ILLINOIS
FAMILY PHYSICIAN

VOLUME 62, ISSUE 5
September/October 2011

Published by the Illinois Academy of Family Physicians
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Enhancing Safety for Patients and Family Medicine Practices

Due Diligence in Prescribing Narcotics/Opioids and other Controlled Substances

By Arvind K. Goyal, MD, MPH, FAAFP, FACPM, Clinical Associate Professor, Family Medicine & Preventive Medicine, Chicago Medical School/Rosalind Franklin University

This article was written in collaboration with Rashmi Chugh, MD, MPH, Chair, Sachin Dixit, MD and Renee M. Poole, MD, members of the IAFP Public Health Committee, and Vince Keenan, MSPH, CAE, IAFP executive vice president and staff for the IAFP Public Health Committee.

Sir William Osler (1849-1919) wrote "…the family doctor is the man behind the gun, who does our effective work. That his life is hard and exacting; that he is underpaid and overworked; that he has but little time for study and less for recreation- these are the blows that may give finer temper to his steel, and bring out the nobler elements in his character."
Lately the family doctor is one of the clinicians considered by many to be behind the national epidemic of unintentional prescription opioid overdose deaths, now responsible for more overdose deaths than heroin and cocaine combined. A recent report authored by the Centers for Disease Control and Prevention (CDC), the University of North Carolina Chapel Hill School of Medicine and Duke University Medical Center, published in the *Journal of Clinical Psychiatry*, April 19, 2011, found that in 40% of the United States, unintentional drug overdose kills more people than motor vehicle accidents and suicide. The report blamed the primary care clinicians' and psychiatrists' failure to follow guidelines and safe prescribing procedures for opioids for the severe increase in overdose deaths. (1)

Also in April 2011, the White House, in conjunction with the Office of National Drug Control Policy, the U.S. Drug Enforcement Administration (DEA), and the U.S. Food and Drug Administration (FDA), released a national action plan to fight prescription drug abuse.(2) The plan outlines several action items:

• Amend the Federal law to require practitioners who request DEA registration to prescribe controlled substances to be trained on responsible opioid prescribing practices as a precondition of registration. The training would include assessing and addressing signs of abuse and/or dependence.

• An Opioid Risk Evaluation and Mitigation Strategy that requires manufacturers to develop effective educational materials and initiatives to train practitioners on the appropriate use of opioid pain relievers.

• Continuing medical education (CME) efforts focused on the proper prescribing and disposal of prescription drugs to be developed by all federal agencies that

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Family medicine's fast fish! Life member Mary Pohlmann, MD wins big at the 2011 U.S. Masters Swimming Summer National Championships at Auburn University. Learn more about her in the Member Spotlight on page 19.

President's Message

David J. Hagan, MD

Have you delivered any babies yet?

This question plagued me for some time early in my medical school career. Whenever I would come home during those first years of medical school and go to my family's church, the family friends would ask me that question. At that time, to most people delivering babies was an important part of being a doctor. I could sense a little bit of disappointment when I replied that, no, I had not done that - yet. Finally during the last year of med school, when I could report that I had in fact delivered a baby, I could see in their smiles a sense of approval and recognition that I was going to be a doctor.

Providing maternity care and delivering babies has been an important part of family medicine, although today more family physicians choose to not include maternity care in their practice. I want to encourage those family physicians that provide maternity care to continue it and encourage today's students and residents to consider maternity care in their futures.

Maternity care and delivering babies, including operative obstetrics, was an important part of my practice for 17 years. Though the last baby I delivered is now almost 11 years old, I still miss that experience occasionally. I believe your Academy encourages maternity care as part of family medicine and will work with you on issues of credentialing and scope of practice. For medical

school instructors and residency program directors, please continue to include this in your curriculum and encourage your doctors to strongly consider this aspect of family medicine.

Over the past year, I have attended many local, regional and national meetings. I can report to you that, in my view, the leadership at all levels of family medicine are deeply involved, motivated and determined to advance family medicine's place in the health care universe. We are all working to ensure the adoption of the patient –centered medical home, build the family medicine workforce and reform the payment structures to be fair to family physicians.

Issues and events on the horizon

A major issue on the agenda at the AAFP Congress of Delegates in Orlando is the AAFP Board of Directors' plan to propose alternatives to the RUC (Relative Value Scale Update Committee). This is generating significant discussion on the chapter presidents' listserv. For more information, please see the AAFP story online at http://www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20110610rucletter.html. AAFP has created a task force including physicians as well as economic and health policy experts to develop an alternative system to the flawed RUC. The task force will make recommendations to the AAFP Board in the next six to nine months regarding alternative methodologies for valuing the health care services provided by primary care physicians. This bold step demonstrates that family medicine will no longer ask for those in power to create a fair system, but rather we will tell them exactly what should be done to correct the inequities in our payment systems.

Our electronic voting for the next IAFP board of directors is now underway, so watch your email for the link to cast your votes online. A postcard will be mailed to active and life members who do not have an email address on file with AAFP. We have several contested positions, so every vote truly counts this year.

Coming up on November 11 and 12, join me for the IAFP annual meeting, with something for everyone. Our new board of directors will be sworn in. We will offer a SAM course on pain management, and we just added a second session to meet the demand! If you can't make the SAM, then take on some of the excellent CME on clinical and practice management topics. Bring the family because there are family fun options, too. A new event is a "fun run" early Saturday morning. Though not my idea, the staff has dubbed this as a "beat the President" run. That shouldn't be hard for some of you, given my advanced age. Nevertheless, I will be there and I will ramp up my training between now and then to give you my best effort.

May you all continue to find the joy in family medicine!

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IAFP News

(Cover story, continued from page 1)

support their own health care systems.

• Requiring the curricula of medical schools and other health professional schools to include instructions on "the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse." Polypharmacy involving opioids and other prescription pain medications, benzodiazepines, anti-depressants, and sleep medications (sedatives and hypnotics), with their potentially harmful additive effects, have each been independently identified by many as a significant problem. Therefore, this article focusing on opioids also includes discussion of other controlled substances.

Pain is one of the most commonly encountered diagnoses in a typical family medicine practice. Research has shown estimates ranging from 4-40% for the prevalence of chronic non-cancer pain. It is well recognized that a significant number of patients with chronic pain have or will have substance abuse problems or mental illness, especially depression and various mood and anxiety disorders. Further, the abuse and diversion of controlled substances by the same individuals who suffer from pain can be a difficult problem to diagnose and manage, even by the most knowledgeable and diligent family physicians.

On the other side, there is a significant body of evidence suggesting that both acute and chronic pain continue to be under-treated. This can also become a serious public health problem adversely impacting a patient's functionality or quality of life. I am aware of a patient who committed suicide on account of severe uncontrolled pain associated with an advanced cancer!

Some of the increased abuse of opioids may be attributable to those who truly believe that medications prescribed by physicians may be safer than the ones available on the street. On the other hand, these medications may be more easily available and accessible because they are prescribed by a physician, filled at a legitimate pharmacy, and possibly covered by insurance.

In my various roles as the chair of the Illinois State Medical Licensing Board, president of a hospital medical staff, chair of a clinical department of family medicine, a physician advisor at another hospital, president of the county and state medical society, chair of a peer review committee at a county medical society, and a Chief Medical Officer at a federally qualified community health center, I have witnessed unfortunate situations when some of our most respected and well-intentioned but unsuspecting colleagues were hit with a variety of sanctions, reprimands, expulsions from a professional membership society or a hospital medical staff, restrictions or loss of their privileges, or an outright loss of their DEA or state license to practice medicine or to prescribe controlled substances.

Usually these investigations are triggered by charges or complaints of over-prescribing by colleagues, nurses, pharmacists, patients or their families. Patients and families frequently seek redress when there is an adverse reaction or death of a person receiving one or more controlled substances, especially with uncertain indications. The documentation in their medical records, in many of these cases, did not support initial prescription or continuation of one or more controlled substance prescriptions; yet there was a "clock-like" visit and prescription pattern every week or every month. In some records, there was no indication of the location, frequency, intensity or etiology of pain and no effort had been made to determine the cause of a patient's pain, and nothing except a narcotic was tried to control that pain. No consultations, no monitoring, and no attempts to wean or decrease the dose were noted. However, the dose was usually escalated or another controlled substance (a narcotic, anti-depressant or a tranquilizer) added, any time the patient complained the pain was not controlled. The investigators concluded the prescriptions were being sold in return for an office visit charge, since no other service was performed! The records were mostly silent. Indefensible, is the word.

Then, there are some high profile cases of Elvis Presley, Michael Jackson and others who died as a result of their chronic prescription drug use, made possible due to actions of physicians and other caregivers who disregarded their patients' safety. Stories in the media revealed multiple prescribers, who were frequently not aware and not communicating with each other.

The Federation of State Medical Boards developed a Model Policy for the Use of Controlled Substances for the Treatment of Pain in 2004, "to clarify the board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management." That model policy has been adopted by several constituent state medical boards, specialty boards and medical societies. (3). Guidelines developed and published by the American Academy of Pain Medicine in 2009 are more specific but may not be applicable to all practices. (4).

The IAFP Public Health Committee chaired by Dr. Rashmi Chugh discussed this issue at length in 2010 and appointed a subcommittee on Narcotic Policy of Drs. Arvind K. Goyal, Sachin Dixit and Renee M. Poole to propose recommendations which could help family physicians develop policies they could implement and follow in their own practices. These following recommendations on page 6 have been

approved by the IAFP Public Health Committee but not adopted by the IAFP Board or any other professional association or a regulatory body. However, they represent a reasonable balance, a template that could be modified to suit one's practice and patient population.

Another template was developed to help family physicians create a Chronic Pain Medicine, Narcotic/Opioid & Controlled Substance Agreement with their patients, popularly called a "Contract", which would serve to formalize those physician-patient discussions.

These recommendations and agreements may need to be tailored further when used for patients with cancer or other terminal illnesses, and may not be necessary in many of those cases. The IAFP Public Health Committee will be very interested in your feedback and your suggestions for improvement. You may also wish to share your written policies and agreements you already use. Email them to iafp@iafp.com.

Remember, that professionalism is a social contract between the professionals and a larger society that is based on trust, and carries with it certain privileges and responsibilities, one of which is, "To establish, maintain, and apply standards of educational practice that are aimed at assuring excellence." These recommendations from your colleagues and ensuing dialogue should be a step in that direction.

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Arvind K. Goyal, MD

Link to the Public Health Committee's sample Chronic Pain Medicine, Narcotic/Opioid & Controlled Substance Agreement web site address: www.iafp.com/whatsnew/ChronicPainMedicine-Contract.pdf

IAFP CME Available!
www.iafp.com/education
The "Pain Management with Opioid Drugs in Primary Care Practice" program will cover the Epidemiology of chronic, non-cancer pain (CNCP), help define treatment goals, and discuss pain management methods and risk management.

AAFP opposes White House proposal of mandatory CME for providers
AAFP president Roland Goertz, MD recently addressed AAFP's opposition to provisions in the White House strategy to address prescription drug abuse in the August 25 issue of AAFP News Now.

"The White House recently announced a multifaceted strategy to curb what it is calling an "epidemic" of prescription drug abuse. Although there are portions of the White House plan (e.g., enhanced monitoring, surveillance and enforcement efforts) that deserve our support, there is one aspect that we cannot accept: the call for mandatory CME for health care professionals who prescribe controlled substances…

…In March, Sen. Jay Rockefeller, D-W. Va., introduced a bill that would amend the Controlled Substances Act and that calls for prescribers to complete 16 hours of mandatory CME related to opioids and pain management every three years.

According to the Obama administration, if this legislation becomes law, physicians would be required to complete the CME to receive or renew their DEA registration, regardless of whether they write prescriptions for long-acting opioids. This approach not only places an undue burden on physicians, it does not address the real and rapidly growing problem of drug diversion."

Link to Goertz's entire column at http://www.aafp.org/online/en/home/publications/news/news-now/opinion/20110824opioidsvoices.html?cmpid=10036-em-1

Recommendations for a Model Controlled Substance Policy for Family Practice

Submitted by the IAFP Public Health Committee, September 2011

a. Family Physicians should adopt a reasonable Chronic Pain Medicine, Narcotic/Opioid and Controlled Substance Policy which fits their practice and patient population and follow it every day, for every patient and at each encounter.
b. The policy need not be applied to prescriptions written for less than two weeks at a time, renewable only once (total of 28 days) for treatment of acute pain and other symptoms.
c. Confirm the identity of all patients at registration. All patients should be checked for some form of legal identity at the time of check in process. Patient should be screened for different names/namesakes as well, if feasible.
d. With few exceptions, post-surgical pain management should be continued by the surgeon who performed a given surgical procedure. For each exception, there should be a written consult, a letter or documentation of a phone conversation in the patient's medical record specifying the exception.
e. For prescriptions beyond a total of 28 days, it is recommended that the medical record documentation include:
    (a) Completion of appropriate evaluation including history and physical exam, nature and intensity of the pain, current and past treatments for pain, sleep, and depression, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, past history of substance abuse and investigation of the cause of symptoms.
    (b) The presence of one or more recognized medical indications and relative contraindications for the use of the prescribed medicine/s.
    (c) Recommendation and arrangement for consultation with appropriate specialists specializing in pain management, psychiatry, rehabilitation medicine, musculoskeletal disorders and nerve disorders, etc. A written consult report or documentation of a phone conversation with the consultant should be available in the patient's medical record.
    (d) Consideration and discussion with the patient regarding alternatives to requested or intended prescriptions for chronic pain medicine/s, narcotics/opioids and controlled substances including non-pharmacological and oral and topical non-opioid therapies.
    (e) Illinois Prescription Information Library accession by prescribing physician or designated staff initially or every 90 days (www.ilpmp.org) and documentation in the patient's medical record.
    (f) Discussion with the patient of the indications and common potential side effects and risks of prescribed medicine/s, need to avoid alcohol and all illegal drugs, limit of no more than 28 day supply at a time with no possibility of replacement if lost or stolen, non-availability of phone prescription refills therefore requiring a face to face office/clinic visit and documentation of progress by the physician or clinician at least once every 28 days, safe keeping of all medicine/s for personal use only, agreement to not get narcotics/opioids and controlled substances prescriptions from any other physician, clinician or ER, agreement to use only one pharmacy, and availability for random urine and serum drug screen without advance notice. Alternatively, a "Narcotic Contract" or agreement developed to cover above expectations signed by the patient and witnessed preferably by a family member of the patient and placed or scanned in the patient's medical record will be acceptable.
    (g) Statement of a plan to try and wean off/taper the prescribed medicine/s.
    (h) Report of a standard Urine Drug Screen initially and every 90 days as a minimum. Additionally, Urine test for Oxycodone and a Serum Drug Screen test may be ordered based on the judgment by the prescribing physician.
    (i) Documentation and appropriate action in case of a positive drug screen for an unprescribed medicine, a negative drug screen for a prescribed medicine, missed scheduled appointments, violent or threatened behavior, hospitalization, alcohol intoxication, intervening acute or new illness, or other instances of non-compliance with agreement and recommendations.
    (j) Physicians should not avoid the prescribing of controlled substances in appropriate patients within the framework of such a policy.
    (k) Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. Attempts to wean off or discontinue the medicine/s should match the documented progress in patient's medical record.
    (l) If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities or referral to an appropriate consultant or rehabilitation facility for further care.

Drug seeking - a lesson in creativity

By Jim Cunnar, MD
DuPage Family Medicine, Naperville

After 14 years of private practice, I think I've seen my fair share of the unbelievable. This week, I saw something new. A patient misspelled their name when they registered with our office. On purpose. You'll understand the importance of this in a minute.

In April, Karla, my physician assistant, saw a new patient who came in for a visit. He had moved to Illinois from out of state, and based on his medication list, we knew this patient was going to need careful monitoring. He was on a significant amount of narcotics and anxiety drugs. Karla came to me for guidance, and we decided that based on the sheer amount of narcotic he was taking (80+ milligrams a day), he would need to get his prescriptions through a pain management physician. So, we gave him some names, asked him to let us know when he secured an appointment with the pain specialist, and sent him on his way.

He called two weeks later, saying he was going out of state and was afraid of running out of medicines. He said he had an appointment with the pain management doctor for when he returned. So, I refilled his medicines, but just one time, and made it clear to the patient I wouldn't refill them again.

This past week, we received a fax from a local big-box pharmacy, with a list of prescriptions filled by the above patient, from 5 different physicians in the last 12 weeks. Narcotics, anxiety drugs, sleep medicines. And there was my name, scattered amongst the other physicians who were prescribing for him. The pharmacy was notifying us they wouldn't fill any further prescriptions for the patient, because he was getting the same medicine from multiple prescribers.

The list which was faxed to us is from the Illinois Prescription Monitoring Program (IPMP). Controlled medicines, like narcotics, are reported by pharmacies to the state, which then posts the information on a website for prescribers and pharmacists. It's a fantastic resource, and 34 states have a monitoring program like this, but Florida does not.

We checked this database the moment the patient left our office. The database didn't show any controlled substance prescriptions for him, because he misspelled his last name on his registration forms. ON PURPOSE. He knew we were going to check the database. The fax from the pharmacy listed the patient's birth date and name, but his last name was spelled differently. We actually addressed the spelling issue when he checked in, because his wife's insurance card had a different spelling on it. In addition, the patient conveniently had forgotten his driver's license, so we couldn't double-check his information against a legitimate form of ID.

We got a call from the pain management physician on Friday that the patient failed to show up for his appointment. I will be discharging the patient from our practice next week.

Chronic pain is a problem for millions of people. Narcotics are a mainstay of managing their pain. The difference between compliant patients and the addict I describe above is that compliant patients are exactly that. They keep appointments. They allow the doctors to count their medicines. They sign narcotic contracts. They don't take advantage of the physician.

Two or three times a year we get new patients like this. A few years ago, we had no way to check if we were being played by patients seeking inappropriate prescriptions. The IPMP has changed the game. Physicians can remain compassionate, without thinking every patient requesting a strong pain medicine is a drug seeker. If we are suspicious, we can easily check to see if they are listed, and if their name doesn't come up, we can take care of them without concern.

Prescription monitoring programs should be in place in all 50 states. There is no reason why physicians and pharmacies shouldn't have the ability to check for patients who abuse medicines. The problem is, we aren't utilizing these resources like we should. If we checked these databases on each and every patient, it would be a significant deterrent to stop this type of behavior. If we could make it harder for them to get their fix, then maybe, with the grace of God, we could help them climb out of the hole of addiction.

This blog post originally appeared June 6, 2011. Reprinted with permission from Dr. Cunnar. Follow his blog at http://oncall24seven.blogspot.com

Connect to the Illinois Prescription Monitoring program database at www.ilpmp.org

A closer look at the Small Practice Pilot

The Illinois Academy of Family Physicians Practice Improvement Network Small Practice Pilot is an innovative program designed to help members make incremental enhancements to their practice's operations over the next two years. These changes can help position these small practices for the long-term establishing sustainable, profitable, patient-centered medical home models. The Small Practice Pilot is one component of the Practice Improvement Network. The "network" also includes an ongoing member communications campaign and upcoming continuing medical education modules across the spectrum of medical home principles. Experienced IAFP members, many of whom have achieved NCQA medical home recognition, will serve as "ambassadors" or peer-mentors to support and educate their IAFP colleagues.

Combined, the elements of the Practice Improvement Network create a compelling framework to connect and empower members as they navigate the changing tides of health care reform and deliver patient-centered medical care. The IAFP is committed to helping members: focus on individuals and families; redesign primary care services and structures; improve population health management; control unnecessary costs and waste; and integrate and execute new systems.

The Small Practice Pilot includes several core elements including a focus on clinical and fiscal improvements, personalized guidance from a practice management coach, guided Plan-Do-Study-Act projects, assessments, and online collaboration tools for peer networking. All IAFP members will be invited to follow their journey in our PIN monthly publications and at the 2011 and 2012 IAFP Annual Meetings. The IAFP has partnered with experienced practice management consultants and the AAFP's TransforMED program to deliver tools and processes to participating practices.

Currently, about 15 practices have enrolled in the pilot program. Each practice is unique and will determine its own goals related to the patient-centered medical home model and practice transformation. Some practices have chosen to focus on enhancement of their health IT system. Other practices are interested in learning best practices in coding or group visits. Practice coaches will help physicians and practice managers identify goal areas and select Plan-Do-Study-Act projects that will support those changes. The Practice Improvement Network team will work to bring the appropriate resources to the table to support our small practices. Applications are still being accepted!

Small Practice Pilot – the details

Small practices of eight or fewer physicians are joining in a practice transformation journey with the help of IAFP and our practice management partners. We still have room for more practices. If you'd like to join the pilot project, download the short and simple pilot application at www.iafp.com/pcmh. AAFP News Now recently reported on the PIN and the Small Practice Pilot in its "Chapter of the Month" series. Find it online at www.aafp.org.

What types of activities will I be required to complete as part of the pilot?

Practices complete several assessments and education modules at the beginning of the program. The remainder of the program is working with your coach to complete Plan-Do-Study-Act projects on clinical quality, fiscal improvements and practice management. Practices also attend webinars and live CME sessions.

What type of time commitment does the pilot require?

Completing the initial assessments and modules will require approximately 5-6 hours. After that, practices should anticipate spending 2-4 hours per week in some combination of planning or executing Plan-Do-Study-Act projects, participating on webinars or attending live CME sessions. Practices and transformation coaches are required to attend the IAFP annual meeting Nov. 11-12, 2011 in Oak Brook.

Will the pilot help my practice obtain NCQA recognition?

The IAFP has established a network of resources to help your practice obtain NCQA recognition if you decide to pursue it. The PIN offers a network of IAFP member ambassadors, many of them have achieved NCQA recognition for their practices and can advise your practice on the process. The IAFP can also recommend learning tools and programs.
Please visit the PIN website http://www.iafp.com/PCMH/ for more information and application materials or email the PIN project manager, Helen Kate Liebelt at hkliebelt@iafp.com or call 630-427-8008.

Illinois student takes 6th place at national poster contest

Madelyn Noyes, a fifth-grader at Rochester Middle School represented Illinois at the National Tar Wars Poster Contest July 11-12 in Washington, D.C. Her poster finished sixth out of 38 state poster contest winners from around the nation. You can link to all the posters on the National Tar Wars web site at www.tarwars.org.

On July 12th, all the state poster contest winners at the event spent the day on Capitol Hill visiting with their Congressional representatives to talk about tobacco and health issues as well as share their posters with their elected officials. Madelyn, her sister Lexie and father Andrew spent an exciting day with U.S. Rep. John Shimkus, (R-19, Collinsville).

The Noyes family accompanied Rep. Shimkus to his committee meeting, which was being broadcast live on C-Span. He took them down to the tunnel where they rode the Capitol tram (which is exclusively for Capitol Hill members and staff!). Together they went up to the House of Representatives gallery – under the famous Capitol Hill dome - where he spent some time talking to them about the House, how he votes, and some of the more interesting sights in the House.

But wait, there is more! Congressman Shimkus then went to his meeting with Speaker of the House John Boehner while his staff member gave them a personalized tour of the Capitol. When the Congressman returned, he took the Noyes family up to the Speaker's office and out onto the Speaker's private balcony which had a clear view of the Washington monument and is right above the site where the President is sworn in! The final stop was to the Capitol steps where they took a photo with the Congressman, who promptly pulled out his BlackBerry and posted the picture to his Twitter page, along with mention that Madelyn was attending the Tar Wars national conference.

The Family Health Foundation of Illinois provided travel funding assistance to the Noyes family, thanks to a grant from Pfizer Health Charitables.

Tar Wars, a program of the American Academy of Family Physicians, is at work in schools around the country, as well as in Canada and overseas. The program is free for schools and for volunteers to teach in their local schools or youth groups. For more information, including the complete program curriculum, visit www.tarwars.org. If you would like to be a Tar Wars presenter at a school in your neighborhood, contact your state coordinator, Ginnie Flynn at 630-427-8004 or gflynn@iafp.com.

Madelyn Noyes accepts her sixth place prize with Tar Wars officials
Saria Carter-Saccocio, MD and Richard D. Feldman, MD

Susan Arjmand, Deputy Director, Chicago Police Department

Susan Arjmand, MD doesn't have any relatives in law enforcement, or any connection to the Chicago Police Department, so how did she become the medical director for the 12,600 officers who serve and protect Chicago? "When I interviewed, because I didn't have any experience or connection to the department or the military, I didn't think I'd be their choice," she recalls, but also sees the logic of hiring an unknown. "I think it's good to have someone in this position with fresh eyes who brings a position of neutrality." The Department had been without a physician leader for five years while the position was unfunded.

As medical director, Arjmand reviews all the light duty and medical absence requests as well as surgery requests for the officers. She works with the staff nurses; some are sworn officers and some are civilian. After the nurse case manager reviews the case, she offers a second opinion or coordinates necessary specialty testing or services. She also works with treating doctors to get more information or to advocate for the patient. On any given day there are about 770 officers absent for medical reasons and approximately 565 currently on light duty, meaning they cannot be on the street.

What can she bring to this role as a family physician? "I love working with the nurses here." Arjmand uses some of the same principles she used when teaching medical students, such as how reason through the cases they encounter. In return, the nurses are more confident in evaluating the requests, knowing a physician will back them up.

Her main goal is helping officers get back on the job. Many have long-term injuries, require multiple specialists and until now had no coordination. Though she doesn't provide direct patient care, she is able to assist officers who may have complex needs and are seeing several providers, helping them understand their treatments. She discusses the treatment options with the specialists to help that officer feel comfortable with next steps and decisions on his or her work status. Her communication with specialists is vital; as multiple providers may have not been aware of each other during the course of treating the officer. She can also provide important information on the officer's medical history and other injuries. "The treating specialists are actually grateful that I'm here now," Arjmand says.

She really treasures talking directly with the officers about their treatments. "It sounds like a simple thing, but when someone is fearful about their health situation, that conversation is extremely helpful. I've had a lot of officers thank me for taking the time to do that."

In addition, Arjmand is charged with developing a wellness and preventive medicine program for the officers of the Chicago Police Department, a project she is looking forward to implementing. Her plan is prepared and she is waiting for the opportunity to present it to Supt. Garry McCarthy. Her priorities mirror Mayor Rahm Emanuel's and McCarthy's priority to get more officers back on the street.

Her plan for wellness and health improvement includes a requirement for a standard level of physical fitness on a yearly basis. She'd also like to create limits on how long an officer can remain on light duty for injuries that are not work related.

"I'd like to see officers take ownership for their own health and well-being, just like all family physicians want for their patients," she says. She hopes

Sgt. Alan Kurth, Susan Arjmand, MD, and Officer Erica Jenkins, RN

to provide education on prevention, such as when to get recommended screenings for cancer. She's also targeting diabetes control, blood pressure and cholesterol checks. She foresees providing lectures and webinars on these topics and others such as cardiovascular health and muscular-skeletal issues to build awareness and get officers connected back to their primary care physicians.

Perhaps the most "on the job" learning takes place in the meetings with the representatives of the Fraternal Order of Policy Union and the City Council Finance Committee every month to discuss grievances brought by the officers related to their medical status. The committee on Finance decides if the injury is "duty related" so there is often haggling with the union. "I'm still getting used to the politics. My job is to represent the officer's best interest and explain my medical decisions to non-physicians. I'm guided by medical necessity in my decision making – what's appropriate and an improvement. It's not always the popular decision with one side or the other." Sometimes her determinations may require a change in plan to get to the right diagnosis and treatment. The Committee has to be concerned with the costs to the city, and Dr. Arjmand provides them with the medical perspective to help them make the right decisions for the officers that serve and protect Chicago.

Illinois Practices are now Ask and Act Champions

This year AAFP took their **Ask and Act** office-based smoking cessation program to a new level with their "Office Champions" pilot project. Fifty practices from throughout AAFP's membership took concrete steps to fully integrate tobacco cessation activities into their practices. Pilot practices were provided with a toolkit filled with a wealth of resources: patient education, conducting group visits, coding information, electronic health records integration, resources like "quit-lines" and other cessation tools for patients. Two of the 50 pilot practices are in Illinois. So Illinois *Family Physician* caught up with the office champion for Family Medicine Center in Woodridge. IAFP member Jennifer McGowen, MD is the Physician Champion for the practice, located in the western suburbs of Chicago. The other Illinois practice is Eastern Illinois University Health Service in Charleston.

Sandra Jaworski, RN is the practice Nurse Manager and the designated Office Champion for Family Medicine Center and relished the opportunity to participate. "Personally, I am a nurse educator – so I love the research and process of validating the good work we are doing here. Cessation has always been important to us, and we wanted to make cessation a more consistent thing. "

One of the biggest changes Family Medicine Center made involved educating the entire practice staff, not just the clinical personnel, on making tobacco cessation a standard component of the patient encounter. The practice designed new name tags for all staff that say "Ask me about quitting smoking!" Posters and patient education materials are set up throughout the lobby. The question "Do you currently or have you ever used tobacco?" is a standard vital sign at each visit. Meanwhile, they eliminated all magazines that had tobacco ads from the practice.

Once a patient has been identified as wanting to quit, they got excellent Ask and Act patient education material. That patient also went into Jaworski's "tickler" file. Sandi then made calls to each planned quitter on the quit date, one week later, and then in pre-determined intervals. Patients were also referred to the state Quitline and some patients would even report back to Sandi about good resources they found online. During the program pilot period, about 20 patients entered this process. Jaworski says most of those cessation candidates range in age from young adults up to their 50s.

One of the best benefits for the practice was integrating cessation efforts with their electronic health record. "There was some tweaking involved, but now we are applying for Medicare Meaningful Use incentive payments and this process was beneficial in preparing for that," Jaworski says.

Asked what they learned overall from this experience, Jaworski says, "You just need to ask the question. In the past we hesitated because it was a 'prickly' topic. Smoking was their choice. You need to get over that. We ask everyone this question because it's important, and not one of those private matters. That said, we did get some push-back from people who don't want to quit."

Ask and Act proved to be a great tool to reinforce the primary care provider as a partner in each patient's health – and the role of prevention and wellness. "It was an excellent opportunity and really enhanced our practice. I hope they can roll it out to more practices. The more people who have access to the materials the better we will all be," summarizes Dr. McGowen.

Learn more at www.askandact.org

ASK AND ACT
A TOBACCO CESSATION PROGRAM

Illinois Tobacco Quitline
www.quityes.org
1-866-QUIT-YES

Illinois boasts two Pisacano Scholars

The Illinois chapter is thrilled that two of the five 2011 Pisacano Scholarships are Illinois medical students. The scholarships, valued up to $28,000 each, are awarded to students attending U.S. medical schools who demonstrate a strong commitment to the specialty of Family Medicine. In addition, each applicant must show demonstrable leadership skills, superior academic achievement, strong communication skills, identifiable character and integrity, and a noteworthy level of community service.

The Scholarship program provides educational programs, leadership training and funding for outstanding 4th-year medical students who have been identified as the future leaders in the field of Family Medicine.

Nathan Kittle is a 4th-year medical student at Loyola University Chicago Stritch School of Medicine, where he is also earning his master's in bioethics and health policy. During college, he participated in and led numerous service trips to poverty stricken areas in the United States.

As a medical student, Nathan has continued his academic achievement and commitment to service. He has received a number of scholarships, including an Albert Schweitzer Fellowship. Additionally, Nathan was chosen for a Dean's Development Award to complete his master's degree at Loyola. Nathan was also recently selected as one of only a few students to represent the Loyola school of medicine in a leadership development program put in place to help discover ways the health system can better serve patients, improve clinical service, and enhance medical education.

As a Loyola Global Health Fellow, Nathan recently began a fellowship in Palacios, Bolivia. This one-year fellowship is part of a four-year longitudinal Global Health Scholars program at Loyola and will focus on health care delivery in resource-poor settings.

Nathan is also a member of the Center for Service and Global Health (CSGH) Student Advisory Board. His most important activity he led as part of the CSGH was organizing Loyola's first annual "Mission in Action: Loyola Day of Service." This project introduces students to the community and gives them the opportunity to volunteer in different areas, ranging from collecting trash on a local prairie path to working with the local Fine Arts Association. In his future career as a family physician, Nathan hopes to continue working among underserved communities both locally and abroad. He specifically has a heart for working with refugee communities and hopes to work to improve their care and bring attention to their struggles by remaining involved in academic medicine and policy work.

Benjamin Preyss is a 4th-year medical student at the University of Illinois at Chicago College of Medicine, where he is pursuing a joint MD/MBA degree. He worked as campus manager for Teach For America during the last two years of college and traveled to the indigenous villages of the Oaxaca Valley in Mexico as a student leader on multiple short-term medical mission trips.

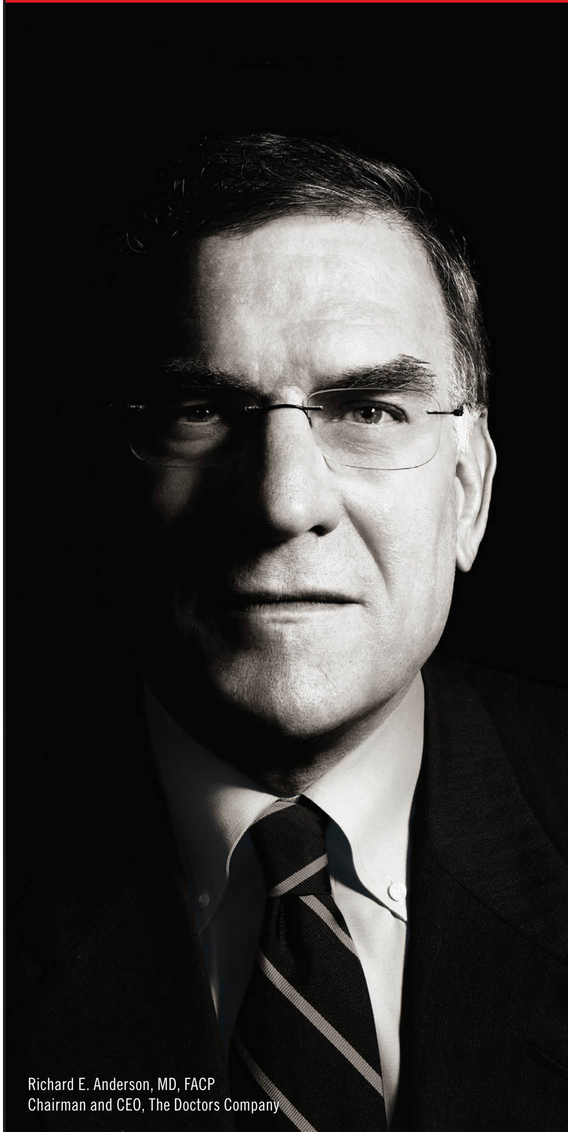
Prior to medical school, Benjamin worked as a research consultant with one of the nation's leading research and consulting firms addressing the organization and financing of health care for vulnerable populations. It was through this experience that Benjamin began to understand how he could impact health services for medically vulnerable populations and stirred his desire to become a physician leader.

Benjamin has also received the Albert Schweitzer Fellowship and he worked to create and implement a health and wellness curriculum for Urban Initiatives – an extracurricular program working with over 500 elementary students in some of Chicago's most underserved communities. Benjamin also recently began serving as a principal mentor to formerly homeless adolescents and young adults as part of a mentoring pilot program with Schweitzer Fellows For Life.

Benjamin is also a member of UIC's Urban Medicine (UMed) program, a unique 4-year medical school curriculum preparing physician-leaders to serve urban communities. Most recently, he was recently inducted into UIC's chapter of the Gold Humanism Honor Society, a national organization recognizing outstanding humanistic character and performance by medical students.

While completing his MBA curriculum, Benjamin was awarded the Grand Prize at UIC's campus-wide business competition for leading a management team in the creation of a business plan to establish a new faith-based community health center in Chicago's Humboldt Park community. Benjamin envisions combining his skills as an administrative leader and a family physician to provide accessible, high quality, and comprehensive care to those communities and patients who remain most in need.

Why choose between national resources and local clout?



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Government Relations

IAFP and Dept. of Insurance Partnership Delivers for Patients

In June of 2010, the Illinois Department of Insurance (DOI) announced a partnership with IAFP to help Illinois families who face medical-related disputes with their health insurance companies. Often, health insurance companies invoke rescissions and patients have no recourse. DOI recognized that medical expertise provided by IAFP's volunteer physicians would enhance the Department's ability to protect Illinois consumers. IAFP also served as an additional resource as the Department implemented the first wave of health insurance reforms of the federal Patient Protection and Affordable Care Act (PPACA). Once the contract with DOI was finalized, IAFP invited veteran leaders with medical record review expertise to review rescission files. Volunteers receive electronic files which meet HIPAA security requirements, review them and render an opinion.

Since November 2010, IAFP members have reviewed approximately 116 files. Here is a summary of just a few of the successfully overturned claims that have resulted from IAFP's volunteer efforts. The IAFP reviews have enabled the Department to challenge 27 complaints that would have previously been closed without further action. These consumers' lives have been positively impacted through our efforts:

A consumer was hospitalized for an extended period of time. Her insurance company claimed that some of the days were not medically necessary. After an IAFP physician reviewed the case and disagreed, the company changed its position and paid for the extra days, which amounted to $3,460.80.

Another consumer's insurance company decided that a medical procedure was incidental or not performed during surgery and refused to pay. After an IAFP physician reviewed her case, the insurance company paid for the procedure in the amount of $1,061.34.

After an IAFP physician reviewed a consumer's case, she was able to settle a complaint regarding a colonoscopy, which resulted in approximately $1,800.00 savings for the consumer.

Another consumer had a claim denied for a pre-existing condition. The IAFP reviewer disagreed with the determination. The Department requested the company have the file reviewed by an independent review organization, which resulted in a reversal of the claim denial. This resulted in payments over $8,000.00 and an additional savings for the consumer of $8,200.00 due to the discounts the insurance company receives.

Another consumer was denied a life insurance payment for the accidental death for her mother in the amount of $50,000. After the IAFP review, the Department challenged the insurer and the claim was paid.

At least two complaints involved consumers whose application for individual health coverage had been declined. After review by IAFP, both consumers were offered coverage.

While the Department will continue its efforts to protect consumers against health rescissions, state and federal law now prohibits this practice and DOI has experienced a dramatic decrease in these cases.

As Illinois is planning for its own health insurance exchange, the Department of Insurance is central to the process. From infrastructure development to implementation, DOI will work to ensure a collaborative process that benefits consumers, small business owners and providers. For more information about DOI's efforts, please visit their website http://insurance.illinois.gov/hiric/hie.asp

IAFP has shared its principles for a health insurance exchange (link to our statement at http://www.iafp.com/legislative/InsuranceExchangePrinciples.pdf) with the Department and will continue to work with all stakeholders in establishing an optimal exchange.

Governor names new acting Director of Insurance

Jack Messmore

Jack Messmore was appointed in June 2011. He has over 35 years of management and regulatory experience and has been with the Department for 25 years. He previously held the DOI positions of Chief Deputy Director; Deputy Director; Assistant Deputy Director; Supervisor; and Examiner-in-Charge.
While at the DOI, Jack has assisted with the authoring of several pieces of legislation relating to insurance regulation enacted by the Illinois Legislature. He has participated on many National Association of Insurance Commissioners (NAIC) committees, task forces and working groups, and has made formal presentations at numerous insurance conferences and seminars. Jack's private sector experience includes positions in senior management or a supervisory capacity with four companies in both insurance and non-insurance businesses.

IAFP joins the fight to lower obesity rates

Obesity continues to take its toll on America – our children and adults. The most recent statistics show Illinois with an unhealthy 28.2 percent obesity rate, with no state currently under 20 percent. In fact, no state had any reduction in obesity rates! The trend continues to go up, with dire consequences ahead if our collective society cannot get our weight back under control.

At the May Board meeting, the IAFP Board of Directors approved an action item from the Public Health Committee that IAFP support each of three policy goals of the Illinois Alliance to Prevent Obesity (www.preventobesityIL.org)

1. Increase access to retailers who serve and/or sell healthy and affordable food options.
2. **Develop state-level obesity prevention resources and infrastructure.**
3. Increase consumption of healthy food and beverages in relation to consumption of unhealthy food and beverages that have minimal nutritional value, such as sugar-sweetened beverages and calorie-dense, low nutrition fast foods.

We are looking for member input on goal #2. Specifically, what are our family medicine practices and/or their surrounding communities doing to prevent and address obesity in their patients? IAFP would like to contribute our family medicine best practices to the state level resources and infrastructure. Please send your best practices directly to vkeenan@iafp.com with "obesity" in the subject line.

Here are two members who recently shared their activities with IAFP.

Goutham Rao, MD of NorthShore University Department of Family Medicine is the lead author of a new Scientific Statement from the American Heart Association (AHA) that offers specific recommendations about how to address obesity with patients in busy out patient settings, which research shows physicians too often don't do. The statement is published in the current edition of Circulation, Journal of the American Heart Association. Rao and colleagues reviewed hundreds of medical reports and studies for the Scientific Statement, and provided recommendations that they said would help physicians engage patients and bring about behavioral change. Their recommendations include:

•When talking to patients about obesity, physicians should take an unhurried, non-judgmental approach. For example, they should use the term "weight" rather than "obese."

•Physicians should develop a specific plan of action that engages the patient in the plan rather than offering vague recommendations about losing weight.

•An extra but important step is assessing readiness to change among patients.

•Central planning and training should be incorporated in a collaborative approach involving physicians, nurses and other caregivers when dealing with obese patients.

Yasmeen Ansari, MD of Adventist GlenOaks Hospital and Wood Dale Family Medicine has taken on the role of a strong advocate in her community to fight the obesity epidemic. She has built two different programs in her community in the last few months. The first program includes a group of students from Addison Trail High School, where Dr. Ansari herself is a graduate. She sees them as a group and then individually to work on a different health topic at each meeting. Their discussions cover topics such as "Water intake: why do we need it?", "Sodas: what is the real story?" and "Exercise: how much, how often?" Dr. Ansari also reviews the student's food diaries and exercise logs at each visit. "The students have enjoyed our meetings and are truly starting to understand the importance of making small steps towards the big goal," she says. All the students who completed the program and maintained their food diaries and exercise logs will be honored at a September awards ceremony. Ansari has also replicated this program at the adult level in the local community resource center. "I believe these programs will have an effect on these individuals for a lifetime, as we are going over true lifestyle changes as opposed to quick fix diets."

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The 2011 IAFP Annual Meeting
November 11-12, 2011
Marriott Oak Brook Hotel

Continuing Medical Education

Make your plans now for the IAFP Annual Meeting. A complete rundown of events, details, and registration form is all on the meeting web page at http://www.iafp.com/Annual%20Meeting/index.htm and look for future informational emails a brochure in your mailbox in late September.
CME fees: $50 per day ($100 for both days) for IAFP members, $75 per day for non-members
If you have any questions, contact the IAFP staff at iafp@iafp.com or call Education Manager Kate Valentine at 630-427-8000.

Thursday November 10
6:00– 9:00 PM Welcome /PIN Reception – if you travel to Oak Brook on Thursday for Friday morning's early events, join us for a welcome reception and meet some of the Practice Improvement Network practices and ambassadors.

Friday November 11
8:00 AM-noon

- **Leadership Workshop** – required for IAFP committee chairs and board members. Any IAFP members, including resident and student members, are welcome to this seminar to learn more about the Academy, as well as develop general leadership skills that will serve you well in any organization or career plans!

- **SAMs Workshop on Pain Management** - Space is limited – sign up today! This event required separate registration and a $150 fee. Get this important Maintenance of Certification module off your to-do list in an engaging, small-group setting.

12:00 PM Lunch / Product Theater: Non-CME event on Diabetes

1:00-5:00 PM Afternoon CME and committee meetings- CME speaker information and course descriptions will be constantly updated on the web site. 9 CME Credits available. *Application for CME credit has been filed with the American Academy of Family Physicians.* ***Determination of credit is pending.***

Clinical Track
-Medical Management of Patients with Schizophrenia and other Psychotic Disorders in Primary Care
-Colorectal Cancer Screening for the Family Physician

-Managing Asthma in Primary Care
-Updates in Contraception

Practice Management Track
-Diabetes Group Visit
-Risk Management
-Coding Workshop: Ask the Experts

Committee Meetings
1pm Family Med Educators and Finance
3pm Government Relations

5:30 PM Product Theater: Non-CME event on Pain Management

Family Fun options - learn more about each event at http://www.iafp.com/Annual%20Meeting/familyfunschedule.pdf

10:00am - Story Time at Barnes & Noble - Oakbrook Center
1:00 pm - IAFP Family Pool Party- your family can join IAFP family members for a beach-themed pool party at the Marriott pool. *No lifeguards on duty – parents are solely responsible for the safety of their children.*
7:00 pm – Two options at Oakbrook Center
-Build-a-Bear Workshop
-Thanksgiving Dinner Cooking Demonstration at Williams-Sonoma

Saturday November 12

6:30 AM Fun Run / Beat the President (open to members and families): Get your running gear on and meet us out front of the hotel for a short run around the Oakbrook Center complex! See if you can beat IAFP president David Hagan, MD who is an avid distance runner. Certificates and bragging rights for finishing before he does!

8:00 AM All Member Assembly will convene to swear in the 2011-12 IAFP board members and officers, as well set the Academy's agenda for the following year. If you have an idea for a resolution to consider, submit it to IAFP executive vice president Vincent D. Keenan, CAE by September 29th at vkeenan@iafp.com. We will also honor AAFP Fellows who elect to have their convocation at our annual meeting.

10:00 AM-5:00pm CME Offerings

Clinical Track
- Improving Major Depressive Treatment Outcomes: Tailoring Strategies for Remission
- Patients at Risk: Improving Pneumococcal Immunization Rates in the Patient-Centered Medical Home
- The Primary Care Management of Patients with Gout
- Coronary Artery Disease

Practice Management Track
- Practice Improvement Network's Quality Improvement in Small Practices
- Surviving in a Solo/Small Practice during Healthcare Reform
- Office Redesign for Chronic Illness Care
- Implementing an EHR to Qualify for Stimulus Funds and Prepare for Healthcare Reform

Committee Meetings

10am - Public Health

2pm – Practice Transformation and CME

10:00am – noon: Resident Fellowship Fair

Residents won't want to miss this incredible networking opportunity to investigate fellowship and employment possibilities from around the state. Fellowship programs and employers should contact Ginnie Flynn at gflynn@iafp.com or 630-427-8004 if you'd like to participate in this event.

New this year: Members showcase area!

Do you have a side business or a product that you've created? This is your opportunity to share it with your family medicine friends. Bring your samples, information and enthusiasm and we'll have a special section of the IAFP exhibit hall FREE for members to showcase their entrepreneurial side! More information and a participation form is on the web site at http://www.iafp.com/Annual%20Meeting/MemberVendorFair.pdf or contact Ginnie Flynn to sign up.

12:00 PM Awards Luncheon

Celebrate family medicine's finest at our awards luncheon to honor the Family Physician of the Year, Family Medicine Teachers of the Year and President's Award honorees. Free for members, fees apply for non-member guests.

5:30 PM Board Meeting

Second Annual ABC Conference November, 18 2011

University of Chicago Gleacher Center

The ABC (Autism, Behavior, Complex Needs) Conference is a day-long event that supports primary care to improve the lives of children in need. Please save the date and share this information with your colleagues.
To register, visit: http://give.almosthomekids.org/register

- Autism
- Behavior
- Complex Medical Needs

Supporting primary care to improve the lives of children in need

The conference will cover topics such as building parenting skills for families in difficult times; autism treatments; structuring the office visit for children with autism; forming healthy attachments; prevention of mood disorders and sleep disturbances; coding for complex children; state and federal medical assistance plans; transition into adulthood; and use of developmental screening tools.

For more information, visit http://illinoisaap.org/about/committees/committee-on-children-with-disabilities/

Mary Pohlmann, MD
Retired family physician
Former Carbondale
City Councilwoman

Why did you choose family medicine?
I always wanted to be a doctor, but I got married at 18 and had two children by age 20. I became a biology teacher and got my master's and Ph.D. I was working part-time as a researcher at the Family Practice Center in Carbondale, evaluating the residency program. My other part time job was at MedPrep, which helps underrepresented students get into medical school. I was in my 30s at the time, and ended up working full time with MedPrep while continuing to get my medical care at the Family Practice Center, essentially establishing my medical home there. So I knew if I got the opportunity to go to medical school, I would be a family physician because I got such good role modeling at the Family Practice Center.

The greatest thing about being a family physician
I think the greatest thing is taking care of the whole patient and not just an organ system… knowing about all the issues – not just for the patient, but for the family. Even though I'm retired, I still get a lot of questions from people about health. And they'll tell me they are seeing this doctor for this, and that doctor for that. I tell them "It sounds like you need a family doctor to help you manage all these issues." I'm a great advocate for family medicine and pushing people to see a family physician.

If you weren't a doctor, what would you be doing?
I'd probably still be a teacher.

What are the Academy's best resources or services?
The American Academy's web site and journals are just outstanding. That's where I get my CME, and the patient education resources are wonderful. At the state level, I think our political advocacy is so important. And prior to my involvement in the Smoke-free Carbondale campaign, I don't think I fully understood that!

How did you get to be chair of Smoke-Free Carbondale?
I was just recently retired, and the Jackson Co. Health Department held a press conference about the smoke-free initiative and the U.S. Surgeon General's report on secondhand smoke. I thought, "With that kind of evidence, we need to do something!" I had been on the Jackson County Board of Health for 20 years. I didn't have the political restrictions of a 501(c)3 organization, and I had the additional credibility of being a family doctor. And since I was retired, they knew I had the time! I'm so glad I did it. I think it's the most important thing I've done to affect the health of the population.

Your journey to the Carbondale City Council
It was funny, because people said I was a one-issue candidate, but at least you knew exactly where I stood. People kept saying I would lose votes because of that issue. I figured if I got knocked out in the primary, then there's my message. But I did very well! [Pohlmann was elected in 2007 with the 2nd highest vote total for the three available council positions. She is not running for re-election this year]. Now that I'm not running re-election, I got so many calls from many of the candidates seeking my advice on how to run a campaign! I was free to offer my support to candidates that I felt could best represent my views.

On her swimming lifestyle
I've been swimming since I was nine months old! In medical school I was swimming regularly at the YMCA and was invited to join the Masters swim team. So I started with them and competed in the YMCA Masters national championships that year (1984). Then I joined U.S. Masters Swimming and competed in the 1985 USMS National Championship and have competed in just about every national championship since. My best stroke is the backstroke. I took third place in my age group in the 2010 Worlds Masters swim championship in Sweden!
EDITOR'S NOTE: Pohlmann competed in the U.S. Masters Swimming Summer National Championships at Auburn University the week of Aug. 1st. There she won the 800 meter freestyle and 400 meter individual medley, took second in the 400 meter freestyle and third in the 50, 100 and 200 meter backstroke events for 65-69 year old women. Her times in the three backstroke events were all new Ozark regional records.

Dr. P. to the rescue
Kenneth Hook from Ohio was competing in a meet in Louisville, Ky in 2007. He and Mary had just finished a heat in the 200-Individual Medley when Hook collapsed in the stands. Mary, along with other Masters swimmers who are health care professionals provided CPR. "We were fortunate to have an AED available on site there. We used it at least six times before the ambulance arrived. In 2009 Kenneth was back competing at the National Championships." Since then, Mary has been an advocate for AEDs in public facilities, including her church.

Currently Dr. Pohlmann is deploying the Map Your Neighborhood program, which is a disaster-preparedness program for neighborhood groups. Fifteen to 20 homes get together and plan to take care of each other and be self-sufficient in the first 72 hours after a disaster when emergency services are overwhelmed. With the support of the City of Carbondale, she has been training others to prepare their own neighborhoods. "It's my next thing," she says. Learn more at http://ci.carbondale.il.us/?q=node/479

Members in the News

Marie McCarthy, MD was selected to receive a 2011 Pfizer Teacher Development Award based on scholastic achievement, leadership qualities and dedication to family medicine. She is one of 16 recipients from across the country honored by the American Academy of Family Physicians Foundation for her commitment to education in the field of family medicine. Dr. McCarthy is currently a part-time instructor at the Saints Mary and Elizabeth Family Medicine Residency Program.

Chet Robson, DO has been named regional director of medical informatics, ambulatory systems for Adventist Midwest Health. He is responsible for the implementation, training and support of the system's electronic health records system. Robson will continue to practice part time at Family Medicine Center in Woodridge.

The UIC Divisions of Specialized Care for Children recognized IAFP member **Quincy Scott, DO** as a DSCC **Champion for Children** on July 18. He was nominated by DSCC staff for his efforts to provide a medical home for children with special health care needs. This award recognizes various individuals in communities around the state who - in an official capacity representing their agency/institution - have partnered with DSCC staff to improve outcomes for children with special health care needs.

Steven Rothschild, MD of Chicago authored a letter to the editor in the Aug. 6 *Chicago Tribune* to challenge the perception that all individuals are responsible for their poor health. Rothschild reinforced the importance of public health education to help tackle all the factors that contribute to poor health status in our communities.

Jennifer McGowen, MD of Woodridge and her son, Jack, were featured in an Aug. 11 *Hinsdale Doings* story about Jack's Eagle Scout project where he created comfort blankets for the Adventist Hinsdale Hospital Emergency Room to hand out to young children and seniors in the emergency room to help ease the anxiety of an emergency. Proud mom Dr. McGowen is a family physician at the hospital.

Also on August 11, **Michael Ward, MD** offers patient education about the need for African Americans to prevent and also be screened for skin cancer in the TribLocal Tinley Park edition. Ward explains that darker skin does not exclude African Americans from risk.

Bryan Albracht, MD of Springfield reminds men that they do indeed need to go to the doctor. His patient education column in the Aug. 17 *State Journal-Register* and BeHealthySpringfield.com web site gives practical advice on what checkups and screenings men need at different intervals at different ages. The column was also picked up by an additional 18 Illinois newspapers and even one in Massachusetts.

MetroSouth family physicians have been busy touting the benefits of primary care and family physicians in the south suburban issues of the TribLocal during the month of August. IAFP found articles with patient education quotes from **Barbara Bellar, MD**; **Catherine Lindsay, MD** and 2010 IAFP President's Award honoree **Yves-Mario Piverger, MD**.

Kim Hanneken, MD of Decatur was part of a mothers and families event at Scovill Zoo about breastfeeding in conjunction with World Breastfeeding Week in early August. The event was covered by the Aug. 5th *Decatur Herald and Review*.

The July issue of *Chicago Parent Magazine* includes their list of Chicago's Top Kids Doctors, as nominated by their readers. They listed 308 physicians in 21 specialties and 14 of the 17 family physicians are IAFP members. Congratulations to **Lara Ellison, DO** of Naperville, **Amy Buchanan, MD** of Maywood, **Marina Claudio, MD** of Chicago, **Charles Crotteau, MD** of Chicago, **Paul Kungl, MD** of Oak Park, **Charles Lin, MD** of Bloomingdale, **Deborah Manus, MD** of Oak Park, **Kathleen Rowland, MD** of Chicago, **Marian Sassetti, MD** of Oak Park, **Paul Schattauer, MD** of Oak Park, **Gina Schueneman, DO** of Chicago, **Robin Uchitelle, MD** of River Forest, **Lise Weisberger, MD** of Chicago and **Shawn Youngs, MD** of Wheaton.

IAFP CME Committee chair **Jim Valek, MD** is quoted in a July 11 *American Medical News* article about the challenges of hiring part-time physicians in a small practice. Dr. Valek owned a small practice until recently selling it to Little Company of Mary Hospital.

Northwestern-University Family and Community Medicine and resident **Beth Dunlap, MD** were featured in the *TribLocal-Evanston* for their innovative community garden project in the nearby Humboldt Park neighborhood of Chicago. Dunlap is a co-leader of the project. Along with a large main garden on land owned by Norwegian American Hospital, the project has created 80 gardens for Humboldt Park families along with 10 community organizations in the hopes of creating healthier food choices and supplying healthy food to local food pantries.

Joe Welty, MD of Dixon authored a July 8th letter to the editor in the *Sauk Valley News* congratulating the community on the 12th annual Reagan Run for the important health contribution to the community.

IAFP members provided excellent patient education to local papers on surviving and taking proper precautions during the summer heat wave.

-**Lisa Liu, MD** and **Thomas James, MD** were featured in the July 20th *TribLocal-Hinsdale*. Dr. Liu addressed sunscreen and skin protection while Dr .James handled issues in preventing and treating heat exhaustion.

-**Scott Morcott, MD** of Arlington Heights was featured in a Daily Herald story about runners who continue to train in extreme heat. Dr. Morcott emphasized taken every precaution, revealing that he lost a friend who died during a South Carolina triathlon in extremely hot conditions.

Tony Miksanek, MD of Benton, Illinois has an essay titled, "Seven Reasons Why Doctors Write," in the July issue of *Minnesota Medicine*. The article can be accessed at www.minnesotamedicine.com.

Sunshine Act Mandates Public Reporting of Payments by Drug, Medical Device and Medical Supply Manufacturers to Physicians

News You Can Use

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The Physician Payment Sunshine Act, enacted into law as part of the Health Care Reform package in 2010, will require the tracking and reporting to the government of payments made on or after January 1, 2012 by drug, medical device and medical supply manufacturers to physicians and teaching hospitals. Manufacturers will be required to file with the government annual reports reflecting payments made in the prior calendar year. The first set of reports, for the calendar year 2012, will be due on March 31, 2013. The new requirements are very broad in scope, applying, with certain exceptions, to any payments or transfers of value of $10 or more. The Sunshine Act will also require the annual disclosure of any financial or ownership interest that physicians (or their immediate family members) have in manufacturing companies and "applicable group purchasing organizations" ("GPOs") that purchase, arrange for the purchase or negotiate the purchase of drugs or medical supplies. The Sunshine Act also requires that the secretary of Health and Human Services ("HHS") establish a website that will make the reported information readily available to the public no later than September 30, 2013. In recent years, the Office of Inspector General ("OIG") of HHS has investigated numerous companies that allegedly used consulting agreements or other payments to physicians to influence medical decision making. The Sunshine Act will undoubtedly cause renewed focus on any financial relationships between manufacturers and health care providers. Manufacturers of drugs, medical devices and medical supplies should carefully scrutinize any payments to, or consulting agreements with, health care providers to ensure that they do not run afoul of the federal anti-kickback statute.

Payments and Transfers of Value
The new reporting requirements apply to manufacturers of drugs, devices, and biological or medical supplies that are reimbursable under Medicare, Medicaid or the Children's Health Insurance Program. The reporting requirements also apply to an affiliate of a manufacturer if it is under common ownership with the manufacturer and if the affiliate provides assistance and support services to the manufacturer with respect to a reimbursable drug, device or supply. The statute applies to payments or transfers of value to physicians, as well as teaching hospitals. Physicians who are employed by the applicable manufacturer are excluded.
All payments and transfers of value must be reported, with the following exceptions:

A transfer of anything less than $10, unless the aggregate value of items transferred in a year exceeds $100
Product samples that are not intended to be sold and are intended for patient use
Educational materials that directly benefit patients or are intended for patient use
The loan of certain medical devices for a period not to exceed 90 days, to permit evaluation of the device by the recipient
Items or services under a contractual warrantly
A payment or transfer of value to a physician who is a patient
Discounts and rebates
In-kind items used for the provision of charity care
A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund
Payments for the provision of health care to employees under a manufacturer's self-insured plan
Payments or transfers of value solely for nonmedical professional services
Payments or transfers of value for services of a physician with respect to a civil, criminal or administrative matter

The required reports, filed electronically with the government, must include the following information for each reported payment or transfer of value:

- The name of the recipient
- The business address of the recipient and, for each physician who is a recipient, the specialty and National Provider Identifier of the physician
- The amount of the payment or other transfer of value
- The date on which the payment or transfer of value was provided to the recipient
- A description of the form of payment or transfer of value (e.g., cash or cash equivalent, in-kind services, stock, etc.)
- A description of the nature of the payment or transfer of value (e.g., consulting fees, honoraria, gift, research, etc.)
- If the payment or transfer of value is related to marketing, education or research specific to a drug, device or supply, the name of the drug, device or supply
- Any other categories of information that the secretary of HHS deems appropriate

Physician Ownership
Manufacturers and GPOs must report the following information regarding any ownership interest or investment interest held by physicians or the immediate family members of physicians:

The dollar amount invested by each physician holding an ownership or investment interest
The value and terms of each such ownership or investment interest
Any payment or transfer of value provided to a physician holding such an ownership or investment interest
Any other information regarding the ownership or investment interest that the Secretary of HHS deems appropriate
A physician's ownership or investment interest in a publicly traded security or mutual fund is exempt from these reporting requirements.

Penalties

Failure to file a timely report is subject to a civil monetary penalty of not less than $1,000 but not more than $10,000 for each payment, transfer of value or ownership interest not reported, up to a maximum total penalty of $150,000 per annual submission.

"Knowingly" failing to submit information required in a timely manner is subject to a civil monetary penalty of not less than $10,000 but not more than $100,000 for each payment, transfer of value or ownership interest not reported, up to a maximum total penalty of $1 million per annual submission.

Publication

No later than September 30, 2013, and on June 30 of each calendar year thereafter, the information submitted by the applicable manufacturers and GPOs for the preceding calendar year will be made available to the public through a format that is "searchable and is in a format that is clear and understandable." The Sunshine Act provides for the delayed publication of payments and value transfers that are made pursuant to certain product research or development agreements and clinical investigations.

Implementation

By October 1, 2011, the secretary of HHS is required to establish and publicize the procedures for manufacturers and GPOs to submit the required information.

Preemption of State Laws

A number of states, including California, Maine, Massachusetts, Minnesota, Nevada, Vermont, West Virginia and the District of Columbia, have statutory requirements that either restrict payments to health care professionals or impose disclosure requirements.

The Sunshine Act will preempt any state statutes or regulations mandating reporting of the same type of information with respect to payments or transfers of value received on or after January 1, 2012. The Sunshine Act will not, however, preempt state statutes or regulations imposing different or more stringent reporting requirements.

Practice Tips

The Sunshine Act should serve as a wake-up call to drug, medical device and medical supply companies regarding any payments to, or consulting agreements with, health care providers. In recent years, the OIG has scrutinized consulting agreements and other payment arrangements with physicians and brought enforcement actions against companies when the consulting agreements or payments appeared to run afoul of the anti-kickback statute. The Sunshine Act will place renewed focus on the legitimacy of such payments or consulting agreements.

The new law will result in the public disclosure of even nominal payments or transfers of value made by drug and medical device and supply manufacturers to physicians and teaching hospitals. Prior to January 1, 2012, companies need to reassess their practices to determine whether some payments or transfers of value, even if relatively nominal, should be discontinued to avoid negative publicity that may result from such payments.

The Sunshine Act is focused on companies that manufacture covered drugs, devices, and biological and medical supplies and that operate in the United States. The Sunshine Act also applies to "any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply." The Sunshine Act leaves open a number of questions, including, for instance, whether companies that are not manufacturers, but are developing products that are intended for license to or are licensed by manufacturers, have a reporting obligation under the Sunshine Act. Ongoing review by counsel is recommended as HHS and the courts provide more guidance as to the scope of the Sunshine Act.

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