNFAIR MANAGED CARE CONTRACTS

Physicians seeking a reasonable alternative to the one-sided contracts offered by some managed care organizations can now rely on a new American Medical Association (AMA) online resource. The AMA recently unveiled its new National Managed Care Contract (NMCC) and database to help physicians analyze and negotiate contracts with insurers and help provide relief from unfair corporate business practices.

“The concentrated market power of large health insurers gives them an unprecedented advantage in dictating key aspects of health care to physicians,” said AMA President J. James Rohack, MD. “The AMA’s new resources will be a welcome guide for negotiating fair contracts with health plans angling for an even greater advantage over physicians.”

The NMCC is the first comprehensive managed care contracting resource geared specifically to the needs of physicians. The AMA created the NMCC in an attempt to create model contract language that complies with the managed care laws of all 50 states and the District of Columbia and to comprehensively cover the broad range of physician concerns with managed care contracts. It provides physicians with a valuable frame of reference to compare and evaluate any prospective managed care contract.

The searchable database associated with the NMCC provides physicians with easy access to updated statutes and regulations in all 50 states and the District of Columbia. It covers the managed care contracting process, the managed care contract itself and the business relationship between physicians and managed care organizations after an agreement has been signed.

The NMCC and its database are invaluable tools that can be used by physicians and their advocates to:

- provide alternative language to support contract negotiations with managed care organizations
- ensure managed care contracts and managed care organizations comply with applicable state legal requirements
- clarify key contract issues and manage ongoing relationships with managed care organizations
- assist with legislative, regulatory and legal efforts to reform unfair managed care business practices
- monitor emerging state and federal legislative and regulatory trends

AMA members can access the NMCC and database at www.ama-assn.org/go/nationalcontract. The NMCC is not designed to take the place of competent, individualized legal advice. It is one of many tools available from AMA’s Private Sector Advocacy that will help physicians in the generally lopsided negotiations with health plans. ■■

INVESTMENT SUCCESS ROOTED IN THEORY



Joel M. Blau, CFP & Ronald J. Paprocki, JD, CFP

Physicians, like all investors, constantly strive to achieve attractive returns on their portfolios in order to have their financial assets grow over time. By accomplishing this feat, investors find that their portfolios, whether earmarked for retirement, college education, or other objectives, can be working for them as opposed to them working harder to save more.

While the perfect investment would have the attributes of high growth with little or no risk, the reality of course is quite different. Not surprisingly, significant time is spent developing methods or strategies that come close to that “perfect investment.” None is as popular or compelling as Modern Portfolio Theory (MPT).

Developed by Harry Markowitz and published under the title “Portfolio Selection” in the 1952 *Journal of Finance*, Modern Portfolio Theory explores how risk-averse investors construct portfolios in order to optimize market risk against expected returns. The theory quantifies the benefits of diversification – not having all of your investment eggs in one basket. In 1990, 38 years after he wrote the paper while teaching at the University of Chicago, Markowitz was awarded, along with fellow academicians Merton Miller and William Sharpe, a Nobel Prize for what has become the most

widely used strategy for portfolio selection.

Recognition for the achievement was delayed because, although developed in the early 1950s, the task of applying MPT was only made possible by the use of modern computers that could handle the vast number of calculations and range of historical data needed by the model. Portfolio management today combines theory and technology in order to optimize portfolio performance.

For most investors, the risk they take in an investment is that the return will be lower than expected. In other words, it is the deviation from the average return. The MPT model calculated for each investment a standard deviation from the mean that the model calls risk. Through diversification, the risk of one investment may offset the risk of another. The key behind the MPT model is the plotting of an “Efficient Frontier” of the varying combinations of investments in a portfolio that provide the maximum return and lowest risk.

For every point along the Efficient Frontier, the MPT model displays the combination of investments that produces the optimal level of return and risk based on past performance of the various investment markets. While the past is not always a predictor of the future, MPT uses this data to estimate various risk/return scenarios.

The key today to the utilization of MPT is understanding that a variety of asset classes provides diversification and quantifies the risk and reward of any given portfolio. Examples of major asset classes include

large U.S. companies, small U.S. companies, international companies, domestic bonds, international bonds, and real estate. Understanding the various asset classes and their respective indices leads to the construction of a portfolio that can still encompass the historical validity of MPT.

Funding the various asset classes can be easily accomplished through mutual funds or exchange traded funds (ETFs) that mirror a specific index or asset class. Even after all these years, and a number of bull and bear markets and new investment vehicles, MPT continues to play a crucial and meaningful role in investment management strategy. ■■

This report prepared for DCMS by Joel M. Blau, CFP, and Ronald J. Paprocki, JD, CFP, MEDIQUS Asset Advisors, Inc. They welcome readers' questions and may be reached by calling 800.883.8555 or e-mailing blau@mediquis.com. Securities offered through Joel M. Blau, CFP, and Ronald J. Paprocki, JD, CFP, registered representatives of Waterstone Financial Group, Member FINRA/SIPC.

EDUCATE STAFF, PATIENTS IN FIGHT AGAINST MEDICAL IDENTITY THEFT

Educate your patients about playing an active role in fighting medical identity theft, make your policies tougher, and take a proactive approach to minimize the increasing risk, experts say.

Booz Allen Hamilton, the firm commissioned in 2008 by the Office of the National Coordinator for Health Information Technology to research medical identity theft in the United States, says all facilities can adopt the following strategies:

Integrate identity theft into staff training. Organizations should incorporate medical identity theft prevention into existing training and awareness programs, says Dan Steinberg, associate at Booz Allen Hamilton and coauthor of the *Medical Identity Theft Final Report*.

“A major step toward preventing medical identity theft is to be sure that staff are familiar with it and will have reason to suspect something is not quite right if the patient presents with conditions or demographics that don’t match their records,” Steinberg says. Make medical identity theft a separate discussion during training and orientation, and use friendly reminders to let staff members know that it remains an organizational concern.

In addition to giving tips on how to spot suspicious activity, educate staff members about what to do with that information. “If a provider discovers an identity theft, it must take immediate action to prevent further unlawful disclosures and should contact its legal counsel concerning how best to notify affected patients,” says Bill Roach, JD, healthcare attorney at McDermott Will & Emery in Chicago.

Educate consumers. Patients need to take a more proactive approach to protect their personal information. But organizations must also teach patients about the risks, says Steinberg. “Hospitals can educate consumers about the value of ensuring the information in their records is accurate and up to date,” he says.

Develop educational material that urges patients to pay attention to personal information to which they have easy access. Few patients, for example, actually read and understand the explanation of benefits notices that many insurers send consumers shortly after using medical services. “It’s unfortunate because this is a mechanism already in place that can help detect medical identity theft,” Steinberg says.

Verify patient information thoroughly. In the past, organizations did not often go the extra mile in order to verify each patient’s identity, they simply took the patient’s word for it. Verifying identity is a challenge for staff members, particularly those in patient access, who may see dozens of patients each shift.

Now, many organizations ask patients to present a form of picture identification. “This measure can backfire, however, if staff members are not well trained on its purpose and use,” Steinberg says. He cites an incident involving a woman who tried to address a medical identity theft occurrence but was rebuffed. The woman was later able to prove that someone stole her license and health insurance information at the same time. “The intake specialist must not have challenged the woman who presented it as her own, despite the fact that the picture on it was clearly not of her,” says Steinberg. Teach staff members the importance of examining the types of identification your organization requires. Doing so will go a long way toward preventing medical identity theft and catching criminals. ■■

MORE AMERICAN KIDS OVERWEIGHT

The percentage of American children who are overweight or obese has been growing for decades, and now nearly one in three has a body mass index that is greater than normal. While there is some evidence suggesting that obesity rates are leveling off overall, for some groups – especially poor or minority kids – the problem continues to grow, according to a recent study published in *Health Affairs*.

While the study shows marked regional differences – the five states with the highest rates of overweight and obese kids are all in the Southeast – when researchers further looked at race and socioeconomic status, as well as behavioral factors, they found even greater disparities.

Christina Bethell, a health policy expert at Oregon Health and Science University in Portland and lead author of the study, explained that the highest rates of overweight or obesity are found in kids who are black (41.1 percent), Spanish-speaking Hispanic (45 percent), living below the poverty level (44.8 percent), publicly insured (43.2 percent) and who do not participate in activities outside of school (40.3 percent).

The likelihood of being overweight or obese is greater if a child has a TV in his bedroom or watches television more than two hours a day (41 percent greater odds), if he is from a single-parent family (25 percent greater odds) or if he lives in a neighborhood without a park or recreation center (21 percent greater odds).

While it is true that kids in a lower socioeconomic group are more likely to be overweight or obese, the biggest proportion of overweight or obese children in the country do have private insurance, are not poor, and have access to parks and recreation centers.

Illinois State Medical Society Trustee, William Kobler, MD, recently testified at the Illinois Department of Public Health's Obesity Prevention Initiative public hearing to identify social and human costs of obesity.

"As a family physician I see the effects of obesity every day in my practice," Doctor Kobler said. "My obese patients are more at risk for chronic diseases including heart disease, type-2 diabetes, cancer and more than 20 other preventable conditions." He called on legislators "to examine requirements for physical education and health education." ■■

NEW BOOK PRESENTS PHYSICIANS "IN THEIR OWN WORDS"

If given a voice, what would physicians themselves say about medical practice in America? What concerns do doctors have about today's medical practice environment, what changes do they plan to make in their practices, and what suggestions do they have for fixing that nation's dysfunctional health system?

A new book, *Physicians, In Their Own Words: 12,000 Doctors Reveal Their Thoughts About Medical Practice*, provides answers to these questions, as well as data from one of the largest physician surveys ever undertaken.

The book is built around hundreds of written comments physicians contributed to a national survey conducted by The Physicians Foundation, a group of physician and medical society leaders committed to improving the medical practice environment for doctors and patients. These comments range from one word exclamations (i.e., "Help") to in-depth, heartfelt explications of the untenable position many physicians find themselves in today.

"We've head from the healthcare policy makers and pundits," notes Louis Goodman, Chief Executive Officer of the Texas Medical Association and one of the co-authors of *In Their Own Words*. "This book allows doctors to tell their side of the story."

The book paints a portrait of a medical profession that is struggling with excessive regulation, problematic reimbursement, and flagging morale. Part fact finding mission, part wake-up-call, *Physicians: In Their Own Words* was called "a book you should not put down until you have read it from cover to cover," by noted healthcare writer Richard Reese, MD. ■■

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CHLAMYDIA TRACHOMATIS

Chlamydia trachomatis infections are not only the most commonly reported notifiable disease in the U.S., they are among the most prevalent of all sexually transmitted diseases (STDs). Since 1994, chlamydial infections have comprised the largest proportion of all STDs reported to CDC, and the prevalence is highest in persons aged 25 or younger.^{1,2}

Statistics: In 2008, 1,210,523 chlamydial infections were reported to CDC from 50 states and the District of Columbia. This case count corresponds to a rate of 401.3 cases per 100,000 population, an increase of 9.2 percent compared with the rate of 367.5 in 2007.¹ Illinois ranked ninth by rate, with 59,169 cases reported in 2008, and a corresponding rate of 460.4 cases per 100,000 population (up from 55,470 and 432.3 in 2007, respectively).¹

Sequelae: Chlamydia is a bacterial infection that can easily be cured with appropriate antimicrobial therapy, but often occurs without symptoms and may go undiagnosed without screening. In women with untreated conditions, chlamydial infections may result in pelvic inflammatory disease (PID), which is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Data from a randomized controlled trial of chlamydia screening in a managed care setting suggested that screening programs can lead to a reduction in the incidence of PID by as much as 60 percent.¹ As with other inflammatory STDs, chlamydial infection can facilitate the transmission of HIV infection. In addition, pregnant women infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in ophthalmia neonatorum and pneumonia.¹ Complications from chlamydia among men are relatively uncommon, but may include epididymitis and urethritis.³

Annual screening of all sexually active women aged 25 years and younger is recommended, as is screening of older women with risk factors (e.g., those who have a new sex partner or multiple sex partners).² All pregnant women should also have a screening test for chlamydia. Screening of sexually active young men should be considered in clinical settings with a high prevalence of chlamydia (e.g., adolescent clinics, correctional facilities, and STD clinics). An appropriate sexual risk assessment should be conducted for all persons and might

indicate more frequent screening for some women or certain men.²

Prevention: In addition to screening and appropriate partner notification and management, the most reliable way to avoid transmission of STDs is to abstain from sex (i.e., oral, vaginal, or anal sex) or to be in a long-term, mutually monogamous relationship with an uninfected partner. Latex male condoms, when used consistently and correctly, can reduce the risk of transmission of chlamydia.^{2,3} As part of the clinical interview, healthcare providers should routinely and regularly obtain sexual histories from their patients and address risk reduction strategies. Counseling skills, characterized by respect, compassion, and a nonjudgmental attitude toward all patients, are essential to obtaining a thorough sexual history and to delivering prevention messages effectively.²

Expedited Partner Therapy: Effective January 1, 2010, Illinois health care professionals have a new option for ensuring effective partner treatment for the sex partners of patients diagnosed with *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. On August 24, 2009, Governor Pat Quinn signed Senate Bill 212 into law (PA 96-613) authorizing the use of expedited partner therapy (EPT). EPT is the general term for the practice of treating sexual partners of patients diagnosed with chlamydia and/or gonorrhea without an intervening medical evaluation. EPT is an alternative strategy for ensuring that sex partners receive needed medication thus reducing the likelihood of re-infection, potential complications, and further dissemination of these diseases within the community.

The EPT law allows health care professionals, including licensed physicians, physician assistants, and advanced practice nurses to dispense antibiotic therapy for the sex partners of individuals infected with *C. trachomatis* and *N. gonorrhoeae*, even if they have not been able to perform an exam of the patient's sex partner(s).

The Illinois Department of Public Health (IDPH) STD Section staff has developed EPT guidelines that provide information on appropriate patients, medications, counseling procedures and fact sheets in both English and Spanish for infected patients and their sex partners. These documents can be found on the IDPH website: www.idph.state.il.us/health/std/ept_cg.htm. For questions or assistance regarding EPT, please call the STD Section at 217.782.2747. ■■

References:

¹www.cdc.gov/std/stats08/chlamydia.htm

²www.cdc.gov/std/treatment/2006/rr5511.pdf

³www.cdc.gov/std/chlamydia/

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MIDWEST RECEIVES LEAST FEDERAL FUNDING FOR PUBLIC HEALTH

States in the Midwest receive the least federal funding support for disease prevention in public health, at only \$16.50 per person in fiscal year (FY) 2009, according to a recent report by Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF). The amount is \$3.30 less per person than the Northeastern states, which receive the highest amount, at \$19.80 per person. Western states receive \$19.22 per person, while Southern states receive \$19.75 per person.

The report, *Shortchanging America's Health: A State-By-State Look at How Public Health Dollars Are Spent*, also documents that Federal spending for public health has remained flat for nearly five years while state public health program cuts totaling nearly \$392 million in that last year. Combined, the funding crisis leaves communities around the country struggling to deliver basic disease prevention and emergency health preparedness services.

"Chronic under-funding for public health means that millions of Americans are needlessly suffering from preventable diseases, health care costs have skyrocketed, and our workforce is not as healthy as it needs to be to compete with the rest of the world," said Jeffrey Levi, PhD, Executive Director of TFAH. "If we are going to improve the health of Americans, we need to fundamentally rethink our approach to funding and managing public health and disease prevention in the United States."

States are expected to cut budgets even more in the coming year, which will further limit the ability of public health departments to carry out services for chronic disease prevention, infectious disease prevention, food and water safety, environmental health issues, and bioterrorism and health emergency preparedness.

Other key findings in the report include that:

- Federal funding for public health averaged out to \$19.23 per person in FY2009. The amount spent to prevent disease and improve health in communities ranged significantly from state to state, with a

per capita low of \$13.33 in Virginia to a high of \$58.65 in Alaska. Illinois ranks number 33, at \$18.29 per person.

- State funding for public health ranged dramatically across the country, from a low of \$3.55 per person in Nevada to a high of \$169.92 per person in Hawaii. The national median is \$28.92 per person. Illinois is ranked number 32, at \$24.32 per person.

"Public health departments are responsible for finding ways to address the systemic reasons why some communities are healthier than others and for developing policies and programs to remove obstacles that get in the way of making health choices possible," Levi said. "But right now, public health departments do not have the resources they need to improve health in communities. Our ability to address the geographic and racial/ethnic disparities in health is limited by our failure to invest adequately in creating a modernized public health system."

The full report includes state-by-state pages of key health statistics and funding information and is available on TFAH's website at www.healthyamericans.org.

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